An EMDR Therapy Primer
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An EMDR Therapy Primer

From Practicum to Practice

SECOND EDITION

Barbara J. Hensley, EdD
EMDR Primer: From Practicum to Practice

Barbara J. Hensley, EdD
Second edition

Springer Publishing Company, LLC
11 West 42nd Street
New York, NY 10036
www.springerpub.com

Acquisitions Editor: Sheri W. Sussman
Composition: Newgen KnowledgeWorks

ISBN: 978-0-8261-9454-1

15 16 17 18 / 5 4 3 2 1

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Library of Congress Cataloging-in-Publication Data
Hensley, Barbara J.
pages cm
Revision of: EMDR primer. 2009.
Includes bibliographical references and index.
1. Eye movement desensitization and reprocessing. I. Title.
RC489.E98H46 2016
616.85'210651—dc23
2015014956

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11 West 42nd Street, 15th Floor, New York, NY 10036–8002
Phone: 877–687-7476 or 212–431-4370; Fax: 212–941-7842
E-mail: sales@springerpub.com

Printed in the United States of America by McNaughton & Gunn.

www.allitebooks.com
To Francine Shapiro,
creator of EMDR Therapy, a ripple in still water,

and to Robbie Dunton, Scott Blech, and Robert Gelbach;
and
Irene Giessl, Jennifer Lendl, Victoria Britt, Marilyn Schleyer, Kay Werk, Zona Scheiner, Deany Laliotis, Katy Murray, and Rosalie Thomas in honor of your dedication and commitment to EMDR Therapy.

And to all the clinicians and clients who have been caught up in the wave, creating ripples of their own.

A single act does make a difference … it creates a ripple effect that can be felt many miles and people away.

—Lee J. Colan (Orchestrating Attitude, 2005)

Fear will make you stand still.

—Sibu Janardhanan (Personal Conversation, November 2014)
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Although Dr. Francine Shapiro’s now-famous walk in the park took place in 1987, the first Eye Movement Desensitization and Reprocessing (EMDR) study was published 2 years later in 1989. The EMDR community celebrated its 25th anniversary at the EMDR International Association (EMDRIA) Conference in Denver, Colorado, in 2014. Today, 26 years later, there are trained EMDR therapists around the world. The efficacy of EMDR Therapy has been demonstrated repeatedly, and it is included as the treatment of choice by mental health groups in the United States (American Psychiatric Association, 2004; Department of Veteran Affairs and the Department of Defense, 2004; SAMHSA, 2011) and abroad (Australian Centre for Posttraumatic Mental Health, 2007; Bleich, Kotler, Kutz, & Shaley, 2002; Clinical Resource Efficiency Support Team [CREST], 2003; United Kingdom Department of Health, 2001; World Health Organization, 2013). We have come a long way!

BACK HISTORY

In the summer of 1989 in San Jose, California, there was a brown-bag luncheon for therapists sponsored by the Giaretto Institute. The guest speaker was an unknown psych intern who presented a case with video clips showing work with a client who was a Vietnam War veteran. As Dr. Shapiro explained her method of treatment from her recently published dissertation (Shapiro, 1989a, 1989b), there was a lot of eye-rolling and uncomfortable shifting in chairs. Then she showed the video. The audience quieted. She had our attention. The client was changing before our eyes. We were
witnessing the rapid processing of trauma but did not understand why it was happening.

In the winter of 1989, the Santa Clara County Psychological Association held a special trauma response meeting for earthquake debriefing. After my presentation (Lendl & Aguilera, 1989), Dr. Shapiro approached me and invited me to her upcoming training. She was looking for trauma-trained community therapists to join her “EMD” team. EMD was considered at the experimental stage, but she wanted to start judiciously training as research proceeded. She did not think it was ethical to withhold treatment when it seemed to alleviate suffering so quickly and thoroughly. In the spring-summer of 1990, the first U.S. EMD training began.

At the 2002 EMDRIA Conference in Coronado, California, I met Dr. Barbara Hensley, who was in her first year on the EMDRIA Board and serving as treasurer. I was immediately impressed by her dedication to EMDR and her no-nonsense work ethic. She was the epitome of the EMDR Therapist. Dr. Shapiro encouraged us all to become

utilizing all her talents to benefit EMDR and her community.

Dr. Hensley had spent 30 years mostly in management for the State of Ohio and honed the ability to pinpoint needs, harvest resources, and bring solutions to fruition. With her colleague, Dr. Irene Giessl, she founded the multidisciplinary Cincinnati Trauma Connection practice with its roots in EMDR. They are Regional Coordinators for their fellow EMDR therapists and for many years have sponsored top specialty trainings in their community. Dr. Hensley served a term-and-a-half as EMDRIA Board president during a very difficult reorganization period. She did it quietly, gracefully, and masterfully. Despite her shyness, one of her personal goals as president was to meet as many of the EMDRIA members as possible. She wanted everyone to feel welcome and part of the EMDR community.

When I asked her why she wanted to write this primer, Dr. Hensley confessed that it was not her intention to write a book. She was becoming aware that many people who were trained in EMDR were hesitant to continue training or use EMDR in their practices. When questioned, they often stated that they were afraid to try such a different, “a possibly dangerous” method. She thought that a few examples might be useful. Voila! A book was born. She also said, “I wanted to make a contribution. I don’t think you can do enough for EMDR…It has changed so many lives.”

It has been my pleasure and honor to be on the editing team for this book. I believe that Dr. Hensley has written a book that is simple, basic, and can mentor therapists who are EMDR trained and yet intimidated. It is the perfect complement to Dr. Shapiro’s text (Shapiro, 2001). Learning EMDR Therapy can be likened to learning a language. Having a strong foundation in grammar helps many years down the line. Ever since my Catholic grammar school education stressed diagramming sentences and studying Latin, I have appreciated the necessity for laying a strong foundation in the understanding, maintenance, and facile utilization of learned information. The importance of going back to basics cannot be overemphasized. Beyond
the therapeutic relationship, a thorough understanding and meticulous use of the EMDR methodology will nurture the best EMDR treatment and therefore the greatest therapeutic effects when applied appropriately. This book brings us back to the basics.

I can see EMDR therapists rereading Dr. Shapiro’s book chapter by chapter as they move through Dr. Hensley’s Primer. And I can hear what Dr. Shapiro would say to us after every training, “Did you learn something? Are you having fun?” Please keep this in mind as you are reading the Primer.

Jennifer Lendl, PhD

REFERENCES


Preface

We are what we repeatedly do. Excellence, then, is not an act but a habit.
—Aristotle

TUNING INTO THE CREATIVE FORCE

Sit back and visualize the small but exciting moment in 1987 when Francine Shapiro became aware of her eyes shifting involuntarily and simultaneously back and forth as she focused on some disturbing events in her life. If she had not stopped to notice the relief she felt as a result of this back-and-forth movement of her eyes, the long and successful journey of Eye Movement Desensitization and Reprocessing (EMDR) Therapy could have ended that fateful day. Dr. Shapiro’s visionary and creative spark began a quiet revolution in the field of psychotherapy—a ripple in still water.

In his book *Creativity: Flow and the Psychology of Discovery and Invention*, Mihaly Csikszentmihalyi distinguishes between what he defines as “small-c” and “big-C” creativity as he describes how creative individuals influence their respective fields and domains of knowledge. While small-c creativity is somewhat subjective, Csikszentmihalyi states that big-C is the kind of creativity that drives culture forward and redefines the state of the art (1997).

Francine Shapiro belongs to a select group of big-C creators in our world. Small-c creativity involves personal creativity, while big-C requires the type of ingenuity that “leaves a trace in the cultural matrix” (Csikszentmihalyi, 1997), something that changes some aspect of how we view or treat something in a big way. Anyone who has conducted a successful EMDR reprocessing session or has experienced its results firsthand can attest to the expanding ripples that Dr. Shapiro began and that continue to grow as we progress further into the future.
Many of you have repeatedly heard the story of Dr. Francine Shapiro’s historic walk in Vasona County Park in Los Gatos, California, in 1987. While taking a walk, she noticed that the disturbing thoughts upon which she was focusing about a recent past traumatic event in her life were suddenly disappearing. When she tried to bring them back up, these thoughts did not seem to her to have the same negative charge or significance that they had at the beginning of her walk. She began to pay careful attention, and what she noticed when a negative thought went through her mind was that her eyes began to move spontaneously in a rapid, diagonal movement. Her thoughts had shifted; and, when she tried to bring them back up, they did not have the same charge.

It was during this famous walk that Dr. Shapiro discovered the effects of spontaneous eye movement and began to develop procedures around the effects of bilateral eye movements. In 1989, she published the first controlled outcome study of EMD and PTSD in the *Journal of Traumatic Stress* (1989a). During this same year, controlled studies were also published on exposure therapy, psychodynamic therapy, and hypnosis for the treatment of PTSD. In 1990, Dr. Shapiro changed the name of EMD to EMDR to recognize and acknowledge the comprehensive reprocessing effect that was taking place. It was also during this time that other forms of bilateral stimulation (tones, taps, or music) were recognized as having the same effect and began to be utilized as an alternative to the preferred eye movement. Table 1.2 briefly describes EMD and EMDR.

From the day of her fateful walk in Vasona County Park in Los Gatos, California, Dr. Shapiro’s destiny began to change. Excited by her chance revelation, she leapt into action, finding friends and subjects to test her new discovery. She quickly set out to develop well-structured principles, protocols, and procedures around the effects of eye movements based on the consistent treatment results she and others had observed. She trained interested and excited clinicians who in turn encouraged others to learn this new methodology. The big-C ripple mounted as the first controlled study of EMDR Therapy appeared in the *Journal of Traumatic Stress* in 1989. Other studies were soon to follow, and the rest is history. Dr. Shapiro’s big-C creativity changed and continues to change the way trained clinicians conceptualize and treat trauma. EMDR Therapy has redefined the state of the art in terms of mental health.

The big-C ripple now encompasses the world many times over—from North to South America, Africa, Europe, India, China, Japan, and Australia. It continues to grow and multiply along with many new ripples that are created every day as clients and clinicians around the world experience for the first time the power of Dr. Shapiro’s personal discovery.
WHO COULD BENEFIT FROM READING THIS PRIMER?

EMDR is a powerful therapeutic approach. However, without the proper training and consultation, an untrained therapist (and this includes very experienced clinicians) could put their clients at risk. A goal of this Primer is to target those clinicians who have completed the EMDR Therapy two-part basic training, 10 hours of supervised consultation, and have read Dr. Shapiro’s basic text (*Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols and Procedures*, Second Edition, 2001) and *Getting Past Your Past* (2012), but still want additional information on using it skillfully. They may have experienced fear or apprehension about trying something so new and different or they may simply want to maximize their preparation and skills as they begin using EMDR Therapy.

In consultation groups, clinicians often report being skeptical before EMDR Therapy training, yet amazed by their practicum experiences during the training. Although they concede that using EMDR Therapy has a great potential to help their clients, many still feel a reluctance to utilize what at first appears to be a radically different treatment approach. Some live in remote areas where they are the only EMDR-trained clinician for miles or where their only access to other clinicians is by boat or airplane. I hope this Primer encourages and raises the confidence levels of those trained but wanting to increase their ability to use EMDR Therapy with consistent success. I also want to provide assurance to those doing EMDR Therapy that they are on the right track.

Learning to implement EMDR reprocessing in session with a client is a process of its own; it is not an event. Thus, it is important to understand the basic theory underlying EMDR Therapy before attempting to implement it. The manner in which you as the therapist implement the eight phases with a client will vary with each and every client assessed for treatment. Every client is unique, and EMDR reprocessing is not a “cookbook” approach. Therefore, familiarity with Dr. Shapiro’s Adaptive Information Processing model is crucial to enhance your understanding as to why some clients make shifts readily and others experience more difficulty. As you become more adept, comfortable, and knowledgeable in EMDR Therapy with *practice, practice, practice*, your EMDR Therapy approach and delivery will likely change and evolve. Each client can teach you something about the process as he or she resolves his or her own issues.

WHAT IS INCLUDED

Much of the information contained in the following pages has already been described by Dr. Shapiro and others in the rapidly growing body of EMDR Therapy literature and research. The primary intention of this Primer is to supplement Dr. Shapiro’s explanation of EMDR Therapy. It is not meant to be a substitute for her training or previous writings. The reader is urged
to read and study them all. It adds case histories and extensive examples of successful EMDR reprocessing sessions. The cases represent composite or conglomerate portraits of the many clients with whom I have utilized EMDR Therapy over the past 20 years.

This text is a Primer and, as such, the writing, examples, and illustrations are presented in a less formal and more personal manner, alternating the pronoun “he” and “she” throughout the book. The Primer has been written from a practical, learning-focused approach so that the clinicians who read it can become more familiar with the principles, protocols, and procedures of EMDR Therapy. It is my desire to facilitate the flow of information so that clinicians can easily and naturally begin to use their EMDR Therapy training as soon as possible. This book is also geared to help clinicians reaccess information that was lost in the weeks, months, or years since they were trained.

PURPOSE OF THE PRIMER

Throughout this Primer are transcripts embellished with relevant details to illustrate important learning points. Other sessions have been created to demonstrate how to identify the touchstone event (if any), set up the procedural steps, deal with blocked processing and blocking beliefs during the Desensitization and Installation Phases, reassess the state of previously targeted material, and identify material for new processing. An attempt is made to take the clinician through complete and incomplete EMDR Therapy sessions, explaining treatment rationale at given points.

The Primer is laid out in the following manner:

- **EMDR Therapy overview**: A straightforward explanation of the Adaptive Information Processing model, the three-pronged approach, the types of targets accessed during the EMDR process, and other relevant information to assist in distinguishing EMDR Therapy from other theoretical orientations are provided.
- **Eight phases of EMDR Therapy**: The eight phases are summarized.
- **Stepping stones to adaptive resolution**: The components of the standard EMDR protocol used during the Assessment Phase are explained, and actual cases are included to demonstrate how the procedural setup is possible with various clients.
- **Building blocks of EMDR Therapy**: The foundation—past, present, and future—is assessed in terms of appropriate targeting and successful outcomes.
- **Abreactions, blocked processing, and cognitive interweaves**: Strategies and techniques for dealing with challenging clients, high levels of abreaction, and blocked processing are the focus.
- **Past, present, and future**: Actual cases demonstrate various strategies to assist the client in reaching adaptive resolution of trauma.
The definitions for EMDR Therapy provided by the EMDR Institute and EMDR International Association (EMDRIA) are also included in the Appendices. These definitions, particularly the one developed by EMDRIA for clinicians, are the yardsticks used to ensure that the explanation and rationale for EMDR Therapy remain consistent from session to session, client to client. In order for clinicians to experience more comfort and familiarity with EMDR Therapy, it is suggested that they keep these definitions close at hand and refer to them frequently until an adequate understanding of the methodology is attained.

A Sacred Space exercise has been added to the Appendices, which can be used side by side with the traditional Calm (or Safe) Place exercise. Simple exercises to teach clients grounding, diaphragmatic breathing, and anchoring in the present can also be found in the Appendices. In addition, scripts for calm (or safe) place, spiral technique, future template, and breathing shift are also included.

The purpose in writing this book is to offer a Primer that can facilitate the process of mental health professionals becoming more confident and experienced clinicians in EMDR Therapy. The process has been simplified as much as possible with diagrams, tables, and other illustrations. Dr. Shapiro’s basic text, *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols and Procedures*, Second Edition, is a masterpiece in itself and contains a wealth of information on EMDR. One needs to read her text over and over again to savor all the kernels of significant information. These kernels have been separated out by providing explanations, as well as anecdotal and illustrative examples throughout. EMDR Therapy is a significant contribution to psychology in the 20th and 21st centuries, and this Primer is offered as a further learning tool.

What is covered in this Primer is but the tip of the iceberg when it comes to all the possibilities in terms of using EMDR Therapy with clients that present from different populations, such as children, athletes, combat veterans, and couples, and those who present with more complex issues, such as dissociation, phobias, obsessive-compulsive disorder, and substance abuse. Regardless of the client populations or the types of issues that the client brings, the basics in this Primer are essential to the overall outcome and success of EMDR Therapy.

**EMDR THERAPY**

At the 2014 Annual EMDRIA Conference in Denver, Colorado, and as the new name of this Primer reflects, Dr. Francine Shapiro encouraged clinicians in attendance to begin referring to EMDR as EMDR Therapy to reflect its status as a unique, integrative psychotherapeutic approach, and to further clarify that EMDR, based on the Adaptive Information Processing model, is a therapy and not a technique. The following letter by Dr. Shapiro (2014)
was sent to the membership of EMDRIA to further explain her rationale for
the name change:

__________________________

Eye Movement Desensitization and Reprocessing
(EMDR) Therapy

As you may know, the World Health Organization (WHO) new practice
guidelines have indicated that trauma-focused Cognitive Behavioral
Therapy (CBT) and EMDR Therapy are the only psychotherapies
recommended for children, adolescents and adults with PTSD. In
addition, the glossary description in the document alleviates multiple
misconceptions:

World Health Organization (2013). Guidelines for the management of con-
ditions that are specifically related to stress. Geneva, WHO.

Eye movement desensitization and reprocessing (EMDR): This therapy is
based on the idea that negative thoughts, feelings and behaviors are the
result of unprocessed memories. The treatment involves standardized
procedures that include focusing simultaneously on (a) spontaneous
associations of traumatic images, thoughts, emotions and bodily sensa-
tions and (b) bilateral stimulation that is most commonly in the form of
repeated eye movements.

Like CBT with a trauma focus, EMDR aims to reduce subjective dis-
tress and strengthen adaptive beliefs related to the traumatic event. Unlike
CBT with a trauma focus, EMDR does not involve (a) detailed descriptions
of the event, (b) direct challenging of beliefs, (c) extended exposure, or
(d) homework.

This description makes clear that EMDR is a “therapy,” not a “tech-
nique,” and is based on a specific model that distinguishes it from other
forms of therapy. This has important implications for our field. Given this
level of validation, I believe it is important to refer to “EMDR Therapy” in
publications, presentations and clinical practice to eliminate the reductive
misconception that it is only a “technique.”

Although EMDR Therapy has been fully validated only for PTSD, there
are numerous research studies underway evaluating applications to a wide
range of disorders. Excellent results have already been achieved with myr-
riad diagnoses. In addition to the reduction of symptoms and the strength-
ening of adaptive beliefs, the client’s experience of self and other typically
shifts in ways that allow the person to respond more adaptively to current
and future life demands. By using the term EMDR Therapy we emphasize
the stature of what we are practicing and the fact that it is on the same level
as the most widely recognized forms of therapy: psychodynamic therapy
and cognitive behavioral therapy.
As indicated below, there are important differences among the various forms of psychotherapy:

Psychodynamic Therapy

- Foundation of pathology: Intrapsychic conflicts
- Treatment: Transference/Verbal “working through”
- Cognitive Behavioral Therapy
- Foundation of pathology: Dysfunctional beliefs and behaviors
- Treatment: Direct procedural manipulations of beliefs and behaviors

EMDR Therapy

- Foundation of pathology: Unprocessed physiologically stored memories
- Treatment: Accessing and processing of memories, triggers, and future templates

While EMDR Therapy is an integrative approach that is compatible with a wide range of orientations, the model and methodology are unique. Likewise, although we may customize the Preparation Phase for individual clients by incorporating a variety of techniques, the conceptualizations of pathology, processing procedures and protocols are distinctly different from those of other therapies. Therefore, I hope you will all join me in consistently referring to our modality as EMDR Therapy and thus provide academics, clinicians and laypeople with a clear understanding of the psychotherapy we practice.

With best wishes for a new year of peace and harmony,

Francine Shapiro, PhD
Since the first edition of this Primer in 2009, the author has heard its title pronounced in two different ways by clinicians espousing its usefulness. It was initially titled the EMDR ‘pri-mär and offered as an introductory textbook much like the McGuffey Primer, which was widely used in American schools from the mid-19th century to the mid-20th century. The other is the more informal pronunciation of the EMDR ‘prim-er, like “priming the pump.” The original intent of the EMDR pri-mär was to mirror and to enhance the teachings detailed in Dr. Francine Shapiro’s 1995/2001 texts and her EMDR Institute–sponsored trainings since their inception to the present. However the reader chooses to pronounce it (‘pri-mär /‘prim-ər), it was my overall intention to encourage the growth of clinicians by preparing them to be more skilled, practiced, and confident in (em)powering a client’s “train down the track” to a healthy, adaptive destination.

A new set of tables has been peppered throughout this second edition called Derailment Possibilities. These tables have been included to alert the engineer (i.e., the clinician) to the possible obstacles ahead on the track that may cause the “train to slow or run off the rails.”
Contributing Editors

Victoria Britt, MSW, is a Clinical Social Worker and Marriage and Family Therapist in private clinical and consulting practice in Montclair, New Jersey. She is an EMDRIA Certified Therapist, Approved Consultant, Regional Coordinator, and a commercial trainer. Ms. Britt is also a frequent EMDR facilitator and lecturer of energy psychology. She is co-author of the book, Evolving Thought Field Therapy: The Clinician’s Handbook of Diagnoses, Treatment, and Theory (2004).

Irene Giessl, EdD, is a Psychologist in private practice and co-founder of the Cincinnati Trauma Connection in Cincinnati, Ohio. Dr. Giessl is an EMDRIA Certified Therapist, Approved Consultant, Regional Coordinator, and EMDR Institute facilitator and logistician. She served on the EMDRIA Board of Directors from 2000 to 2006 including two terms as secretary. In 2011, she received the EMDRIA Outstanding Service Award in recognition of her persistence and fortitude in educating others about the value of EMDR Therapy. She is also currently a member of the EMDRIA Conference Committee.

Deany Laliotis, LCSW, is a Licensed Clinical Social Worker in private practice in Bethesda, Maryland, specializing in the treatment of traumatic stress disorders and attachment issues with EMDR. She is currently an EMDRIA Certified Therapist, Approved Consultant, and senior EMDR Institute trainer and has presented at numerous conferences on the clinical application of EMDR both in the United States and abroad. Ms. Laliotis has also contributed a chapter in the book, Psychotherapist Revealed: Therapists Speak About Self-Disclosure (2009).
Jennifer Lendl, PhD, is a Psychologist in San Jose, California, and was one of the first EMDR trainers. She is coauthor of *EMDR Performance Enhancement for the Workplace: A Practitioner’s Manual* (1997). Dr. Lendl is an EMDRIA Certified Therapist and Approved Consultant, EMDR Institute facilitator, and currently sits on the EMDRIA Conference Committee. She is also the 2006 recipient of the Francine Shapiro Award and is a frequent presenter at the annual EMDRIA Conferences.

Katy Murray, LICSW, is a Licensed Independent Clinical Social Worker in Olympia, Washington, where she has a general clinical practice with specialties in trauma-related disorders, chemical dependency, and psycho-oncology. Ms. Murray is a Trauma Recovery/EMDR-HAP trainer, the EMDR Institute’s Internet Discussion Listserv Moderator, EMDR Institute facilitator, and an EMDRIA Certified Therapist and Approved Consultant. She is on the board of the EMDR Research Foundation and is an EMDRIA Regional Coordinator. In the past, she served on EMDRIA’s Standards and Training Committee. She has presented at the annual EMDRIA Conference and other EMDR specialty workshops and is a trainer for Trauma Recovery/EMDR-HAP.

Zona Scheiner, PhD, is a Psychologist, partner, and co-founder of both Family Therapy Associates of Ann Arbor and the EMDR Resource Center of Michigan, a provider of specialty presentations and basic training in EMDR. In addition, Dr. Scheiner is an EMDRIA Certified Therapist and Approved Consultant, EMDR Institute regional trainer and facilitator, and Trauma Recovery/EMDR-HAP trainer. She served on the EMDRIA Board of Directors from 1999 to 2006 and was its president in 2006. Dr. Scheiner was the 2010 recipient of the Outstanding EMDRIA Service Award for her dedication and commitment to EMDR therapy. She is currently on the EMDRIA Conference Committee and the EMDR Research Foundation Board.

Marilyn Schleyer, PhD, is an Advanced Registered Nurse Practitioner and Clinical Counselor with a private practice in northern Kentucky. She is a professor and first Chair of the Department of Advanced Nursing Studies, College of Health Professions, at Northern Kentucky University. Dr. Schleyer is credited with enlisting Northern Kentucky University to originally house and maintain the Francine Shapiro Library. She is an EMDRIA Certified Therapist and past board member of EMDRIA from 2003 to 2006.

Rosalie Thomas, RN, PhD, is a licensed Psychologist in Washington State. She continues to offer EMDR consultation as an EMDRIA Certified Therapist and Approved Consultant since retiring from an active clinical practice. Dr. Thomas has served as board member, treasurer, and president of the EMDR International Association, as well as receiving their Outstanding Service and Francine Shapiro Awards. She currently chairs the EMDRIA Conference Committee and serves as a board member of the EMDR Research Foundation, for which she is the principal author of the
EMDR Research Toolkit. Dr. Thomas is also a facilitator and trainer for EMDR-HAP and facilitator and regional trainer for the EMDR Institute, having participated in training programs throughout the United States, Japan, Bangladesh, and India.

Kay Werk, LISW, is a Licensed Independent Social Worker in Columbus, Ohio. In the past, she served as an EMDR senior trainer throughout the United States and Europe and is an EMDRIA Certified Therapist and Approved Consultant. Ms. Werk has presented at EMDRIA and other conferences on the topic of EMDR and critical incident stress management and has provided numerous EMDR-HAP trainings in a variety of settings related to disaster response. Before she retired, she was a manager of Community Crisis Response and Critical Incident Stress Management for NetCare.
Acknowledgments

My thanks to Dr. Francine Shapiro for providing me with an opportunity to be part of the ripple she created after taking her famous walk in the park. From that memorable walk, I was motivated to create my own small ripples in writing this Primer and in creating the Francine Shapiro Library. Dr. Shapiro has had an enormous impact on my life both personally and professionally as a result of her revolutionary work. My hope is that my efforts on behalf of Eye Movement Desensitization and Reprocessing (EMDR) Therapy will feed her spirit as hers have fed mine. I also want to thank Ms. Robbie Dunton for her continued support, encouragement, and wisdom. She is the heart and energy behind EMDR Therapy.

It never was my intent to write a book, let alone a Primer on the basics of EMDR Therapy. While involved in working on an EMDR presentation to local colleagues, I began to think about the significance of understanding the intricacies of the EMDR Therapy model. Letting that slip from my lips, friends and colleagues started to offer ideas and give feedback. It became a personal challenge to boil down “EMDR talk” into small portions so that more clinicians might be intrigued to follow the client’s train down the track and not be daunted by the process. Therefore, I started writing to the novice, imagining the questions, creating tables of explanations and diagrams. Thus, the birth of this Primer. What an adventure!

There are nine exceptional individuals who put part of their life on hold to help me edit this Primer to ensure the fidelity of EMDR Therapy. It was an editing marathon in which they volunteered to engage. These wonderful women—Irene Giessl, Marilyn Schleyer, Victoria Britt, Kay Werk, Jennifer Lendl, Zona Scheiner, and Deany Laliotis and, later, with this second edition, Katy Murray and Rosalie Thomas—helped to make this Primer a
realities. Their names are listed in the order they became involved in the project, not by their importance or level of involvement. Thanks to all of you for reading my manuscript, sometimes more than once, for your invaluable comments, and for your encouragement.

Special thanks to Irene Giessl for her relentless pursuit of perfection and clarity. Her support, inspiration, faith in my ability to write this Primer, and sharp eye for the flaw, moved me when courage wavered.

Thanks to Marilyn Schleyer who urged me to “keep it simple” and to provide tables and diagrams to nurture the reader’s learning process. Her mentoring and constant assurance that the Primer could be an important contribution to EMDR Therapy literature spurred me on.

Thanks to Jennifer Lendl. Jennifer truly is an EMDR pioneer, “a trainer before there were trainers.” I am eternally indebted to her for all the time, hard work, guidance, encouragement, and support she has given throughout the entire process of writing this Primer. Jennifer read the entire manuscript over and over again to ensure its fidelity to the EMDR Therapy model.

Thanks to Victoria Britt for “holding my feet to the fire,” as she promised, and for consistently and continually pointing out inadvertent deviations from EMDR Therapy standard procedure. Her commitment, ideas, and suggestions were deeply appreciated and valued.

Thanks to Kay Werk and Zona Scheiner for providing invaluable input from their experience as clinicians and teachers of EMDR Therapy. Kay allowed me to interrupt her complicated schedule to lend an ear at all times of day and night with no admonishments for my uncertainties. Her gracious demeanor and complete knowledge of the EMDR Therapy model calmed me when I started second guessing my efforts. Zona was called upon later in the writing stage. She worked with amazing speed and generosity to edit all the chapters. She added valuable effectiveness.

Thanks to Deany Laliotis for her astute editing assistance on Chapter 5, “Abractions, Blocked Processing, and Cognitive Interweaves.” She graciously took time out of her busy teaching schedule to lend assistance when asked. Having EMDR Therapy trainers and facilitators oversee my writing is the only way I could dare to endorse these chapters.

The second edition of the Primer has been further guided by the astute eyes and expertise of Irene Giessl, Deany Laliotis, Jennifer Lendl, Katy Murray, Zona Scheiner, and Rosalie Thomas, all excellent EMDR Therapy clinicians. They are amazing women who have dedicated their professional careers to foster and further the understanding of EMDR worldwide.

As a first-time editor of the Primer, Katy Murray combed through the revised Primer, refining the text, culling out discrepancies and adding changes and variations taken from Dr. Shapiro’s basic and advanced EMDR Therapy trainings.

Without question or hesitation, Rosalie Thomas generously and graciously entered the editing phase of the Primer in its 11th hour, offering
her skilled trainer’s eye in refining advanced EMDR Therapy concepts and detailed client transcripts. Dr. Thomas exemplifies the essence of the EMDR Therapy community by her willingness to jump to action when called upon. I greatly appreciate her efforts on the Primer’s behalf.

Additional thanks go to Deborah Korn for her generosity in working with Deany Laliotis on revising and enhancing the cognitive interweave section, a very important aspect of EMDR Therapy.

As can be seen, these women made special and unique contributions to the editing of this Primer. I know they made sacrifices and encountered personal challenges along the way. All the clinicians involved in this Primer are wonderful examples of the many individuals throughout the world who have nurtured and honored the evolution of EMDR Therapy. I owe all of them a deep debt of gratitude for their time, talents, and expertise. These women are dear friends and colleagues. They are all ripple creators extraordinaire! They are the true mothers of EMDR Therapy. From my grateful heart, I offer my sincere thanks.

Thanks also to Sheri W. Sussman, Executive Editor for Springer Publishing, for her encouragement and assistance throughout. Sheri’s interest in and support of this Primer was evident from the beginning when I first was introduced to and approached her about the Primer at the EMDRIA Conference in Phoenix.

I have always believed in the spirit of generosity, giving freely without strings attached. This philosophy includes making financial contributions, offering pro bono therapy services, and sharing personal and professional resources to support those who might need a step up. I am so rewarded in life for taking this stance. For me, EMDR Therapy is a work of the heart, spurred on by my belief in the power of EMDR’s healing properties. I chose to write and assist those beginning to study EMDR Therapy as a way of continuing to “pay forward.” In offering this Primer to the EMDR Therapy community, it is my hope that many clinicians and their clients will reap the benefits of my efforts.
The goal of EMDR is to achieve the most profound and comprehensive treatment effects possible in the shortest period of time, while maintaining client stability within a balanced system. (Shapiro, 2001, p. 6)

This chapter summarizes the information covered in the most recent Eye Movement Desensitization and Reprocessing (EMDR) Therapy trainings, as well as Dr. Francine Shapiro’s primary text (2001), in the hope of providing additional clarity to the newly trained clinician. It takes a look at different ways trauma can be conceptualized and includes a reintroduction to the Adaptive Information Processing (AIP) model, the concept of the three-pronged approach, targets associated with EMDR Therapy, and clinical guidelines pertinent to EMDR Therapy. References to educational learning materials, research, other relevant supplementary information, and key points that are important to remember during the EMDR Therapy learning process are also covered.

Although the EMDR Therapy principles, protocols, and procedures have been simplified with tables and figures in this Primer, it is not a mechanistic or cookie-cutter approach. EMDR Therapy is a fluid process, and the results will vary from client to client. Formal training in EMDR Therapy allows clinicians to initiate understanding its model, methodology, and
mechanism. This knowledge, combined with their own clinical intuition, allows them to begin practicing this therapeutic approach. No one should read this book thinking that it is a substitute for formal training. EMDR Therapy seems simple on its surface; however, in reality, its competent execution is complex and complicated.

Extensive familiarity with Dr. Shapiro’s primary text is a prerequisite for the reading of this Primer, which is intended to supplement, not replace, her required pre-training readings. No clinician who intends to utilize EMDR Therapy with clients can afford to be without Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures, Second Edition (Shapiro, 2001). In the early days of implementation, you may need to refer to Dr. Shapiro’s book on a daily basis. Read it often and use it as your primary EMDR Therapy reference guide. Every time you read it, you will probably notice something that you did not quite understand or retain the first few times around. Read it thoroughly and refer to it often. It is not necessary that you memorize the book; just remember that it is there for you as an ongoing guide to your clinical work. It is also suggested that clinicians read Getting Past Your Past (Shapiro, 2012). This book provides clinicians and clients alike a greater understanding of why people act the way they do.

EMDR Therapy, a reprocessing therapy, is a robust, comprehensive psychotherapeutic treatment approach comprising eight distinct phases that begin with the clinician’s initial contact with the client. These include taking a thorough client history, preparing the client for the EMDR Therapy process, setting up the protocol, desensitizing and reprocessing the trauma, installing a positive cognition (PC), doing a body scan to check for residual trauma, closing down a session, and reevaluating the status of a trauma. All of these eight phases must be in place in the order described previously. Chapter 2 contains an in-depth discussion of these phases. There have been other offshoots of EMDR Therapy since its inception (e.g., Grand, 2011; Kip et al., 2013; Pace, 2003; Schmidt, 2004). These techniques have their supporters and many successes may have been reported, but these treatments, to date, have not been validated in the research literature. The efficacy of these models has not been tested within a scientific, empirical setting. EMDR Therapy’s validity has been proven over and over again.

TRAUMA

What Is Trauma?

The diagnostic criteria for posttraumatic stress disorder (PTSD; 309.81) cited in the Diagnostic and Statistical Manual of Mental Disorders, 5th ed. (DSM-5; American Psychiatric Association [APA], 2013) is the definition used most frequently to describe acute trauma in adults. In essence, this definition describes trauma as an event experienced or witnessed by a person that results in intrusive symptoms, avoidance, negative alterations in cognitions
EMDR Therapy Overview

and mood, and alterations in arousal and reactivity (APA, 2013). Flannery describes trauma as “the state of severe fright that we experience when we are confronted with a sudden, unexpected, potentially life-threatening event, over which we have no control, and to which we are unable to respond effectively no matter how hard we try” (1995).

A child who was sexually abused by her older brother may grow up to believe, “I am bad” or “The world is unsafe.” When an individual experiences a traumatic event, the event can become entrenched (or fixed) in the form of irrational beliefs; negative emotions; blocked energy; and/or physical symptoms, such as anxieties, phobias, flashbacks, nightmares, and/or fears. Regardless of the magnitude of the trauma, it may have the potential for negatively impacting an individual’s self-confidence and self-efficacy. The event can become locked or “stuck” in the memory network in its original form, causing an array of traumatic or PTSD symptoms. Triggers activate images, physical sensations, tastes, smells, sounds, and beliefs that might echo the experience as though it were the day it originally happened or cause other distortions in perception of current events. Reminders of the event have the potential for triggering an emotional or physical response. By utilizing EMDR Therapy, the client can unblock the traumatic information and can fully experience and integrate the trauma toward a healthy resolution.

Types of Trauma

Dr. Shapiro distinguishes between large “T” and other adverse life experiences or disturbing life events (formerly referred to as small “t” traumas; 2001). When a person hears the word “trauma,” he usually thinks of man-made events, such as fires; explosions; automobile accidents; or natural disasters, which include hurricanes, floods, and tornados. Sexual abuse, a massive heart attack, death of a loved one, Hurricane Katrina, and the 9/11 attacks on the World Trade Center by international terrorists are graphic examples of large “T” traumas. Among other descriptors, these types of traumas can be defined as dangerous and life threatening and fit the criteria in the DSM-5 (APA, 2013) as stated above.

Then there are the traumas Dr. Shapiro (2001) has designated as adverse life experiences. These types of events may be more subtle and tend to impact one’s beliefs about self, others, and the world. Adverse life experiences are those that can affect our sense of self, self-esteem, self-definition, self-confidence, and optimal behavior. They influence how we see ourselves as a part of the bigger whole. They are often ubiquitous (i.e., constantly encountered) in nature and are stored in state-dependent mode in our memory network. Unless persistent throughout the client’s childhood, adverse life experiences usually do not have much impact on overall development, yet maintain the ability to elicit negative self-attributions and have potential for other long-term negative consequences.

To illustrate the difference between an adverse life experience and a large “T” trauma, let us consider the case of Rebecca, who grew up as “the
As the offspring of a local pastor, Rebecca grew up, figuratively speaking, in a glass house. She believed that her father’s job rested on her behavior inside and outside of her home. In her world, everyone was watching. She was always in the spotlight, and no one seemed to want to share his or her life with her. She went through childhood with few friends. “I remember before and after church, the groups of kids forming. I was the outsider. No one invited me in.” All the kids were afraid that every move they made would be reported to her daddy. Being at home was not much better. Her father was never home. He was always out “tending to his flock” and had little time left for his own family. Her mother was not of much comfort either because she spent much of her time trying to be perfect as well. Living in a glass house was not easy for any of them, especially Rebecca, the oldest of three. By the time Rebecca entered therapy, she was a wife and mother. She thought she had to be perfect in motherhood and in her marriage as well. She became frustrated, angry, and lonely. She felt misunderstood and neglected by her husband. He was never there. He never listened. She thought she could do nothing right, as hard as she tried.

Probing into Rebecca’s earliest childhood memories, no tragic or traumatic memories (i.e., large “T” traumas) emerged. As she continued to explore her past, the hardships and rigors of living in a glass house as the preacher’s daughter slowly became apparent. The original target that initiated a round of EMDR sessions focused on Rebecca “sitting on my hands in church and being a good little girl.” Her negative belief about herself as she focused on this global touchstone event was “I have to be perfect.” She felt isolated, overlooked, and abandoned by her parents and the parishioners of her father’s church. These were undoubtedly adverse life experiences. There was no one single event or series of traumatic events that set her current problem or issue in place. It was her way of life; and how, where, and why she was forced to live as a child caused a specific set of symptoms and interfered with her living happily and successfully in the present.

The differentiation between adverse life experiences and large “T” traumas often appears too simplistic. Another way of discussing the types of trauma is to look at it in terms of shock or developmental trauma.

Shock trauma involves a sudden threat that is perceived by the central nervous system as overwhelming and/or life threatening. It is a single-episode traumatic event. Examples include car accidents, violence, surgery, hurricanes and other natural disasters, rape, battlefield assaults, and war.

Developmental trauma refers to events that occur over time and gradually affect and alter a client’s neurological system to the point that it remains in a traumatic state. This type of trauma may cause interruptions in a child’s natural psychological growth. Examples of developmental trauma are abandonment or long-term separation from a parent, an unstable or unsafe environment, neglect, serious illness, physical or sexual abuse, and betrayal at the hands of a caregiver. This type of trauma can have a negative impact on a child’s sense of safety and security in the world and tends to set the
stage for future trauma in adulthood as the sense of fear and helplessness that accompany it goes unresolved.

Table 1.1 outlines more definitely the differences between large “T” and adverse life experiences or disturbing life events (i.e., small “t” traumas).

<table>
<thead>
<tr>
<th>BIG “T” TRAUMA</th>
<th>SMALL “t” TRAUMA (DISTURBING/DISTRESSING LIFE EVENTS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major event normally seen as traumatic</td>
<td>Disturbing/distressing life event that may not always be perceived as traumatic</td>
</tr>
<tr>
<td>May be a single- or multiple-event trauma</td>
<td>More common and ubiquitous; usually accumulates over time from childhood</td>
</tr>
<tr>
<td>May be pervasive</td>
<td>More often it is pervasive and ongoing</td>
</tr>
<tr>
<td>Most often there is intrusive imagery</td>
<td>Often there is no intrusive imagery</td>
</tr>
<tr>
<td>Still elicits similar negative beliefs, emotions, and physical sensations</td>
<td>Still elicits similar negative beliefs, emotions, and physical sensations</td>
</tr>
<tr>
<td>Lasting negative effect on the client’s sense of safety in the world</td>
<td>Lasting negative effect on the client’s sense of self (self-confidence, self-esteem, self-definition)</td>
</tr>
</tbody>
</table>

**Examples:**
- Serious accidents, (e.g., automobile or bike accidents, plane crashes, serious falls)
- Natural disasters (e.g., earthquakes, tornadoes, tsunamis, forest fires, volcanic eruptions, floods)
- Man-made disasters (e.g., 9/11, explosions, fires, wars, acts of terrorism)
- Major life changes (e.g., serious illnesses, loss of loved ones)
- Physical and sexual assaults
- Major surgeries, life-threatening illnesses (e.g., cancer, heart attacks, craniotomies, heart bypasses)
- Ongoing life events (e.g., sexual abuse, domestic violence)
- War- and combat-related incidents

**Examples:**
- Moving multiple times during childhood
- Excessive teasing or bullying
- Persistent physical illnesses
- Constant criticism
- Rejections
- Betrayals
- Disparaging remarks
- Losing jobs
- Divorce or witnessing parental conflict
- Unmet developmental needs
- Death of pets
- Public shaming, humiliation, or failure
- Unresolved guilt
- Physical or emotional neglect
- Getting lost
- Chronic harassment
ADAPTIVE INFORMATION PROCESSING—“THE PAST DRIVES THE PRESENT”

EMDR Therapy is a distinct integrative psychotherapeutic approach and is compatible with other major orientations of psychotherapy. This eight-phase approach is led by an information processing model and guides clinical practice (i.e., case conceptualization and treatment planning) in general.

Dr. Francine Shapiro developed a hypothetical information processing model of learning called the Adaptive Information Processing (AIP) model (changed from Accelerated Information Processing model in 1995) to provide a theoretical framework and principles for EMDR Therapy. Accelerated Information Processing clarifies how EMDR Therapy works, and Adaptive Information Processing guides how it is used (see Table 1.2). Dr. Shapiro recognized the need to more efficiently explain the consistent treatment effects being obtained and reported from EMDR Therapy.

Adaptive Information Processing (AIP) elaborates on the observed treatment effects of EMDR Therapy by describing an innate physiological system that helps to transform disturbing information into adaptive resolution by psychologically integrating the information. In this model, memory networks constitute the basis of our perceptions, attitudes, and behaviors. These memories consist of stored information, such as sensory input (i.e., captured by our five senses), thoughts, emotions, and beliefs. Dr. Shapiro believes that disturbing events, whether large “T” traumas or adverse life experiences, are the primary source of our current dysfunction. When trauma happens, it causes a disruption in our information processing system, leaving any associated sights, sounds, thoughts, or feelings unprocessed and, subsequently, dysfunctionally stored as they are perceived (Shapiro, 2001). See Table 1.3 for examples of adaptive versus maladaptive resolution.

Dr. Shapiro posits that inherent in the AIP model is a psychological self-healing construct similar to the body’s healing response to physical injury.

<table>
<thead>
<tr>
<th>TABLE 1.2</th>
<th>Accelerated Information Processing vs. Adaptive Information Processing</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCELERATED INFORMATION PROCESSING (HOW IT IS USED)</td>
<td>ADAPTIVE INFORMATION PROCESSING (HOW IT WORKS)</td>
</tr>
<tr>
<td>Working hypothesis</td>
<td>Working model</td>
</tr>
<tr>
<td>Explains how EMDR works</td>
<td>Explains why EMDR works</td>
</tr>
<tr>
<td>Developed to explain the rapid manner in which clinical results are achieved</td>
<td>Developed to explain the clinical phenomena observed</td>
</tr>
<tr>
<td>Simple desensitization treatment effect</td>
<td>Entails an information processing effect</td>
</tr>
</tbody>
</table>
For example, if you get a splinter stuck in your finger, your body’s automatic response is to heal the area of injury. However, because the area is blocked by the splinter, healing cannot easily occur until the sliver is removed. In terms of mental processes, it is the inherent tendency of the information processing system to also move toward a state of health. So, even when something mildly disturbing happens, you may think about it, talk about it, and process it. You usually find that, within a day or so, you are no longer thinking so intensely about the event and, when you do, you have come to a resolution. For instance, if you are angry at your spouse, you may start to remember that your spouse has some good qualities as well as these very annoying ones. It is a case of the mind adaptively processing the disturbing material and connecting that disturbance into the larger picture of the experience. Table 1.4 demonstrates how EMDR Therapy catalyzes healing and learning.

On the other hand, when a trauma occurs that is too large for your system to adequately process, it can become “stuck” (i.e., dysfunctionally

<table>
<thead>
<tr>
<th>ADAPTIVE</th>
<th>MALADAPTIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large “T” (e.g., Safety)</td>
<td></td>
</tr>
<tr>
<td>I survived.</td>
<td>Driving phobia</td>
</tr>
<tr>
<td>I can learn from this.</td>
<td>Flashbacks</td>
</tr>
<tr>
<td>I can protect myself.</td>
<td>Intense driving anxiety</td>
</tr>
<tr>
<td>I am safe.</td>
<td>Night terrors</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Small “t” (i.e., Disturbing Life Events) (e.g., Responsibility)</td>
<td></td>
</tr>
<tr>
<td>I am fine as I am.</td>
<td>Low self-esteem</td>
</tr>
<tr>
<td>I did the best I could.</td>
<td>Irrational guilt</td>
</tr>
<tr>
<td>I am significant/important.</td>
<td>Self-neglect, codependence</td>
</tr>
</tbody>
</table>

**Table 1.3 Adaptive vs. Maladaptive Resolution**

Learning is a continuum

**Table 1.4 EMDR Therapy Catalyzes Learning**

<table>
<thead>
<tr>
<th>TARGET</th>
<th>When the target is a disturbing memory</th>
<th>When the target is positive (i.e., an alternative desirable imagined future)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Negative images, beliefs, and emotions become less vivid, less enhanced, and less valid</td>
<td>Positive images, beliefs, and emotions become more vivid, more enhanced, and more valid</td>
</tr>
<tr>
<td></td>
<td>Before reprocessing, links to dysfunctional material</td>
<td>Links with more appropriate information</td>
</tr>
</tbody>
</table>

Learning is a continuum

stored) in the central nervous system. Maladaptive responses, such as flashbacks or dreams, can be triggered by present stimuli, and there may be attempts of the information processing system to resolve the trauma (Shapiro, 2001). When the system becomes overloaded as just described, EMDR Therapy is proving to be the treatment of choice for many to help restart this mental healing process and allow the traumas to be reprocessed. See Figure 1.1 for a graphical representation of the AIP model.

The AIP model also posits that earlier life experiences set the stage for later life strengths or problems. Information from earlier disturbing life events can be physiologically and dysfunctionally stored in the nervous system if not properly assimilated at the time of the event. Problematic behaviors and disorders can occur as a result. Table 1.5 describes the differences between dysfunctionally stored and adaptively stored memories.

At the time of disturbing or traumatic events, information may be stored in the central nervous system in state-specific form (i.e., the negative cognitive belief and emotional and physical sensations the client experienced at the time of the traumatic event remain stored in the central nervous system just as if the trauma is happening in the now). Over time, a client may develop repeated negative patterns of feeling, sensing, thinking, believing, and behaving as a result of the dysfunctionally stored material.

---

**FIGURE 1.1** Adaptive Information Processing model: the information processing system at work.
These patterns are stimulated, activated, or triggered by stimuli in the present that cause a client to react in the same or similar ways as in the past. Dr. Shapiro (2001) states throughout her basic text that the negative beliefs and affect from past events spill into the present. By processing earlier traumatic memories, EMDR Therapy enables the client to generalize positive affect and cognitions to associated memories found throughout the “neuro” networks (i.e., memory networks), thus allowing more appropriate behaviors in the present. Table 1.6 demonstrates a more simplified version of how EMDR reprocessing works (Shapiro, 2009–2014).

| TABLE 1.5 Differences Between Dysfunctionally Stored and Adaptively Stored Memories |
|---------------------------------|---------------------------------|
| **DYSFUNCTIONALLY STORED MEMORIES** | **ADAPTIVELY STORED MEMORIES** |
| Information processing system is overwhelmed and becomes “stuck” | Information processing system is able to connect to current information and resources and adequately process information |
| Embraces an inappropriate, developmentally arrested lack of power in the past | Embraces an age-appropriate power in the present |
| Past oriented or developmentally arrested, dysfunctional perspective | Present oriented and age appropriate, adaptive perspective |
| Stored in incorrect form of memory (i.e., implicit/motoric) | Stored in correct form of memory (i.e., explicit/narrative) |
| Past is present | Past is past |

<table>
<thead>
<tr>
<th>TABLE 1.6 Activation Components of EMDR Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access</strong></td>
</tr>
<tr>
<td>Frozen dysfunctional memory</td>
</tr>
<tr>
<td><strong>Stimulate</strong></td>
</tr>
<tr>
<td>Information processing system</td>
</tr>
<tr>
<td><strong>Move</strong></td>
</tr>
<tr>
<td>Information to adaptive resolution</td>
</tr>
<tr>
<td><strong>Results</strong></td>
</tr>
<tr>
<td>Lessening of disturbance</td>
</tr>
<tr>
<td>Gained information and insights</td>
</tr>
<tr>
<td>Changes in emotional and physical responses</td>
</tr>
</tbody>
</table>
Cognitive behavioral techniques, such as systematic desensitization, imaginal exposure, or flooding, require the client to focus on anxiety-provoking behaviors and irrational thoughts or to relive the trauma or other adverse life experiences. EMDR Therapy accesses or develops adequate current resources, and then targets the experiences that caused the negative cognition, affect, and physical sensations to become “stuck” in a client’s nervous system. Once the memories have been reprocessed utilizing EMDR, a physiological shift can occur that causes the disturbing picture to fade appropriately with the associated negative self-belief, feelings, and physical sensations. The “block” (i.e., dysfunctionally stored information) in the client’s nervous system is shifted, and the disturbance is brought to an adaptive resolution as the natural healing process is activated. The primary by-product of reprocessing is a decrease or elimination of the negative charge associated with the trauma or disturbing life events.

Changes in perception and attitude; experiencing moments of insight; and subtle differences in the way a person thinks, feels, behaves, and believes are by-products as well. The changes can be immediate. Take, for instance, a session with a young woman who had been brutally raped by her ex-boyfriend. During the Assessment Phase, Andrea’s terror appeared raggedly etched in her face and slumped demeanor. After many successive sets of bilateral stimulation (BLS), her pale facial features began to redden, her posture began to straighten, and her breath began to gain strength and resolve as she spontaneously stated, “He took my power that night. No more! I am taking my power back. He no longer has the power to terrorize me!” Or consider Billy who was teased unmercifully in high school by his football teammates. Prior to desensitization and reprocessing, he appeared tense, anxious, and short of breath. After just a few sets of BLS, his body appeared more relaxed, his breath slowed, and his anxiety dissipated into a state of calm. “That was then. This is now. They are nobody to me now.”

Figure 1.2 demonstrates in action the inherent information processing mechanism as it highlights the changes that occurred as a result of Andrea and Billy’s dynamic drive toward mental health with EMDR Therapy.

Because the heart of EMDR Therapy is the AIP model, it is critical that the clinician has a clear understanding of it before proceeding. An adequate conceptual understanding helps the clinician determine a client’s appropriateness for EMDR Therapy, as well as explain the process to the client during the Preparation Phase, so that he has some understanding of the potential treatment effects. Table 1.7 highlights the before and after treatment changes of EMDR in terms of the AIP model.

Why and how does EMDR Therapy work? What are the fundamental procedures and elements that contribute to the EMDR Therapy overall treatment effect? Unfortunately, no one really knows the neurobiological underpinnings as to why EMDR Therapy works. Many questions remain to be answered and, at the same time, clients experience continued positive clinical effects. The following are the three primary aspects of EMDR Therapy:

1. **Model**—The Adaptive Information Processing model provides the theoretical model for EMDR Therapy.
2. **Methodology**—Eight phases of EMDR plus the ethics, safeguards, and validated modifications for basic and specific clinical situations and populations
3. **Mechanism**—Current hypotheses on how and why EMDR Therapy works on a neurobiological level

![Adaptive Information Processing (AIP) model: information processing mechanism.](image)

**FIGURE 1.2** Adaptive Information Processing (AIP) model: information processing mechanism.
Model—How?

The Adaptive Information Processing (AIP) model guides its clinical practice (i.e., case conceptualization and treatment planning) and predicts the EMDR treatment effects, and it is independent from the “why” stated later. It is through the lens of the AIP model that the developmental phenomenon is understood, any clinical phenomena that arise during EMDR processing are interpreted, and successful application and positive treatment outcomes are predicted.

Guided by this information processing model, memory networks are believed to form the basis of clinical symptoms and mental health in general, and “unprocessed memories are considered to be the primary basis of pathology” (Shapiro, 2009–2014). The important components of the model as outlined by Dr. Shapiro (1995, 2001, 2009–2014) are summarized in Table 1.8.

| TABLE 1.7  
Client’s Experience: AIP in Action |
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BEFORE</strong></td>
</tr>
<tr>
<td><strong>Client experiences negative event, resulting in:</strong></td>
</tr>
<tr>
<td>Intrusive images</td>
</tr>
<tr>
<td>Negative thoughts or beliefs</td>
</tr>
<tr>
<td>Negative emotions and associated physical sensations</td>
</tr>
<tr>
<td><strong>What happens?</strong></td>
</tr>
<tr>
<td>Information is insufficiently (dysfunctionally) stored</td>
</tr>
<tr>
<td>Dysfunctional information gets replayed</td>
</tr>
<tr>
<td>Developmental windows may be closed</td>
</tr>
<tr>
<td><strong>Resulting in:</strong></td>
</tr>
<tr>
<td>Depression</td>
</tr>
<tr>
<td>Anxiety</td>
</tr>
<tr>
<td>Low self-esteem</td>
</tr>
<tr>
<td>Self-deprecation</td>
</tr>
<tr>
<td>Powerlessness</td>
</tr>
<tr>
<td>Inadequacy</td>
</tr>
<tr>
<td>Lack of choice</td>
</tr>
<tr>
<td>Lack of control</td>
</tr>
<tr>
<td>Dissociation</td>
</tr>
</tbody>
</table>

Model—How?

The Adaptive Information Processing (AIP) model guides its clinical practice (i.e., case conceptualization and treatment planning) and predicts the EMDR treatment effects, and it is independent from the “why” stated later. It is through the lens of the AIP model that the developmental phenomenon is understood, any clinical phenomena that arise during EMDR processing are interpreted, and successful application and positive treatment outcomes are predicted.

Guided by this information processing model, memory networks are believed to form the basis of clinical symptoms and mental health in general, and “unprocessed memories are considered to be the primary basis of pathology” (Shapiro, 2009–2014). The important components of the model as outlined by Dr. Shapiro (1995, 2001, 2009–2014) are summarized in Table 1.8.
There is a body of literature including both research and case reports on a variety of clinical complaints that illustrates the predictive value of the AIP in terms of body dysmorphic disorder (Brown, McGoldrick, & Buchanan, 1997); generalized anxiety disorder (Gauvreau & Bouchard, 2008); olfactory reference syndrome (McGoldrick, Begum, & Brown, 2008); adolescent depression (Bae, Kim & Park, 2008); posttraumatic stress disorder (Mol et al., 2005; Raboni, Tufnik, & Suchecki, 2006); the role of EMDR Therapy in medicine (Shapiro, 2014); dental phobia (Doering, Ohlmeier, de Jongh, Hofmann, & Bisping, 2013); perpetrators with a trauma history (Ricci, Clayton, & Shapiro, 2006); adult attachment (Wesselman & Potter, 2009); psychosis (van den Berg & van den Gaag, 2012; Varese et al., 2012); peer verbal abuse (Teicher, Samson, Sheu, Polcari, & McGreenery, 2010); obsessive-compulsive disorder (Nazari, Momeni, Jariani, & Tarrahi, 2011); and phantom limb pain (de Roos et al., 2010; Russell, 2008; Schneider, Hofmann, Rost, & Shapiro, 2007, 2008; Wilensky, 2006).

---

**TABLE 1.8**

**Important Components of the Information Processing Model**

| The AIP model views maladaptive/negative memory networks as the “underlying basis of both pathology and mental health.”

Disturbing memories are dysfunctionally stored (i.e., perceived in the same way as when the memory was originally formed) and may disrupt the information processing system.

Emotions, physical sensations, and thoughts and beliefs associated with unprocessed memories are experienced by the client as his perceptions in the present link to the historical memory networks.

In order to be interpreted, a client’s perceptions of present situations link into networks of physically stored memories (negative or dysfunctional) from the past. In other words, the past is present.

As the processing begins, disruptions may be caused by high levels of emotional disturbance or dissociation, which can block adaptive processing.

When a client is processing the memory of a traumatic event, he has the opportunity to forge adaptive associations with memory networks of functional information stored in the brain. This EMDR associative process allows these connections to be made.

During processing, the unprocessed elements of a client’s memory (i.e., image, thoughts, sounds, emotional and physical sensations, beliefs) have the ability to transform/transmute to an adaptive resolution. At this point, learning may take place. By discarding maladaptive information and storing adaptive information, a client has new learning that may better inform future experiences and choices.
Methodology—How/What?

EMDR Therapy employs an eight-phase integrative treatment approach. Often customized to reflect a client’s clinical diagnosis or individual presentation, EMDR Therapy utilizes a distinct set of procedures and protocols to address a client’s presenting issues. BLS is only one component of the methodology that guides this therapeutic practice of EMDR. EMDR Therapy is also a three-pronged approach that includes a client’s past experiences, present triggers, and a future template of how the client may want to be or respond in a particular situation. EMDR Therapy is flexible in that it also combines aspects of a clinician’s previous orientations to psychotherapy as part of the process.

For further reading on the “how” and “what” of EMDR Therapy, an overview of the model and procedures is elaborated on in Table 1.9.

<table>
<thead>
<tr>
<th>Year</th>
<th>Reference</th>
</tr>
</thead>
</table>

(continued)
TABLE 1.9  (continued)
Model—Adaptive Information Processing (AIP)
and EMDR Therapy Procedures: How/What?

2004
the contributions of early adverse experience to neurobiological findings
in depression. *Neuropsychopharmacology*, 29, 641–648. doi:10.1038/
sj.npp.1300397.

2005
stress disorder after non-traumatic events: Evidence from an open
bpj.186.6.494.

2006
in bonding through EMDR. *Clinical Case Studies*, 5(4), 271–286.
by eye movement desensitization reprocessing (EMDR) improves sleep
of EMDR on previously abused child molesters: Theoretical reviews and
preliminary findings. *Journal of Forensic Psychiatry and Psychology*,
17(4), 538–562. doi:10.1080/14789940601070431.
Shapiro, F. (2006). *New notes on adaptive information processing: Case
formulation principles, scripts, and worksheets*. Hamden, CT: EMDR
Humanitarian Assistance Programs.
the negative information processing on patients who suffer depression.
*Revista Electrónica de Motivación y Emoción (REME)*, 9, 23–24.
(EMDR) as a treatment for phantom limb pain. *Journal of Brief Therapy*,
5(1), 31–44.

2007
and reprocessing in the treatment of panic disorder with agoraphobia.

(continued)
TABLE 1.9 (continued)
Model—Adaptive Information Processing (AIP) and EMDR Therapy Procedures: How/What?


**2008**


**2009**


(continued)
TABLE 1.9 (continued) Model—Adaptive Information Processing (AIP) and EMDR Therapy Procedures: How/What?

2010


2011


2012


(continued)
TABLE 1.9  (continued)
Model—Adaptive Information Processing (AIP)
and EMDR Therapy Procedures: How/What?


Mechanism—Why?
Over the past 25 years, numerous studies have indicated that eye movements have effects on a client’s memory in terms of vividness, retrieval, emotional arousal, and more. The randomized control studies that evaluated EMDR Therapy’s mechanism of action, primarily eye movements, are outlined in Table 1.10.

THREE-PRONGED APPROACH

Past, Present, Future

EMDR Therapy is a three-pronged treatment approach that focuses on reprocessing of past events, current triggering stimuli, and adaptive rehearsal in future situations (see Figure 1.3). This may seem simple, but it is often a concept that escapes many newly trained EMDR Therapy clinicians.

Regardless of what you as a participant were taught in the earlier didactic trainings, what you most likely will remember is what was on the instructional sheet that sat on your lap. The first question that you asked the client was, “What old issue or old memory would you like to focus on today?” It is important to note that this question was only used in the
### TABLE 1.10
Mechanism of Action—Why?

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>MacCulloch and Feldman (1996) proposed that the rapid effectiveness of EMDR was due to a clinical method of Pavlovian conditioning by which the positive visceral element of the investigatory reflex may be paired with clinically induced noxious memories to remove their negative affect. Wilson, Silver, Covi, and Foster (1996) supported the hypothesis that, when the parasympathetic system is activated, eye movements caused a “compelled” relaxation response.</td>
</tr>
<tr>
<td>1999</td>
<td>In a study conducted by Rogers et al. (1999), different recovery responses were observed. The EMDR group demonstrated a more rapid decline in self-reported stress than the exposure group.</td>
</tr>
<tr>
<td>2002</td>
<td>Rogers and Silver (2002), in discussing whether EMDR is exposure therapy, also posited possible reasons for the effectiveness of EMDR. The possibilities ranged from the fundamental nature of trauma reactions to the nonexposure mechanisms utilized in information processing models. Stickgold proposed that “the repetitive redirecting of attention in EMDR induces a neurobiological state, similar to that of REM sleep, which is optimally configured to support the cortical integration of traumatic memories into general semantic networks. We suggest that this integration can then lead to a reduction in the strength of hippocampally-mediated episodic memories of the traumatic event as well as the memories’ associated, amygdala-dependent, negative affect.”</td>
</tr>
<tr>
<td>2004</td>
<td>Exploring the differences between memory consolidation and extinction, Suzuki et al. (2004) conferred that the underlying mechanism of EMDR may be reconsolidation.</td>
</tr>
<tr>
<td>2006</td>
<td>Lee, Taylor, and Drummond (2006) noticed the greatest improvement of PTSD symptoms with EMDR (i.e., distancing) rather than with the more traditional exposure treatments (i.e., reliving) when comparing the content of participants’ responses. This study demonstrated the underlying mechanisms of EMDR and exposure are different and the importance of dual focus of attention (i.e., internal and external) in allowing the participants to process trauma in a more detached manner. Servan-Schreiber et al. (2006) suggested that eye movement and other alternating stimulation may confer an additional benefit that may require further attention in the future.</td>
</tr>
</tbody>
</table>
In examining the effects of eye movement used in EMDR reprocessing on interhemispheric electroencephalogram coherence, Propper et al. (2007) looked at the effects of bilateral EMs on the retrieval of episodic memories and found evidence that the eye movements may enhance interhemispheric interaction. In comparing non-eye movements to bilateral eye movements, the later bilateral EMs led to a decrease in interhemispheric gamma electroencephalogram coherence.

An EMDR study by Sack, Hofmann, Wizelman, and Lempa (2008) investigated during-session changes in autonomic tone in patients suffering from PTSD. Information processing was followed by these during-session changes: decreased psychophysiological activity and reduced subjective disturbance and stress activity to the traumatic memory. The findings of another study (Sack, Lempa, Steinmetz, Lamprecht, & Hofmann, 2008) suggested the association of EMDR with patterns of autonomic activity and substantial psycho-physiological de-arousal over time. Elofsson, von Scheele, Theorell, and Sondergard (2008), in a study of the physiological correlates of EMDR reprocessing, documented changes in heart rate, skin conductance, LF/HF ratio, breathing frequency, finger temperature, and oxygen and carbon dioxide levels. The conclusion of this study was that the eye movements activated cholinergic and inhibited sympathetic systems. In addition, similarities were found between EMDR reprocessing and patterns during REM sleep. Solomon and Shapiro (2008) also discussed a variety of mechanisms of action. Stickgold (2008) provided explanation of the potential links to the processes and mechanisms that occur in REM sleep.

Compared to counting and exposure only, Lilley et al. (2009) demonstrated that eye movement condition had a significant effect on emotionality and vividness of a client’s traumatic memory. Neither exposure nor counting had an effect on vividness. This suggested that eye movement, far from serving as a general distractor, had a more specific effect.

Hornsved et al. (2010) reported that emotionality of loss-related memories is reduced after recall utilizing eye movements, but not with recall only or recall with music. Kapoula et al. (2010) speculated that EMDR processing may reduce distress by activating a cholinergic effect known to improve ocular pursuit.
TABLE 1.10 (continued)  
Mechanism of Action—Why?

<table>
<thead>
<tr>
<th>Year</th>
<th>Authors</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>El Khoury-Malhame et al.</td>
<td>Supported the existence of an attentional bias in PTSD patients due to a disengagement difficulty. Kristjánsdóttir and Lee (2011) found that eye movement produced the greatest benefit and that the vividness and emotionality associated with memories decreased significantly after eye movement and counting.</td>
</tr>
<tr>
<td>2012</td>
<td>van den Hout et al.</td>
<td>Found tones inferior to eye movements in the EMDR treatment of PTSD.</td>
</tr>
<tr>
<td>2014</td>
<td>Leer, Engelhard, and van den Hout</td>
<td>Provided corroborating evidence that recall with EM causes 24-h changes in memory vividness/emotionality.</td>
</tr>
</tbody>
</table>

training exercises and not in daily clinical practice. Fortunately, this teaching method has changed as the training focus now is to establish a more formalized plan that attempts to identify past events (and a touchstone event, if available), present triggers, and a future template, and to encourage the participant to process in this order. Dr. Shapiro (2006a) referred to this strategy as the Treatment Planning Guide (TPG).

To completely resolve a client’s issue and achieve adaptive resolution, EMDR Therapy is designed to: (a) address a client’s past events; (b) clean out related current stimuli that might trigger distress in the client and/or

![FIGURE 1.3 Self-actualization: EMDR Therapy and the three-pronged hierarchy.](image-url)
reprocess difficult present experiences; and (c) prepare the client for future situations involving the same kind of circumstances (or reaction). The concept of the three-pronged approach is so important that an entire chapter in this Primer has been devoted to it (see Chapter 4).

**Three-Pronged Targets—Experiential Contributors to Present-Day Problems**

The order of the processing is important. First, it is necessary to strive to adaptively resolve past traumas, then process current stimuli that trigger distress, and finally do a future template on the present trigger. See Figure 1.4 for a breakdown of what is identified and processed under each prong of the EMDR approach.

The clinician may want to consider targeting the memories that lay the groundwork for any present problems and/or issues first. It may be a single traumatic event or what is called a *touchstone event*, a primary and self-defining event in the client’s life. In AIP language, Dr. Shapiro refers to the touchstone memory as a node to which similar events *will attach* in the continuous formation of a “neuro” or memory network that is critical to the client’s sense of self (2001; see Figure 1.5a and 1.5b).

![Figure 1.4 Three-pronged targets: order of reprocessing.](image-url)
Once all presently charged past events are processed (i.e., after the touchstone event is processed), other past events may or may not have a cognitive or affective charge remaining. The clinician may want to consider processing those that have a “charge” before continuing to recent events. Then any recent events, circumstances, situations, stressors, or other triggers that might elicit a disturbance are targeted. After the past events and present disturbances have been identified and reprocessed, focus on the future desired behavior and the client’s ability to make better choices or cope more effectively. This entails education, modeling, and targeting what Dr. Shapiro calls a future or positive template (2001). It is important for the client to appropriately and properly assimilate the new information gained through the previous prongs (i.e., past, present, and future) by providing her with experiences that ensure future successes.

FIGURE 1.5 (a) Targets or nodes and (b) targets or nodes with examples.
During recent EMDR trainings, the order of processing the three prongs (i.e., past, present, and future) and strategically identifying the touchstone event, if any, have been emphasized more dramatically. If trained in EMDR prior to 2008, the clinician needs to pay particular attention to Chapters 3 and 4 of this Primer.

The Importance of Past, Present, and Future in EMDR Therapy

The foundation of the three-pronged protocol postulates that earlier memories are processed before current events, and current events are processed before future events. Why is it so important to process these events in this order? What is the effect on the overall treatment result if it is not processed in order of past, present, and future? Earlier life experiences set the groundwork for present events and triggers. Hence, it is useful to reprocess as many of the historical associations with the triggers as possible. Once these associations have been transformed, some, if not many, present triggers will dissipate. There may, however, still be current triggers that exist outside of these channels of association that will need to be targeted and processed independently. Or there may be unprocessed material that surfaces when processing these triggers. These triggers will be the next targets to be processed.

The focus on the future template provides the client an opportunity to imaginally rehearse future circumstances and desired responses. This is yet another opening for unprocessed material to surface. The use of the future template provides the client a means of resolving any anticipatory anxiety that he may still experience in similar future situations. The three-pronged approach appears to be a bottom-up process in that the future is subsumed by the present and the present is subsumed by the past. It has been suggested that bypassing the three-pronged approach as part of the full EMDR treatment means obtaining only a fraction of the full treatment effect. If one does not complete the full protocol and believes that the material is resolved because the past has been successfully reprocessed, the client may remain unprepared for being triggered in the present and may still hold anxieties about the future.

TARGETING POSSIBILITIES

Targets May Arise in Any Part of the EMDR Therapy Process

When a clinician instructs a client to focus on a target in EMDR reprocessing, she is asking the client to tune into a specific memory, image, person, or event or the most disturbing part of it. The target or node then becomes the pivotal point of entry into the associated psychologically stored material. If a client’s presenting issue relates to the way he responds to his
mother-in-law when she first sees him, the target he selects may be the image of her hugging and kissing him as a form of greeting. Because the target image has a constellation of associated experiences around it, Dr. Shapiro (2001) calls it a *node*.

Throughout Dr. Shapiro’s clinical books (2001, 2006), she refers to several different targets that may arise in certain parts of the process. The past, present, and future targets referred to earlier are the primary focus in the EMDR Therapy training. Her text also introduces the reader to other associated words, such as node, channel, cluster, and progression. Figure 1.6 attempts to provide a better understanding of the relationship between these types of targets from a more visual perspective.

### FIGURE 1.6 Three-pronged targets: types of targets.

<table>
<thead>
<tr>
<th>PAST</th>
<th>PRESENT</th>
<th>FUTURE</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>What is the touchstone event or experiential contributors? What does a client need to stabilize, and what resources does a client need before reprocessing begins?</em></td>
<td><em>What are the current experiences that bring the client to therapy (i.e., disturbing symptoms and reactions)?</em></td>
<td><em>Identify client’s positive vision for the future. What challenges does the client face in the future? What is a client’s capacity to allow for a positive outcome?</em></td>
</tr>
</tbody>
</table>

- **Past**
  - Single event
  - Acute stress response
  - Recent event
  - Single dominant issue/symptom
  - Multiple issues/symptoms

- **Present**
  - Present circumstance
  - Internal/external triggers

- **Future**
  - Desired future state
  - Positive template

**ANCILLARY TARGETS** *(Blocked Processing)*
- Feeder memories
- Blocking beliefs
- Peelback memories
- Fears
- Wellsprings of disturbance
- Secondary gains

**Cluster memories**
- Representational
- Generalizable

**Nodes**
- Progressions
TYPES OF EMDR TARGETS

As you think about your client sessions, do you recognize any of the types of targets, including the ancillary targets (i.e., other factors that may be contributing to a client’s disturbance) listed in Figure 1.6? The following definitions are provided as a refresher:

Targets From the Past

**Touchstone Memory.** A memory that lays the foundation for a client’s current presenting issue or problem. This is the memory that formed the core of the maladaptive network or dysfunction. It is the first time a client may have believed, “I am not good enough” or that this conclusion was formed. The touchstone event often, but not necessarily, occurs in childhood or adolescence. Reprocessing will be more spontaneous for the client if the touchstone events can be identified and reprocessed earlier in the treatment.

*Example:* As an adult, Mary Jane reported being uncomfortable engaging with large groups of people (i.e., 20 or more). She frequently experienced high levels of anxiety before and during office meetings, in church, and at social events. She was nervous, tentative, fearful, and unsure because she could not trust herself to be in control. During the history-taking process, it was discovered that, when she was in the second grade, Mary Jane wet her pants often. She was afraid to use the restroom because she feared its “tall, dark stalls.” Students often teased her, calling her “baby” and yelling out to the other students that she had wet her pants. What she came to believe about herself was, “I cannot trust myself.” This belief carried over into her later life and caused her to react tentatively in group situations.

**Primary Events.** These are stand-alone events that may emerge during the History-Taking and Treatment Planning, Reprocessing, and Reevaluation Phases, as well as over the course of treatment itself.

*Example:* Eddie entered therapy months before complaining of headaches and nightmares caused by memories of long-term sexual abuse by his paternal uncle. During the course of treatment, Eddie reported an event involving an automobile accident that occurred 13 years ago. As a result, Eddie still had some anxiousness around driving. This was targeted once the sexual abuse issues had been resolved.

Targets From the Present

**Circumstances.** Situations that stimulate a disturbance.

*Example:* Having his principal observe one of his classes caused Pierre to flush with anxiety, even though he had been Teacher of the Year three
times running and was a 25-year veteran in the public school system as a high school teacher.

**Internal or External Triggers.** Internal and external cues that are capable of stimulating dysfunctional stored information and eliciting emotional or behavioral disturbances.

*Examples:* Sights, sounds, smells, or sensations may be triggers. A client reports becoming triggered by driving on or near a section of roadway where he was involved in a fatal crash in which his best friend was killed. Or a client becomes anxious and ashamed when being questioned by a police officer, even though he has not done anything wrong. The client may react to his own physiological stimuli. For example, he may be triggered by a slightly elevated increase in heart rate, which he fears might lead to a panic attack. One cancer survivor was triggered by an unexplained headache and loss of appetite, leading to fears of recurrence of cancer.

**Targets From the Future**

**Future Desired State.** How would the client like to be feeling, sensing, believing, perceiving, and behaving today and in the future? What changes would be necessary? The third prong of EMDR Therapy focuses on targeting a positive template that will assist in incorporating positive new learnings and anticipatory events. This stage may involve teaching the client assertiveness skills, modeling good decision making, or having the client imagine future situations, such as coaching people to help them respond more appropriately.

*Example:* Ryan had always been a passive guy who never could say, “No.” “Peace at any cost” was his motto. The touchstone event identified with his conflict-avoidant behavior was a memory of his usually calm mother lunging at his father with a butcher knife during the heat of his father’s verbal attack. Before the night was over, his father had beaten his mother so severely that she was hospitalized for 3 days. Once this memory had been targeted and reprocessed, Ryan felt more empowered but needed instruction on how to stand up for himself more assertively. After assertiveness training, he was able to imagine himself successfully interacting and responding appropriately in conflict-laden circumstances.

**Positive Template (i.e., Imaginal Future Template Development).** A process in which the client uses the adaptive information learned in the previous two prongs to ensure future behavioral success by incorporating patterns of alternative behavioral responses. These patterns require a client to imagine responding differently and positively to real or perceived negative circumstances or situations or significant people.

*Example:* Joe came home from a business trip and found his wife in bed with his best friend. Joe and his wife had reconciled despite the obvious upheaval it had caused in their already shaky relationship. In the processing
of this abrupt discovery, Joe had mostly worked through his reactions and feelings toward his ex-best friend, but he never wanted to interact with him again. However, both worked at the same firm, and it was inevitable that their paths would cross. What the clinician had Joe imagine was a chance meeting with this man and how Joe would like to see this encounter transpire from beginning to end.

Other Potential Targets

**Node.** In terms of the AIP model, a node is an associated system of information (Shapiro, 2001). It is “the biologically stored experience central to the memory network designated for therapeutic targeting” (Shapiro, 2009–2014). It represents a memory network. A node could represent a cluster, a progression, or a feeder memory. To further clarify, a node is the target on which the client focuses during the reprocessing phases; and it represents the unprocessed (i.e., dysfunctional) incident. A target then is the agreed-upon incident the client focuses on and is identified in the initial treatment plan.

*Example:* Jeremy initially entered therapy because he had difficulty interacting professionally with his supervisor. Whenever his boss called or e-mailed asking him to come to his office, Jeremy felt like a small child being summoned to the principal’s office. “What did I do now?” he thought. After a thorough investigation of his past and present, Jeremy related how he felt and reacted around his father. “I always felt as though I had done something wrong.” Jeremy’s father worked and traveled extensively and was not home very much. When he was, Jeremy could find his father in his office working steadily and mostly unaware of the rest of the family activities in their home. His father was gruff and matter-of-fact and never paid much attention to Jeremy. When he wanted something from Jeremy or would reprimand him for something he did, he would call Jeremy to his office. It was one of those memories that became the target for Jeremy’s presenting issue.

**Cluster Memories.** These memories form a series of related or similar events and have shared cues, such as an action, person, or location. Each event is representational or generalizable to the other. These nodes are not targeted in the sessions in which they have been identified. The clinician usually keeps an active list of any nodes that arise during reprocessing and reevaluates them at a later date to see if further treatment is necessary.

*Example:* Anna between the ages of 7 and 10 years was stung by a bee three different times. Each of these events has varying degrees of trauma attached, but each possesses a shared cue, the bees. These are cluster memories and can be grouped together as a single target.

**Progression.** A progression is a potential node. It generally arises in the course of the reprocessing of an identified target during or between sets (Shapiro, 2001).
Example: Tricia was targeting incidents related to her mother publicly humiliating her when the memory of how her mother acted at her grandfather’s funeral arose. The clinician knew from previous sessions that Tricia had a close, loving relationship with her grandfather and that he was her primary advocate in the family. The clinician wrote down in her notes that her grandfather’s funeral may need to be targeted in and of itself. When a progression (i.e., potential target) arises, it is important not to distract the client from her processing of the current target. Rather, the clinician continues to allow the client to follow the natural processing of the present target and note any disturbance around this event that she may need to explore and target during a future session.

Feeder Memory. This type of memory has been described by Dr. Shapiro as an inaccessible or untapped earlier memory that contributes to a client’s current dysfunction and that subsequently blocks its reprocessing (2001). Unlike progressions, which typically arise spontaneously, feeder memories usually are discovered more by direct inquiry and are touchstone memories that are yet to be identified. If a client becomes stuck during reprocessing, there may be a feeder memory stalling the processing. A feeder memory also differs from a progression in that the feeder memory is an untapped memory related to the current memory being processed. When this type of memory emerges during reprocessing, it should be investigated immediately, especially if a client is blocking on an adolescent or adult memory (Shapiro, 2009–2014). A feeder memory is usually treated before the current memory (i.e., EMDR reprocessing within EMDR reprocessing). This is unlike a progression, which is a new target (i.e., memory) that pops up during the processing of another traumatic incident (see earlier, under Progression). The progression is acknowledged and processed at a later time. Direct questioning, floatback, and affect scan may be utilized to identify feeder memories.

Sometimes the identification and spontaneous processing of the feeder memory is sufficient to unblock the processing of the current memory. The feeder memory still needs to be checked following completion of the current memory to determine if it holds any additional disturbance. Sometimes, the current memory needs to be contained and the feeder memory reprocessed (i.e., Phases 3–6) before resuming reprocessing of the current memory.

Example: Brittany was in the midst of reprocessing a disturbing event involving malicious accusations by her mother (i.e., “You’re a slut.” “You must have brought it on somehow.” “You deserved everything that happened.”). These comments were made by her mother after Brittany at the age of 18 years was nearly raped while walking home from school 2 months earlier. Following several sets of reprocessing and clinical strategies to unblock or shift her processing, Brittany’s level of disturbance did not change. The clinician strategically asked Brittany to focus on the words “I am dirty” (her
original negative cognition) and to scan for earlier events in her life that were shameful and humiliating. The memory that finally emerged was the memory of her brothers waving her dirty underwear out a second-story window of their home for all the neighborhood boys to witness. The memory of her brothers’ cruel behavior is what is called a feeder memory.

Blocking Belief. A blocking belief is a belief that stops the processing of an initial target. This type of belief may resolve spontaneously during reprocessing or may require being targeted separately. Blocking beliefs typically show themselves when the clinician is evaluating the Subjective Units of Disturbance (SUD), Validity of Cognition (VoC), or Body Scan. In the Desensitization Phase, the SUD level will not move below 1 and, in the Installation Phase, the VoC remains below 7. Typically, when the clinician asks the client in the Desensitization Phase to focus on where the client feels it in her body and, if needed, asks after subsequent sets, “What keeps it a ___?” or “What prevents it (i.e., SUD) from being a 0?” or, if the client is in the Installation Phase, “What keeps it a ___?” or “What prevents it (i.e., VoC) from being a 7?” the client may be able to respond with a negative belief and an appropriate, associative early memory. At this point, the processing on the initial target is stopped until the blocking belief memory has been targeted and reprocessed. This does not necessarily require a new target but may be processed with the current target. The direct questioning, floatback, and affect scan techniques are generally useful in identifying blocking beliefs. If after processing there is no change, the clinician may consider the ecological validity of the blocking belief.

Example: Heather, a sergeant in the military, returned home after sustaining injuries during a rocket attack while on a routine field mission in Afghanistan. Two of her fellow soldiers died from the blast. Heather was hit by flying shrapnel that literally left a hole in her leg. She required two subsequent surgeries, neither of which resulted in removing all of the rocket shrapnel from her leg. During recuperation, Heather reported disturbing recurring dreams, flashbacks, and thoughts of the rocket attack, which were frequently accompanied by high levels of anxiety or a panic attack. While reprocessing the event, the sergeant’s negative cognition was “I’m unsafe” and her positive cognition was “I can be safe.” When assessing the sergeant’s positive cognition during the Installation Phase, she reported a VoC of 6. After attempting to shift her response by asking, “Where do you feel it in your body?” with no success, Heather was asked by the clinician, “What prevents it (i.e., VoC) from being a 7?” Heather immediately responded with the blocking belief, “I can never be safe.” Further questioning by the clinician revealed that, when Heather was 5 years old, she had been digitally penetrated by an older cousin who had said to her, “If you tell anyone what happened, you will never be safe. I will find you. And I will kill you.” This is also a feeder memory in that it contributes to the current dysfunction and blocked processing. This feeder memory is represented by the blocking belief, “I can never be safe.”
Peelback Memory. A peelback memory usually occurs when a touchstone has not been identified and, during reprocessing, other associations begin to “peelback” to expose prior disturbing memories. There is often confusion between a progression and a peelback memory. A peelback memory is an earlier unsuspected memory, whereas a progression is any new associated memory.

Example: After the processing of an earthquake, Taylor continued to exhibit symptoms of PTSD for which there seemed to be no reason. She continued to have many problems associated with the earthquake despite the fact that her house had remained intact, and she or others in her family did not sustain any injuries. Her initial intake showed no indications of previous trauma. On further processing of the earthquake, an early association “peeled back” a memory in her 20s when she was date raped and then again to an even earlier time when she was molested by a neighbor in her adolescence. Her initial negative cognition, “I am not safe,” may have helped to uncover these earlier memories. Unlike a feeder memory, which is an earlier disturbance that blocks the reprocessing of the event, a peelback memory emerges spontaneously during reprocessing. It is similar in terms of the emotional, physical, or cognitive content of the memory being reprocessed but does not block the processing of the current memory being reprocessed.

Fears. Fear in the processing of targeted information can become a blocking mechanism. It stalls the process. Dr. Shapiro identified fears to include fear of the clinical outcome of EMDR Therapy or the process itself, fear of going crazy, fear of losing good memories, and fear of change. Fear of the process can be readily recognized whenever a client begins to identify elements of EMDR Therapy that appear to be problematic for her (2001). Also check to ensure that any expressed fears of the process are not related to secondary gain.

Example: It is not unusual for a client to express concern or fear that he is not “doing it” (i.e., the process) correctly or is afraid of extreme abreaction or that the clinician cannot handle the potential level of distress that he might express during the reprocessing.

Wellsprings of Disturbance. This phenomenon is indicative of “the presence of a large number of blocked emotions that can be resistant to full EMDR processing” (Shapiro, 2001) and is often caused by the existence of an extensive negative belief system. A wellspring is similar to a feeder memory in that both feed the emerging emotions. Clients who are resistant to therapy or who seek therapy involuntarily at the urging of someone else (e.g., therapy is court ordered, military command ordered, or requested by a persistent and threatening spouse or parent) are most susceptible to this phenomenon. They are in therapy because of someone else and possess no desire to report or deal with any feelings (Shapiro, 2001).
Example: A man who is forced into therapy at the urging of a disgruntled spouse may possess the belief that “real men don’t cry.” This belief may be associated with an earlier traumatic memory and result in the client suppressing any high level of disturbance that might otherwise naturally occur under a current circumstance (e.g., dealing with his wife’s raging episodes). The true level of affective disturbance is never reached by the client, and it is this same level that contributes to the client’s present dysfunction. Earlier experiences taught him that men (or boys) are not allowed to express themselves emotionally. If there is no change in the client’s imagery, body sensations, or insight, but he continues to report a low level of disturbance, the wellspring phenomenon is probably in effect. When present, the clinician may need to provide additional EMDR strategies in order to access the blockage. See the formulas in Figure 1.7.

The distinctions between wellsprings of disturbance and blocking beliefs are important because the presence of either determines what course of action a clinician may take to resolve the blocking issues.

Secondary Gain. A secondary gain issue has the potential of keeping a presenting issue from being resolved.

Example: Typical examples involve the following: what would be lost (e.g., a pension check); what need is being satisfied (e.g., special attention); or how current identity is preserved (e.g., “If I get over my pain, I’m abandoning those who have stood by me since the war.” Or, “If I lose my disability, how will I support my family?”).

Channels of Association. Within the targeted memory, events, thoughts, emotions, and physical sensations may spontaneously arise or arise when a client is instructed to go back to target (i.e., return to the original event [incident, experience]). These are called channels of association and may emerge any time during the reprocessing phases (i.e., Phases 3–6).

When cognition based, channels of association may be another level of the same plateau (responsibility/defectiveness, safety/vulnerability, or power/control [or choice]) or can be another plateau entirely.

Example: Cara was in the middle of reprocessing being robbed (e.g., safety) after a movie one Friday night. After about five or six sets, she remembered that she had failed to zip up her purse while still in the theater when getting her keys out to drive home. She had a huge bank envelope largely visible for anyone to see (i.e., responsibility). When this channel cleared (i.e., continued to remain positive or remained neutral), the clinician

| Blocking Belief | A negative belief about oneself that stalls reprocessing |
| Wellsprings of Disturbance | Negative Beliefs + Unresolved (Early Memories) + Blocked Emotions |

FIGURE 1.7 Difference between wellsprings of disturbance and blocking belief.
took her back to target, and another channel of association emerged. Cara remembered seeing the robber in the movie theater and that he had been intensely staring at her. She decided it was nothing to worry about and went out to her car (e.g., choice, control).

Channels of association may emerge during reprocessing, where related memories, thoughts, images, emotions, and sensations are stored and linked to one another. The following example demonstrates a series of channels related to the client’s emotions.

**Example:** Cara was robbed after a movie one Friday night. After one set of BLS, the fear that she reported during the Assessment Phase worsened as her hands began to tremble and chest tightened. When this channel cleared (i.e., continued to remain positive or remained neutral), the clinician took her back to target, and another emotional channel of association emerged. Cara expressed anger with the robber and with herself for being so careless with the bank envelope.

Now that you have a clearer picture of what these targets are and how they are related, can you think of examples for each? Recollect targets from some of your reprocessing sessions with clients to help you identify examples of each. Targets—*past, present, future*—especially ancillary targets, can emerge in any of the three prongs in the EMDR protocol. Refer to Figure 1.8 for assistance. It is important to be on the lookout for them through the entire process in order to ensure adaptive resolution of every aspect of the client’s traumatic history.

**BILATERAL STIMULATION (BLS)**

What Does It Do?

Bilateral stimulation, along with dual attention (i.e., simultaneous awareness of the traumatic memory and the present) and the eight-phase, three-pronged protocol, are the core components of EMDR Therapy. Research has validated that BLS makes a unique and effective contribution. The client simultaneously focuses on a negative aspect of an internal experience (e.g., image, thought, emotion, physical sensation) while experiencing rapid, alternating external stimuli (e.g., eye movements, taps, tones).

When Dr. Shapiro was in the early stages of developing the theory, procedures, and protocol behind EMDR Therapy, she thought that it was the saccadic eye movements or eye tracking that helped to activate the information processing system, which processes the dysfunctionally stored material around a traumatic event. Alternating bilateral hand taps and auditory tones may also be utilized. The type of BLS utilized is important in terms of what the client can best tolerate while facilitating dual attention. A person with an eye disorder obviously might not be able to track a clinician’s fingers well. Someone who does not like to be touched may not be able to tolerate being tapped by the clinician or the
close proximity of the clinician to them. The type of stimulation chosen depends on the client. Although eye movements are the preferred form of BLS, it is important to be able to offer alternative types of BLS to accommodate the client’s needs.

A client’s preferred means of BLS is not always the most effective. De Jongh, Ernst, Marques, and Hornsveld’s (2013) discrepant findings “suggest that patients are not the ones that should choose or decide which modality is best for them when they request EMDR Therapy.” Dr. Shapiro (2014)
EMDR Therapy Overview

recommends eye movements as the preferred method of BLS but also suggests that clients be offered tactile or tones when deemed necessary.

In the event that information during reprocessing is not moving or becomes stuck, it is important to have the client agree beforehand on two preferred directions (i.e., back and forth, up and down, or diagonal) or two types of modalities (i.e., eye movements, audio, tapping) from which the client can choose. Thus, if a need for change in direction or modality occurs, the client has agreed to his preferences in advance. Any time a change in BLS is indicated, the clinician should check with or inform the client that a change is being made before implementing the change.

Preferred Means of Bilateral Stimulation (BLS)

Dr. Shapiro’s (2001) preferred means of BLS is eye movement. All the research involved in establishing the efficacy of EMDR Therapy was conducted utilizing eye movements. This type of stimulation also supports dual attention, whereby the client can attend to both internal and external stimuli. The client processes using eye movements with his eyes open so that he remains aware of his present environment.

Many studies have focused on investigating the role of eye movements in EMDR to date (Acierno, Tremont, Last, & Montgomery, 1994; Andrade, Kavanagh, & Baddeley, 1997; Barrowcliff, Gray, MacCulloch, Freeman & MacCulloch, 2003; Boudewyns & Hyer, 1996; Chemtob, Tolin, van der Kolk, & Pitman, 2000; Christman, Garvey, Propper, & Phaneuf, 2003; Christman, Propper, & Brown, 2006; Davidson & Parker, 2001; Devilly, Spence, & Rapee, 1998; Engelhard et al., 2011; Engelhard, van den Hout, Janssen, & van der Beek, 2010a; Gunter & Bodner, 2008; Kavanagh, Freese, Andrade, & May, 2001; Kuiken, Bears, Miall, & Smith, 2002; Kuiken, Chudleigh, & Racher, 2010; Lee & Drummond, 2008; Lohr, Tolin, & Kleinknecht, 1995, 1996; MacCulloch, 2006; Maxfield, Melnyk, & Hayman, 2008; Parker, Buckley, & Dagnall, 2009; Parker & Dagnall, 2007; Parker, Relph, & Dagnall, 2008; Pitman et al., 1996; Propper & Christman, 2008; Renfrey & Spates, 1994; Samara et al., 2011; Sanderson & Carpenter, 1992; Schubert, Lee, & Drummond, 2011; Sharpley, Montgomery, & Scalzo, 1996; Solomon, Gerrity, & Muff, 1992; van den Hout et al., 2011; van den Hout, Muris, Salemink, & Kindt, 2001; van Etten & Taylor, 1998; Wilson, Silver, Covi, & Foster, 1996).

Two dominant theories have emerged as a result of these research studies about the effects of eye movement during EMDR: (a) eye movements have a tendency to interfere with working memory by reducing emotional vividness of autobiographical memories (Andrade, Kavanagh, & Baddeley, 1997; Barrowcliff et al., 2003; Barrowcliff, Gray, Freeman, & MacCulloch, 2004; Engelhard et al., 2010a, 2011; Engelhard, van den Hout, Janssen, & van der Beek, 2010b; Gunter & Bodner, 2008; Kavanagh et al., 2001; Maxfield et al., 2008; Schubert et al., 2011; van den Hout et al., 2001); and (b) eye movements are linked into the same processes as REM
sleep (Barrowcliff et al., 2004; Christman et al., 2003; Christman et al., 2006; Elofsson, von Scheele, Theorell, & Sondergard, 2008; Kuiken et al., 2002, 2010; Parker & Dagnall, 2010; Parker et al., 2008, 2009; Sack, Lempa, Steinmetz, Lamprecht, & Hofmann, 2008; Schubert et al., 2011; Stickgold, 2002, 2008). Stickgold (2002) proposed that “the repetitive redirecting of attention in EMDR induces a neurobiological state, similar to that of REM sleep” (i.e., the effect of BLS is related to REM in a waking state).

Studies suggest that eye movements are superior to tones (van den Hout et al., 2012) and saccadic eye movements are superior on all parameters in all conditions to vertical eye movements (Parker et al., 2008). One study found that eye movements increased the true memory of an event (Parker et al., 2009). No research presently exists to support having the client process with his eyes closed. Lee and Cuijpers (2013) reported positive effects of eye movements in their meta-analysis.

Table 1.11 outlines the randomized studies of hypotheses regarding eye movements in EMDR reprocessing.

**Shorter or Longer? Slower or Faster?**

During the Preparation Phase, BLS is originally introduced with the calm (safe) place and any other resource enhancement or stabilization exercises deemed appropriate by the clinician prior to using EMDR reprocessing and, then again, during reprocessing in the Desensitization, Installation, and Body Scan Phases. There is a difference in the speed and number of BLS passes used. A single pass in terms of BLS is a “round trip” from center to right, then to left, and back to center again. A series of passes make up a “set.” The recommended rate of speed is slower, and the number of round-trip passes is fewer (i.e., 4–6 round trips) when using BLS with resource, coping, relaxation, and stress reduction exercises and strategies. Slower and shorter sets are utilized in stabilization efforts so as to not activate any disturbing material prior to actual reprocessing.

While using BLS when reprocessing, including installation and, when necessary, the body scan, the speed is tolerably comfortable (i.e., much faster) for the client and number of passes is increased (i.e., from 24 to 40 round trips is average during the reprocessing phases). The number of sets of BLS is determined by attention to the client’s response and is customized to the needs of the client. Faster and longer sets of BLS are more likely to activate linkages to other memory networks and trigger associated channels of information. The longer and faster the eye movement, the faster the associative linkages occur. Always increase the speed of BLS with caution because, if associative linkages come too fast for a client’s window of tolerance, it can lead to a loss of dual awareness. Faster BLS may impede effective processing and consequently lead to slower reprocessing. On the other hand, if a client is trying to “think” rather than just observe during reprocessing, faster eye movements can help move him into actual reprocessing.
**TABLE 1.11**

**Hypothesis Regarding Eye Movements—Randomized Studies to Date**

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<thead>
<tr>
<th>Year</th>
<th>Authors</th>
<th>Methods and Results</th>
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### TABLE 1.11 (continued)

**Hypothesis Regarding Eye Movements—Randomized Studies to Date**

<table>
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<tr>
<th>Year</th>
<th>Study Details</th>
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<tbody>
<tr>
<td>2004</td>
<td>Barrowcliff, A. L., Gray, N. S., Freeman, T. C. A., &amp; MacCulloch, M. J. (2004, June). Eye-movements reduce the vividness, emotional valence and electrodermal arousal associated with negative autobiographical memories. <em>Journal of Forensic Psychiatry and Psychology, 15</em>(2), 325–345. doi:10.1080/14789940410001673042. In testing the reassurance reflex model, it was found that eye movements were found to be superior to control conditions in terms of reducing image vividness and emotionality.</td>
</tr>
<tr>
<td>2007</td>
<td>Parker, A., &amp; Dagnall, N. (2007). Effects of bilateral eye movements on gist based false recognition in the DRM paradigm. <em>Brain and Cognition, 63</em>, 221–225. doi:10.1016/j.bandc.2006.08.005. Bilateral saccadic eye movement groups “were more likely to recognize previously presented words and less likely to falsely recognize critical non-studies associates.”</td>
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(continued)
Hypothesis Regarding Eye Movements—Randomized Studies to Date

Supported the working memory explanation on the effects of eye movement on dual-attention tasks on autobiographical memory.


Bilateral saccadic eye movement group superior on retrieval of the item and associative and contextual information.

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<th>Year</th>
<th>Study Details</th>
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TABLE 1.11 (continued)
Hypothesis Regarding Eye Movements—Randomized Studies to Date


In healthy adults, 30 seconds of bilateral saccadic eye movements “enhanced the episodic retrieval of non-traumatic emotional stimuli.”


Eye movements led to increased reduction in distress, decrease in heart rate at onset of EMs, decrease in skin conductance during EMs, increase in heart rate variability and respiration as EMs continued, and increased frequency of orienting responses at the start of exposure.


Supports a working memory account of EMDR Therapy and that eye movements are superior to the effects of beeps on negative memories.

2012


Supports the theory that emotionality reduces only after vividness has dropped.

2013


Functional connectivity between the two hemispheres of the brain increased by bilateral activation of the same.


Evidence for the value of employing eye movements in EMDR treatment, and evidence that a client’s preference of BLS (eye movements, tactile, or auditory) may not necessarily be the most effective form of bilateral stimulation.
During the Desensitization Phase, the suggested average number of BLS sets (i.e., 24 longer, faster sets) is only a starting point for the client’s processing. As the clinician wants to avoid sets that are too long or too short, it is suggested that she begin with 20 or more passes and watch the client’s facial expressions and body language to determine the best length for any particular set. After this initial set, the clinician may customize the number of sets according to the client’s need or response.

Some clients may require shorter or longer and/or slower or faster sets. For instance, clients who are anxious and/or unsure of the process may require longer sets of BLS. In addition, some clients need more time to shift from an external (outward) to an internal (inward) focus. The longer sets of BLS create adequate time for the client’s processing to unfold and increase the likelihood of the client experiencing success with reprocessing. If a clinician watches eyes and other body language, clues will usually arise that indicate the appropriate pace and number of BLS sets. It is always appropriate to ask the client for feedback as well.

In terms of desensitization and speed, eye movements (or passes) that are too slow have a tendency to stimulate a relaxation response and may not facilitate sufficient dual attention. Therefore, it is imperative for optimal processing that the clinician facilitates the passes as fast as the client can comfortably tolerate. In addition, the clinician should avoid long pauses between sets without a specific reason (e.g., the client feels the need for clinician connection). The client is discouraged from talking at any length between sets. It is suggested that the clinician minimally or nonverbally acknowledge what the client has reported and say, “Notice that” or “Go with that.”

Although the purpose of the Installation Phase is to fully integrate a positive self-assessment with the targeted information, there is still the possibility that other associations could emerge that may need to be addressed. The faster, longer sets of BLS facilitate the emergence of any lingering disturbing material related to the original targeted event. Remember, a completely successful treatment of the original target memory cannot be attained until the early memories that caused the blocking belief are reprocessed. There is little research regarding this widely practiced distinction in the speed and number of sets of BLS. However, it is considered a guideline by many EMDR trainers, consultants, facilitators, and therapists.

With the exception of the reprocessing phases of treatment, shorter, slower sets of BLS (approximately 4–6) are used to reinforce and strengthen the client’s positive networks. The clinician wants to ensure that the client’s brain is not activated in such a way as to associate the positive networks with maladaptive experiences. Especially with more complex cases, the client may not possess sufficient adaptive memory networks; and the client must have access to adaptive memory networks in order for reprocessing to occur. During the Installation Phase, the sets of BLS should be longer and faster (i.e., 24–40) because the client is strengthening the connection between the newly processed memory and its connection to other existing adaptive
information networks and/or continued reprocessing of associated negative networks as well. Therefore, in essence, when a clinician wants to manage a client’s response, use slow, shorts sets; when a clinician wants to allow a client’s associations to roam freely, use longer, faster sets. Table 1.12 demonstrates when to use long or short and slow or fast sets of BLS.

**Note:** If a positive association occurs during reprocessing, do not slow the speed of the BLS or decrease the number of sets. During Phases 3 to 6, the sets of BLS are faster and longer as there is always the possibility of negative associations emerging at any phase.

**Continuous Bilateral Stimulation (BLS)**

Although there may be clinicians who administer one continuous sequence of BLS throughout the Desensitization, Installation, and Body Scan Phases, Dr. Shapiro (2001) clearly outlines the reasons for breaking the stimulation into sets (Table 1.13).

Table 1.14 lists what can happen if BLS (i.e., in terms of speed and number of sets) is used inappropriately.

**How to Do Eye Movements**

Table 1.15 outlines the specific criteria outlined by Dr. Shapiro (2001) on the proper and acceptable way to facilitate eye movements in terms of preference, duration, speed, distance, height, and more.

**Is Bilateral Stimulation (BLS) EMDR Therapy?**

Bilateral stimulation is but one component of EMDR Therapy. Stimuli, such as directed and accelerated eye movements, are used to activate the client’s information processing system as he focuses on a past trauma, present-day trigger, or future event. Over the years, many beginning students of EMDR...
Therapy, consultees, and even seasoned veterans have referred to BLS as EMDR. BLS is used when facilitating the sacred space, calm (safe) place, and resource development exercises (Appendices B and C). When coupled solely with BLS, does this mean that sacred space, calm (safe) place, resource installation, or even the reprocessing phases are EMDR Therapy? EMDR Therapy is clearly identified as an eight-phase, three-pronged process. If one of the phases is eliminated or substituted with something else, it can no longer be called EMDR Therapy.

**IMPORTANT CONCEPTS TO CONSIDER**

**Memory Network Associations**

No one knows what a memory network looks like, but these networks represent the basis of the AIP model. Metaphorically, Dr. Shapiro pictures these networks as a series of channels “where related memories, thoughts, images, emotions, and sensations are stored and linked to one another” (Shapiro, 2001). The negative memory network associations may consist of a series of memories linked to a person (e.g., critical mother); auditory, tactile, or other sensory stimuli (e.g., the sound of a car backfiring); events (e.g., automobile accident, plane crash, tornado); physical sensations (e.g., chest or leg pain);

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<thead>
<tr>
<th>TABLE 1.13 Reasons for Breaking Bilateral Stimulation (BLS) Into Sets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides an opportunity for the clinician to determine if processing has occurred based on the client’s feedback</td>
</tr>
<tr>
<td>Gives the client a break from processing, especially if a set contained an intense abreactive response</td>
</tr>
<tr>
<td>Helps a client reorient in terms of present time and consequent safety (i.e., helps to keep “one foot in the present”) and, thereby, facilitates dual awareness</td>
</tr>
<tr>
<td>Allows a client to share any new revelations or insights that arise during processing</td>
</tr>
<tr>
<td>Allows a clinician to reaffirm a client’s experience throughout the process</td>
</tr>
<tr>
<td>Enables a client to better integrate any new information that emerges on a verbal or conscious level</td>
</tr>
<tr>
<td>Allows a clinician to continually reassess or judge the need for any additional clinical interventions or strategies</td>
</tr>
<tr>
<td>Provides multiple opportunities for a clinician to give and a client to receive encouragement and reassurance</td>
</tr>
<tr>
<td>In terms of abreactive responses, it solidifies for a client that he is larger than the disturbing experience and in control as he demonstrates he can approach and distance from the disturbance during these breaks</td>
</tr>
</tbody>
</table>
TABLE 1.14
Derailment Possibilities—Bilateral Stimulation (BLS) Errors

**Using long and fast sets when doing stabilization.** Doing so may activate processing prematurely (i.e., speeds up the train) and cause a client to begin processing any dysfunctionally stored past memories or present triggers.

**Using short and slow sets when doing reprocessing.** Slow, short BLS may stimulate a relaxation response and inhibit a client from being appropriately activated by the targeted incident/event. When doing reprocessing, the BLS should be tolerably uncomfortable for the client. Using slow, short sets may also not facilitate dual awareness. It becomes too easy for a client to become absorbed in the memory when following eye movements that are too slow or too short.

*Note:* Wilson, Silver, Covi, and Foster (1996) and Schubert, Lee, & Drummond (2011) found that faster BLS may, at times, cause a compelled relaxation response.

**Continuing with eye movements if a client reports pain or dryness because of the process.** If this occurs, switch to a previously agreed-on, alternate form of BLS. For example, if a client was reportedly poked in the eye when he was a child, auditory or tactile stimulation may be a better alternative.

**Pausing too long in between sets.** There should be a specific reason for pausing too long between sets. Maybe the client is overwhelmed, “needs” to talk, or wants assurance that she is “doing it right.” If the client tends to relay everything that happened between sets, gently explain the information he gives is for baseline reasons only (i.e., to let the clinician know where the client is in the process), that the “mind is faster than the mouth,” and only minimal information is needed between sets. When a clinician or client talks excessively between sets, it inhibits the reprocessing (i.e., slows the train) of the targeted material.

**During reprocessing, using sets that are too long or too short.** Using sets that are too long may cause a client to lose track of the primary event and become overwhelmed with too many thoughts, images, and emotions, and may inhibit or derail processing. Sets that are too short may inhibit processing by not giving a client enough time to initiate complete processing. The rule of thumb is to start with 20 plus sets of eye movements and judge from a client’s response (i.e., facial expression and body language) to determine what the appropriate number of sets is for each individual client. However subtle, a client will usually give a clue as to when a set is complete.

(continued)
Using continuous BLS (i.e., taking no breaks). Using continuous BLS throughout an entire EMDR session follows the same logic for long sets. The primary purpose of stopping the train is so dysfunctional information may be unloaded and more adaptive information may be loaded. Also, taking a break between sets helps a client keep “one foot in the present.”

Continuing with BLS when the client has indicated that he is finished with the set. It is not uncommon for a client to look at a therapist and say, “Can we take a break right now. I need to say something?” In the event this occurs, simply stop the train and allow the client to unload any material; and restart the train when the client is willing and able.

TABLE 1.15
How to Do Eye Movements

<table>
<thead>
<tr>
<th>BEFORE CONCENTRATING ON EMOTIONALLY DISTURBING MATERIAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initially using horizontal or diagonal eye movements, find the best fit for a client (e.g., horizontal, vertical, diagonal).</td>
</tr>
<tr>
<td>Note: The vertical eye movements may be preferred if a client has a history of vertigo. It is also reported to be helpful in reducing extreme emotional nausea, agitation, eye tension, or dizziness. Vertical eye movements have been known to produce a calming effect.</td>
</tr>
<tr>
<td>Experiment to find a client’s comfort level (i.e., distancing, speed, height).</td>
</tr>
<tr>
<td>Switch immediately to an alternate form of BLS if a client reports eye pain or dryness.</td>
</tr>
<tr>
<td>Generate a full eye movement set by moving a clinician’s hand from one side of a client’s range of vision to the other.</td>
</tr>
<tr>
<td>The speed of the eye movement should be as rapid as possible and without any undue physical discomfort to a client.</td>
</tr>
<tr>
<td>Use at least two fingers as a focal point (i.e., two fingers held together is usually the preferred number in American culture).</td>
</tr>
<tr>
<td>With palm up approximately 12–14 inches from a client’s face (i.e., preferably chin to chin or contralateral eyebrow, some say shoulder to shoulder), hold two fingers upright and ask a client, “Is this comfortable?”</td>
</tr>
<tr>
<td>Note: It is important to determine distance and placement of the eye movement with which a client is the most comfortable prior to the Assessment Phase.</td>
</tr>
<tr>
<td>Demonstrate the direction of the eye movements by starting in the middle and slowly moving the fingers back and forth in a client’s visual field, and then ending in the center.</td>
</tr>
</tbody>
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(continued)
TABLE 1.15 (continued)
How to Do Eye Movements

Evaluate and monitor a client’s ability to track the moving fingers. Start slowly and increase the rate of speed to the fastest a client can comfortably tolerate physically and still keep in her window of emotional intensity. Ask a client during this testing phase if he has any preferences in terms of speed, distance, and height prior to concentrating on any negative emotions or dysfunctional material.

AFTER CONCENTRATING ON EMOTIONALLY DISTURBING MATERIAL

Listen to the client’s feedback to determine if adequate processing is taking place at the end of a session.
If the client appears comfortable and shifts are occurring, maintain the predetermined speed.
If the client is uncomfortable and shifts are not occurring, the clinician may need to adjust the speed, direction, and number of eye movements.
If the client appears stuck (i.e., after successive sets of eye movements, the client reports no shifts), change the direction of the eye movement.
If a client experiences difficulty (i.e., manifests in irregular eye movements or “bumpiness”) following a clinician’s fingers, attempt to assist the client to establish a more dynamic connection and sense of movement control that results in smoother tracking by instructing the client to, “Push my fingers with your eyes.”
Assess the client’s comfort, preferred speed, and ability to sustain eye movements by listening to her feedback between sets.
If the client reports an increase in positive shifts, continue to maintain the same direction, speed, and duration.
Note: If a clinician believes it might be beneficial, it is appropriate to experiment. However, a client’s feedback should be the final determinant whether to decrease or increase the duration of a set.
Continue BLS until a shift or plateau is observed in the client unless the client utilizes his stop sign.
If a client experiences weakness in her eye muscles, she may be unable to do more than a few eye movements at a time.
If a client is experiencing high levels of anxiety, demonstrates a tracking deficit, or finds them aversive, he may be unable to track hand movements.
Note: If this occurs, reprocess the underlying experience of discomfort, and if need be, use the two-handed approach or auditory or tactile stimulation. The two-handed approach entails having the therapist position his closed hands on opposite sides of the client’s visual field at eye level and then alternating raising right and left index fingers while instructing the client to move eyes from one raised finger to the other. This type of BLS creates an orienting or attentional response and eliminates the need for client tracking.
emotions (e.g., fear, sadness); or beliefs (e.g., I am unlovable). The goal is to assist the client’s progression through these memory networks and toward an adaptive resolution.

Stop Signal

It is important to heed a client’s wishes at all times to ensure a sense of safety in the therapeutic environment. EMDR treatment is a choice, and the desire to stop or continue in whatever context is a choice as well. It is one a clinician should always respect. It is imperative a client feels at all times that the process is a choice and not an imposition or demand.

In the Preparation Phase, the client is asked to provide the clinician with a cue that indicates he wants to stop the processing. It may be a hand, finger, or body gesture. The client may simply just turn away or hold her arms up in the air. Whatever the cue is, the processing should be discontinued immediately when used. This allows the client to maintain an ongoing sense of comfort, safety, and control. When this cue to stop is utilized, the clinician assists the client in accessing whatever is needed to stabilize the client and to proceed with the processing. Discontinue all BLS until the client is willing and able to continue reprocessing. The clinician may explore what is needed in order that reprocessing may resume. The clinician should inquire of a client, “What happened? Why do you want to stop?” Perhaps a client needs to take a break because he is confused or overwhelmed or he simply wants to share concerns about the processing itself. The clinician may ask, “Why did you stop?” and address any concerns the client may have. And then, “What is it you need to continue processing? If a client does not want to continue, the clinician may suggest that a client go to his calm (safe) place or sacred space. Be certain a client has what he needs before continuing processing. If a client still insists that he does not want to continue, a clinician should respectfully use the procedures for closing down an incomplete session and only return to processing when a client is ready (Shapiro, 2009–2014). Table 1.16 demonstrates some appropriate ways for a client to indicate he wants to discontinue or pause the process.

It is important not to accept words for stop signals (e.g., “Stop,” “No more,” “I can’t do this,” “I want to throw in the towel,” or “Whoa!”) as it may be confused with what is actually going on in the processing.

EMDR Therapy Is Not Hypnosis

A frequent question asked by clients is “Is EMDR hypnosis?” When this question is asked, the clinician may want to spend some time with the client explaining the basic differences between the two. Clients may be concerned
that EMDR reprocessing will induce a deep trance state where he may lack control. Unlike hypnosis, EMDR reprocessing causes a state of heightened emotional arousal. This is an important distinction for the clinician to make when this question arises.

The differences between hypnosis and EMDR Therapy are summarized in Table 1.17.

**What Once Was Adaptive Becomes Maladaptive**

Some behaviors are learned. Some serve us well and others do not. Some serve us for a period in our life and eventually become a nuisance. For example, a woman who was repeatedly sexually molested by a relative as a young child may have learned to dissociate during the molestation. This was her automatic coping response to the fear and pain of the trauma at the time of the abuse. Years later, as an adult, she may still find herself dissociating during stressful situations in her work and life. As a child, dissociation was the only response available and allowed her to cope; it worked well at the time. As a maturing adult, the dissociation begins to cause problems at home, at school, and/or at work.
<table>
<thead>
<tr>
<th>EMDR</th>
<th>HYPNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrative psychotherapy model</td>
<td>Medium within which EMDR may be practiced and enhanced (Brown, 2006)</td>
</tr>
<tr>
<td>Efficacious treatment for PTSD (Bisson et al., 2007; Spates, Koch, Cusack, Pagoto, &amp; Waller, 2009)</td>
<td>Case reports available that suggest the efficacy of hypnosis for trauma treatment outcomes (Cardena, Maldonado, van der Hart, &amp; Spiegel, 2009)</td>
</tr>
<tr>
<td>EEG readings taken during EMDR reprocessing show a brain-wave pattern within normal waking parameters (Nicosia, 1995)</td>
<td>Theta (Sabourin, Cutcomb, Crawford, &amp; Pribram, 1990), beta (DePascalis &amp; Perrone, 1990), or alpha (Meares, 1960) waves are characteristic of hypnotized subjects</td>
</tr>
<tr>
<td>During desensitization, the client may be in a state of heightened emotional arousal</td>
<td>After induction, the client usually is in a deep hypnotic state</td>
</tr>
<tr>
<td>Therapist follows a set procedure and generally does not include therapist-generated suggestions (i.e., lacks suggestibility; Hekmat, Groth, &amp; Rogers, 1994)</td>
<td>There is no set procedure and includes therapist-generated suggestions (i.e., encourage suggestibility)</td>
</tr>
<tr>
<td>Each set of eye movements lasts about 30 seconds</td>
<td>Client is in a trance lasting anywhere from 15 to 45 minutes or longer</td>
</tr>
<tr>
<td>Memories may emerge, but memory retrieval is not the primary purpose</td>
<td>Is often used for memory retrieval</td>
</tr>
<tr>
<td>Images of memories generally become more distant and less vivid and more historical</td>
<td>Images of memories are generally enhanced and made more vivid and experienced in real time</td>
</tr>
<tr>
<td>Clients tend to jump from one associative memory to another</td>
<td>Clients follow a moment-by-moment (“frame-by-frame”) sequence of events</td>
</tr>
<tr>
<td>Eyes are usually open</td>
<td>Eyes are closed throughout the induction and treatment phase</td>
</tr>
<tr>
<td>Uses BLS (e.g., eye movements, taps, tones)</td>
<td>Does not use BLS</td>
</tr>
<tr>
<td>Clients appear more alert, remain conscious, and are less susceptible to inappropriate suggestion</td>
<td>Clients are less alert, not conscious, and more susceptible to suggestion</td>
</tr>
</tbody>
</table>

(continued)
Differences Between EMDR Therapy and Hypnosis

<table>
<thead>
<tr>
<th>EMDR</th>
<th>HYPNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not induce a trance state</td>
<td>Induces a trance state</td>
</tr>
<tr>
<td>Dual focus of attention is deliberately maintained at all times</td>
<td>Dual focus of attention may occur (Harford, 2010)</td>
</tr>
<tr>
<td>For long-term trauma issues, duration of treatment is often brief</td>
<td>For long-term trauma issues, duration of treatment is often lengthy</td>
</tr>
</tbody>
</table>

Developing and Enhancing Adaptive Networks of Association

Before processing of the negative networks may begin, clients with more complex cases may need to access, strengthen, and reinforce positive life experiences and adaptive memories (e.g., positive resources and behaviors, learning, self-esteem). It is possible to access these positive experiences by developing new and enhancing existing positive networks described as follows.

**Developing New Positive Networks**: (a) New positive experiences are created when the clinician teaches the client calm (safe) place and other stress management and relaxation techniques; (b) the initial introduction of BLS with stabilization exercises creates a positive experience with eye movements or other forms of BLS; and (c) the use of slower, shorter sets of BLS with the safe place, sacred space, or resource development and installation (RDI) imagery helps to create a positive experience for a client by inducing and fortifying agreeable or satisfying feelings (e.g., sense of safety, self-confidence, assurance) that currently exists within a client’s positive neural networks. The goal is to create a positive experience in which a client begins to trust the BLS process, as well as strengthening and enhancing the therapeutic alliance. This may become its own positive network.

**Enhancing Already Existing Positive Networks**: Investigate and determine what positive life experiences and adaptive memories already exist. As the client holds these positive experiences in mind, the clinician implements BLS until the client feels the earlier positive emotions. If a client cannot come up with a positive memory, have him imagine one and facilitate the same steps mentioned previously. Identifying these positive memories is an important part of the Preparation Phase and facilitates later processing. This exercise works particularly well with a child who may need a stronger sense of safety or assurance before undergoing reprocessing.
Example. A client presents with a history of anxiety. The clinician asks the client to imagine a time in her past when she felt empowered and safe and instructs her to imagine how it might have felt to look, feel, and act that way again in a positive way. As she imagines this positive image, the clinician initiates short and slow sets of BLS until she can feel in the present what she believes it felt like in the imagined scene. This exercise works well with children.

Regardless of how and when they come about, it is important for these positive networks to be present and accessible for reprocessing to occur. With clients who experience difficulty in identifying positive networks of association or role models, plan on a longer preparation time before any processing of negative experiences.

**State vs. Trait Change**

Dr. Shapiro (2008) differentiated between state and trait change. She defined a state change as momentary or transitory, whereas a trait change reflected a permanent change. A state change is a change of mind. It instills a sense of hope in the client. A state change also requires the use of coping mechanisms to continue the change, whereas a trait change no longer requires the same. With a trait change, the client changes how he sees or views the event and, as a result, can experience it differently.

When a client changes his perspective about a previous traumatic event and has the needed skills, he is able to function more appropriately. An example of a state change is the client saying, “I am able to soothe myself by breathing and using my calm (safe) place when my boss asks me to come to his office. I feel much calmer.” A trait change may be, “I am no longer triggered when my boss asks me to come to his office.” To simplify, “states are weather” whereas “traits are climate.” “All traits are states” but “not all states are traits” (Shapiro, 2006a). See Table 1.18 for a better understanding of the differences between the two.

**Dual Awareness—Internal/External Balance**

Dual awareness or mindfulness or what Dr. Shapiro calls “dual focus of attention” (2001) allows the client to maintain a sense of present awareness and for the client’s internal processes to function without interference during reprocessing. In essence, it allows the client to be a nonevaluative observer with respect to whatever emerges during a reprocessing session. It helps the client keep “one foot in the past and one foot in the present.” The client is on the “train” watching the scenery go by.

One of the primary reasons to teach a client grounding and breathing skills and anchoring her in the present is to help her learn to keep one foot in the present while reprocessing something traumatic from her past. This provides her with a dual focus of attention and reduces the possibility or
risk of a client dissociating, blanking out, becoming overwhelmed, and/or resisting. Teaching her these skills prior to the reprocessing will help facilitate a smoother therapeutic experience. It also allows the client to maintain a sense of safety in the present while accessing and stimulating negative information from the past. The clinician can solidify the client’s connection to the present by utilizing verbal reassurances, such as “Good,” “You’re doing fine,” “It’s over,” or “You’re safe now.” The clinician may also stop and change the direction or speed of the BLS. When a client is in an abreactive state, these types of clinical strategies are particularly important to help the client maintain an external focus (Shapiro, 2001).

**Ecological Validity (i.e., Soundness)**

In attempting to discern whether a client’s target has been resolved, take a look at what resolution of this particular traumatic event would look like in the real world given the individual, the timing, and the situation. To what degree does the current situation “fit” the circumstances? Ask yourself, “If a woman was processing a rape that occurred months before and the rapist was still on the loose, would it be appropriate for her to continue to feel fear and demonstrate vigilance around this event?” The answer depends on how her information processing system works. Is there a reason she may be or may think she is still in danger? Is her sense of vigilance and fear around the rapist emotionally appropriate under the circumstances? If the answer to these questions is “Yes,” there is ecological validity in this instance.
How does one recognize ecological validity? And how do you work with it within the EMDR Therapy framework? First, use Wolpe’s SUD scale (SUD; Wolpe, 1990; see Figure 1.9).

The SUD scale is an 11-point Likert scale utilized to rate the anxiety level of a memory being accessed by a client in the present. When you ask the client during the Desensitization Phase to focus on the original event (incident, experience) and again ask, on a scale from 0 to 10, “How disturbing does it feel now?” and the client says a 1, the clinician needs to check out what is blocking (i.e., blocking belief) desensitization of the original target by: (a) having the client focus on where she feels it in her body; and by asking (b) “What keeps it a __?”; or (c) “What prevents it from being a 0?” In the case of a rapist, the client might respond, “He’s still out there.” Ask the client to “go with that” and continue to process to a more complete resolution. Do not assume that the client has reached the end of the channel just yet. Continue to process and check the SUD again before proceeding to the Installation Phase.

If the client still clings to the 1 and “he’s still out there,” you can consider this to be ecologically valid. Ecological validity is the only reason you may go directly to the Installation Phase without the client’s SUD level getting down to a 0. The SUD scale will be discussed in more depth in Chapters 2 and 3.

A blocking belief may also arise in the Installation Phase when evaluating the VoC, a seven-point Likert scale, which measures the validity (i.e., felt sense of the trueness or falseness) of the client’s stated positive cognition. If the client reports a VoC of 6 or 6.5, use the same questioning mentioned earlier when the SUD does not equal 0 (i.e., focus on where the client feels it in her body, “What keeps it a __?” “What prevents it from being a 7?”) to discern if there is: (a) a blocking belief; or (b) ecological validity.

Dr. Shapiro has been known to say, “Forgiveness is like rain—it may or may not happen.” If a person forgives someone who has hurt her, it does not mean she uses poor judgment with respect to that person (e.g., she would never leave her children with a past abuser). However, clients often arrive at forgiveness or compassion more quickly and more completely than they

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**Developed by Joseph Wolpe in 1969, the SUD scale is an 11-point Likert scale utilized to measure the subjective units of disturbance being experienced and reported by a client at a given time.**

<table>
<thead>
<tr>
<th>Neutral/No Disturbance</th>
<th>Highest Disturbance</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>10</td>
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</tbody>
</table>

**FIGURE 1.9 Subjective Units of Disturbance (SUD) scale.**
might with other forms of therapy. A clinician must be alert to not use her own experiences or experiences of her other clients to determine “ecological validity” for any specific client. If processing stops at a certain place, first attempt to remove the block by changing the direction or modality of the BLS. Always get the client’s permission before doing so. Then do a couple more sets of BLS before determining if it is ecologically valid for the person to move further toward forgiveness or compassion.

**Side Benefits of EMDR Therapy**

The primary goal of EMDR Therapy is to reprocess any irrational, negative cognitions; emotions; sensory stimuli (e.g., images, sounds, smells, tastes); and physical sensations associated with a trauma. It does not, however, remove or eliminate any irrational, negative sensations and cognitions related to a traumatic event. In the rape example mentioned earlier, it may be ecologically appropriate that the client maintain a healthy sense of fear and an appropriate level of vigilance until the rapist has been caught and her physical safety is ensured.

Reprocessing will not eliminate any negative thoughts, emotions, or physical sensations that are appropriate to the situation. For example, a client may experience hate toward his abusive, neglectful, and distant mother. In response to ongoing experiences, the client may have developed low levels of self-esteem and confidence. Reprocessing may be successful in improving the client’s self-esteem and other issues, but the client may or may not still feel hatred toward his mother.

EMDR Therapy does not have the potential for making you fall back in love with your significant other if you do not love him, secure a raise at your job if you do not deserve one, believe that your abusiveness to another was okay to have committed, or make you the next race car champion of the Indy 500 if you do not have the ability to drive a race car. It cannot make the true untrue or the untrue true. It only has the ability to decompress the negative thoughts, feelings, and physical sensations from the client’s internal system so that natural healing can take place. In the process of EMDR Therapy, new insights may occur; behavior, perceptions, and attitudes can shift; and physical and emotional responses can change.

**Holistic Nature of the Approach**

Even though it has been around for more than 25 years, EMDR is very much a “cutting edge” therapy. One of the reasons that it continues to be cutting edge is that it appears to be a permanent means of flushing traumatic memories with the accompanying negative cognitions, emotions, and physical sensations from the client’s system in a way that seems unique. It is a whole-system approach. It can reach down into the depths of a client’s
despair, attach itself to every negative element connected to a traumatic event, and then flush it out.

**USEFUL METAPHORS**

**Train Metaphor**

Dr. Shapiro prescribes the use of a train metaphor to help clients move along their processing “tracks.” Reference to and use of this metaphor will be utilized frequently throughout this Primer. During the Desensitization Phase, this metaphor can be applied as a means of noticing, yet distancing the client from fear of the trauma. Dr. Shapiro favors this metaphor because it conveys a sense of movement and safety (Shapiro, 2006a). The train metaphor may be used throughout the reprocessing as needed. It goes like this: “In order to help you just notice the experience, imagine riding on a train and the feelings, thoughts, etc., are just scenery going by” (Shapiro, 2001).

During the reprocessing, the image of the train going down the track is also used to encourage the client to continue. The passenger is the client, and the scenery represents the dysfunctional information that she is reprocessing. The clinician might say, “It’s just old scenery. Just watch it go by.” This metaphor is a reminder to the client that the train passes the scenery as quickly as it appears.

Dr. Shapiro describes the processing as “metaphorically like moving down a train track” (Shapiro, 2006a). From the point of origination to the destination, there are freight depot stops where useless cargo is unloaded (i.e., dysfunctional information is unloaded) and new, useful cargo is loaded (i.e., adaptive information is loaded). In between stops, linkage to adaptive networks can occur. See Figure 1.10 for a pictorial rendition of this metaphor. Again, the damaged material is unloaded and discarded at the freight depots found along the track during the stopping and starting of the BLS. It is also at this freight depot where adaptive information is loaded. When the train reaches its final destination, the client has reached adaptive resolution.

Whether suggesting the train or another example, the metaphor is an option being offered to a client if the trauma becomes too much to bear and distancing from it will allow reprocessing to continue. Installation of the metaphor is unnecessary.

During an abreaction, the train metaphor is a useful strategy for supportively assisting a client to allow movement down the tracks. The clinician can assist by saying, “It’s just old information. Watch it like scenery going by.”

Dr. Shapiro also uses the train metaphor to describe information that moves adaptively from dysfunctional to functional. It is a common experience for a client’s once-vivid negative images, affect, and cognitions to become less vivid and less valid while the opposite happens to the
FIGURE 1.10 Adaptive Information Processing model: metaphoric train moving down the track toward a more adaptive, functional resolution.

1 – Origination (dysfunctionally stored information is identified)
2 – Train rolls along the track to a stop (accelerated processing occurs/information is stimulated)
3 – Useless freight is unloaded (dysfunctional information drops off)
4 – New, useful freight is loaded (some adaptive—less problematic—information is added)
5 – Destination (adaptive resolution is achieved)
positive images, affect, and cognitions. Can you visualize a train traveling down its track? Each time the dysfunctional information is stimulated or when accelerated processing takes place, the train moves down the track and stops. At each stop, the client unloads dysfunctional information and loads more functional or adaptive information. The train continues on this route until it reaches its final destination (i.e., adaptive resolution).

**Tunnel Metaphor**

Another metaphor used by Dr. Shapiro (2001) is driving a car through a tunnel. In order to get through the tunnel as quickly as possible, the driver will need to increase his pressure on the accelerator (i.e., “You are in a tunnel. Just keep your foot on the pedal and keep moving”). In EMDR reprocessing, the eye movements or other BLS act as the accelerator (i.e., the processing of the dysfunctional information is accelerated by the speed and length of the BLS). This metaphor is utilized to encourage the client to pass through the tunnel as fast as possible (i.e., keep moving his eyes quickly). If he eases up on the accelerator or chooses to stop during transit, the car moves slower; and it takes much longer to get through the tunnel. Or the person is left in the midst of unprocessed material.

**ANCILLARY TARGETS**

A yellow or redboard in train lingo is a fixed signal to slow and eventually stop a train. When an engineer encounters one of these, he knows he needs to stop and then, if possible, proceed with caution, depending on what is further down the line. In some cases, there may be workers and equipment ahead indicating that the track is being repaired, or there may be an obstacle or debris blocking the tracks that needs to be cleared. Blocking beliefs and feeder memories have the ability to activate yellow or redboards. When one of these emerges, it could be an indicator to a clinician that he may need to slow the “train” with successive sets of BLS or switch tracks in an attempt to clear the track of this additional debris. Once this track has been cleared, the track is switched once again to allow the original “train” to continue down the line.

**Secondary Gains**

Secondary gain issues have a tendency to obstruct or stall processing. Therefore, it is advisable for a clinician to attempt to ferret these out prior to any actual processing taking place. In the Treatment Planning and History-Taking Phase, the clinician may investigate the presence of these gains by
asking a client if she is aware of any reasons why processing might be unsuccessful? Is there something a client may be uncomfortable giving up to help resolve the issues she brings to therapy? What other issues are served by the presenting complaint, such as positive consequences (e.g., pension checks); needs (e.g., fear of dishonoring the dead by getting better and moving on; fear of bears may keep a wife from going on camping trips with her husband); or identity issues (e.g., fear of loss of professional or social identity)? Identify what feeds these secondary gains (e.g., low self-esteem, irrational fears, boundary issues, lack of assertiveness). Whatever the issues are, these fears need to be resolved before a successful therapeutic outcome can be expected or maintained. A clinician also needs to ensure that a client has the stability and resources available, which assists her in giving up the gains. Noncompliance may also be related to other fears (e.g., fear of success, fear of terminating therapy, fear of failure). When this occurs, the clinician may ask the client, “What is the worst that could happen?” or “What would change if you were successful?” The secondary gain issues and fears may need to be addressed before any successful processing can occur.

Blocking Beliefs

Blocking beliefs generally arise during EMDR processing toward the end of the Desensitization, Installation, and Body Scan Phases. They become evident when a client’s SUD level does not lower to a 0, VoC does not rise to a 7, or a clear body scan is not achieved.

Subjective Units of Disturbance (SUD) and the Emergence of Blocking Beliefs

If, after repeated applications of different directions and types of BLS, the client cannot attain a 0 for a SUD level, the clinician may ask the client to: (a) focus on where he feels it in his body. If it still does not lower, the clinician is directed to look for the presence of a dysfunctional blocking belief by asking (b) “What keeps it a ___?” or (c) “What prevents it from being a 0?” If a benign or nonproblematic blocking belief (e.g., “I don’t believe in absolutes”) arises, the clinician should ask the client to “Just notice that,” and add another set of BLS. Sometimes this allows the SUD to drop to 0. If not, then proceed to the Installation Phase. If a dysfunctional blocking belief surfaces, and, after successive sets of BLS it does not remit, the clinician should target it with full reprocessing (i.e., Phases 3–6). This means that processing of the original target should be stopped until the blocking belief has been identified, targeted, and reprocessed. After a blocking belief has been successfully processed, the clinician should reevaluate the original targeted event and then complete the Desensitization Phase and proceed to the Installation Phase.
Validity of Cognition (VoC) and the Emergence of Blocking Beliefs

Except for the wording, the same procedures cited earlier for blocking beliefs and the SUD level apply to blocking beliefs and the VoC. For assessing a blocking belief at the Installation Phase, the clinician asks the client: (a) to focus on where he feels it in his body; (b) “What keeps it a ___?”; or (c) “What prevents it from being a 7?” When assessing a client’s level of validity, ecological validity should be taken into consideration by the clinician. What current life circumstances may keep a client’s VoC from rising to a 7? If a woman is processing a rape and her positive cognition is, “I am safe,” her 7 level may not be realistic or possible for her if her rapist is still at large. If blocking beliefs are revealed during the Installation Phase, they need to be fully processed using Phases 3 through 6. Once it was been reprocessed, the clinician should reevaluate the original targeted event and then complete the Desensitization Phase and proceed to the Body Scan Phase.

Body Scan and the Emergence of Blocking Beliefs

Blocking beliefs can emerge anywhere during EMDR treatment, including the body scan. If a blocking belief emerges during this phase and it appears more dysfunctional than innocuous, it should be targeted and processed with full reprocessing (i.e., Phases 3–6). Once resolved, the original target should be accessed, processed, and completed at the Body Scan Phase.

Feeder Memories

When Dr. Shapiro (2001) first began developing and implementing Eye Movement and Desensitization (EMD) in 1987, she started by targeting a client’s current dysfunction. The result was that, when a client focused on his negative reaction to present stimuli, he would become more anxious and processing remained blocked. What she readily discovered was, after several sets of BLS and often earlier, related memories would spontaneously emerge; and the client would get better once the processing of them was complete. It was then that Dr. Shapiro developed and introduced the three-pronged protocol—past, present, and future—whereby her first area of focus changed from a client’s presenting issue to the precipitating event that fueled his current dysfunction.

At this stage of development, Dr. Shapiro also began asking a client to focus on a presently held negative belief and scan back in the past for an earlier time he may have had this negative belief about himself. As a result of these changes, Dr. Shapiro (2001) wrote, “The theoretical assumption of EMDR treatment is that any current dysfunctional reaction (with
the exception of organically or chemically based pathologies) is always the result of a previous experience, although, of course, not necessarily one from childhood.

The earlier untapped memories that may emerge and appear to continue to feed a client’s current dysfunction and block successful processing are called feeder memories and may arise in any of the three stages of the EMDR approach. Clinicians are now encouraged to initially treat the earlier memories with the standard protocol, followed by the present triggers, and desired future outcome.

There are several ways to elicit the existence of feeder memories from a client: (a) direct questioning; (b) floatback; and (c) affect scan. If a feeder memory surfaces during the processing of another related event, these strategies may be utilized to ascertain the existence of a feeder memory within the reprocessing session or may be targeted at a later time.

In addition to ancillary targets, there are other client obstacles that may obstruct reprocessing. In these cases, the clinician will need to determine the cause and rectify in order to initiate or continue processing. The obstacles highlighted in the following table were adapted from Dr. Shapiro’s work (2009–2013, pp. 38–39).

<table>
<thead>
<tr>
<th>OBSTACLES</th>
<th>REASONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headaches, nausea, and dizziness</td>
<td>Secondary gain issues</td>
</tr>
<tr>
<td></td>
<td>May be artifact of eye movements</td>
</tr>
<tr>
<td></td>
<td>Client resistance</td>
</tr>
<tr>
<td></td>
<td>State of hypervigilance</td>
</tr>
<tr>
<td></td>
<td>May be part of the memory itself</td>
</tr>
<tr>
<td></td>
<td>May be the result of dissociation or dissociative disorder</td>
</tr>
<tr>
<td>Client cannot feel</td>
<td>Memory may be processed fully</td>
</tr>
<tr>
<td></td>
<td>Client cannot tolerate affect</td>
</tr>
<tr>
<td></td>
<td>Presently held beliefs exist that inhibit feelings (e.g., Big boys don’t cry. If I start to cry, I will never stop. It is dangerous, unsafe, or shameful to express feelings.)</td>
</tr>
<tr>
<td></td>
<td>Cultural or gender restraints or constraints with parents</td>
</tr>
<tr>
<td>Oververbalizing</td>
<td>May serve as a buffer</td>
</tr>
<tr>
<td></td>
<td>Client believes he is supposed to talk</td>
</tr>
<tr>
<td>Client blaming</td>
<td>Client was mandated to therapy (i.e., client uncooperative or unresponsive)</td>
</tr>
<tr>
<td></td>
<td>Client shuts down experience</td>
</tr>
</tbody>
</table>
TO INTERVENE OR NOT TO INTERVENE

As a rule of thumb or when in doubt, *do not intervene* during reprocessing. Simply say, “Go with that.” There are many indicators of successful processing, such as shifts: (a) in the memory itself; (b) from one memory to another; (c) in the reported changes or the emergence of new images, sounds, cognitive content, levels of affect, or physical sensations; (d) in a client’s self-worth, self-efficacy, affect, and self-assessment; and (e) from dysfunctional to adaptive. It is important for a clinician to remember anything that emerges between sets is related to a client’s experience, and only memories associated in some way with this experience will emerge. To ensure the success of the reprocessing, it is imperative that a client be allowed on his own to discern the importance of the connections of all associations that may arise. As these associations arise and connections are made, the sets are continued, and the need to engage in any complex EMDR interventions is curtailed.

Table 1.19 provides some examples of changes that may occur in multi-memory and single-event channels of association. When any of these shifts occur, stay out of the way and say, “Go with that.”

EMD VS. EMDR THERAPY

In 1987, Dr. Francine Shapiro inadvertently discovered the effects of spontaneous eye movements while focusing on disturbing thoughts of her own. She developed standardized procedures and a protocol that she called *Eye Movement Desensitization (EMD)*. Two years after Dr. Shapiro’s famous walk in the park, her seminal article, “Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories” (1989a), was published in the *Journal of Traumatic Stress*. In 1991, Dr. Shapiro renamed her psychotherapeutic method Eye Movement Desensitization and Reprocessing (EMDR) to recognize its shift from a desensitization paradigm to one of information processing.

While EMDR protocols are used within EMDR Therapy to accomplish reprocessing of traumatic memories and comprehensive treatment, EMD is a brief strategy that can be used to reduce symptomatic reactions to a specific target or cluster of targets. EMD intentionally limits the linkages to associated memories. Associations that are reported outside of the target memory require that the client be returned to the target, the SUD reassessed, and BLS be initiated. Specifically,

If during BLS, the client reports a free association that appears unrelated to the precipitating event, gently say “Ok, now I would like you to go back to the bombing incident (name the event), what do you notice now?” Obtain a SUDS rating each time the client returns to the target memory. After obtaining the SUDS instruct, “Just think of that…” (and then initiate the next set of BLS). (Russell & Figley, 2013, p. 99)
### TABLE 1.19
Patterns of Response

<table>
<thead>
<tr>
<th><strong>CHANGES IN MULTI-MEMORY ASSOCIATIVE CHANNELS</strong></th>
<th><strong>EXAMPLES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dominant belief inherent in trauma</strong></td>
<td>The memory of a boat accident brings up an associated memory of being bullied and physically assaulted by classmates in the second grade (both shared the same negative belief, “I am powerless”).</td>
</tr>
<tr>
<td><strong>Major participant or perpetrator</strong></td>
<td>A client associates being beaten by his mother with his mother driving drunk while he was in the car.</td>
</tr>
<tr>
<td><strong>Pronounced stimuli</strong></td>
<td>While processing waking up to a bedroom fire set by a lit cigarette, a firefighter remembers an associative memory of being overcome by smoke in a raging prairie fire.</td>
</tr>
<tr>
<td><strong>Specific type of event</strong></td>
<td>During the processing of a memory when a teller was robbed at gun point, an associated memory of being pistol whipped in a previous robbery years earlier emerges.</td>
</tr>
<tr>
<td><strong>Dominant physical sensations</strong></td>
<td>As a client processes his childhood memories of being tied to a bedpost by a babysitter while his parents were away, an associated memory of being assaulted and tied up so the perpetrator can flee spontaneously surfaces.</td>
</tr>
<tr>
<td><strong>Dominant emotions</strong></td>
<td>Disappointment over being looked over for a much-deserved promotion is shared with an associated memory of failing a CPA examination for the third time.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>CHANGES IN SINGLE-EVENT ASPECTS OF MEMORY</strong></th>
<th><strong>EXAMPLES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Images</strong></td>
<td>Change in content or appearance. A father’s outraged face becomes a smiling one. Change to an image of a different but associated event. The image of a father’s outraged face changes to remembering his anger when he failed a class. Change to a different aspect of the same event. The image of a father’s outraged face changes to one of a grief-stricken man.</td>
</tr>
</tbody>
</table>

(continued)
### TABLE 1.19  (continued)

**Patterns of Response**

<table>
<thead>
<tr>
<th>CHANGES IN SINGLE-EVENT ASPECTS OF MEMORY</th>
<th>EXAMPLES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shift in perspective:</strong> A son begins to see the image of his father’s outraged face as more pathetic or laughable.</td>
<td></td>
</tr>
<tr>
<td><strong>Expansion of a scene to include more details.</strong> Original image picture is one where a son sees the outrage on his father’s face on hearing that his son was expelled from school. As processing continued, the scene opened up; and he suddenly remembered that he was expelled because of a physical fight that ensued on school property between his father and himself. The father started the fight.</td>
<td></td>
</tr>
<tr>
<td><strong>Shifts in the appearance of an image.</strong> The image of an outraged father may become larger (or smaller), blur or fade, become closer (or more distant), turn gray or black or white, transform into a still image, or disappear altogether.</td>
<td></td>
</tr>
<tr>
<td><strong>Sounds</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Shifts in the sound of a voice.</strong> The voice of an outraged father’s voice may become softer, louder, quieter, distorted, or simply become mute.</td>
<td></td>
</tr>
<tr>
<td><strong>Shifts in dialogue.</strong> The son suddenly commences to voice words of assertiveness toward his outraged father.</td>
<td></td>
</tr>
<tr>
<td><strong>Shifts in language.</strong> The son is from Germany and reverted to his first language to express his assertiveness toward his outraged father.</td>
<td></td>
</tr>
<tr>
<td><strong>Cognitions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Emergence of insight.</strong> As processing continues, the son suddenly realizes that the outrage his father demonstrates toward him is really about his father’s sense of failure.</td>
<td></td>
</tr>
<tr>
<td><strong>A polar shift occurs.</strong> In the earlier part of processing, the son’s negative cognition (e.g., “I am not good enough”) is replaced by a positive one (e.g., “I am okay as I am”).</td>
<td></td>
</tr>
</tbody>
</table>
### TABLE 1.19  (continued)
Patterns of Response

<table>
<thead>
<tr>
<th>Changes in Single-Event Aspects of Memory</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emotions</strong></td>
<td>Increases/decreases in intensity. After the first set of BLS, the son’s fear of his outraged father becomes overwhelming (or becomes less fearful).</td>
</tr>
<tr>
<td></td>
<td>Shifts from one emotion to another. The son’s fear of his outraged father changes to disgust or crying changes to laughter.</td>
</tr>
<tr>
<td></td>
<td>Shifts toward more appropriate or ecologically valid emotions. The son’s emotion shifts from fear to sadness to disgust during the course of processing.</td>
</tr>
<tr>
<td><strong>Physical sensations</strong></td>
<td>Reexperiences physical sensations tied to the emotions. The son experiences chest pains and shortness of breath as he processes fear of his father.</td>
</tr>
<tr>
<td></td>
<td>Experiences physical sensations felt at the time of the original event. The son felt a punch in his stomach as he processed a memory where his outraged father hit him in the gut.</td>
</tr>
<tr>
<td></td>
<td>Increases/decreases in intensity. The son’s physical sensations of being hit in the stomach become less/more intense during subsequent sets of BLS.</td>
</tr>
<tr>
<td></td>
<td>Shifts in the location. The physical sensation of being hit in the gut moves from the heart to the throat.</td>
</tr>
<tr>
<td></td>
<td>Shifts in the type of sensations felt in a certain location. The son’s stomach awareness changes from nauseous to tight to feeling empty.</td>
</tr>
</tbody>
</table>

The clinician may find the use of EMD helpful when the goal is to desensitize a current or recent disturbing incident without accessing an associative memory network of experiences. This helps the client to decrease reactivity, obtain emotional regulation, and maintain dual awareness. This intervention can be used on its own or as a bridge to reprocessing. In these instances, EMD works much like other stabilization
techniques, in that it helps a client establish or regain a sense of resiliency and mastery.

EMD is being used in the treatment of recent traumatic events or episodes and in several specific situations. One is when the target is an intrusive element, such as a disturbing image, sensation, thought, or feeling. Another is when processing overwhelms the AIP system. Switching briefly to EMD often helps to reduce the distress enough to start the processing again (E. Shapiro & Laub, 2014).

The EMD procedure possesses the capacity to: (a) desensitize a highly disturbing or traumatic event, often within one session without an intense emotional reaction; (b) result in cognitive restructuring of the negative self-assessment along with a diminished visual representation of the original image; and (c) shift thoughts, feelings, and behaviors (Shapiro, 1989a).

Table 1.20 outlines the differences between EMD and EMDR.

<table>
<thead>
<tr>
<th>EMD</th>
<th>EMDR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informed by the Desensitization model</td>
<td>Informed by the Adaptive Information Processing model</td>
</tr>
<tr>
<td>Procedure for desensitization</td>
<td>Psychotherapeutic orientation</td>
</tr>
<tr>
<td>Used for decreasing reactions to individual memories</td>
<td>Used for comprehensive cognitive and emotional restructuring</td>
</tr>
<tr>
<td>Brief sets of alternating eye movements or tapping facilitate effective desensitization</td>
<td>Longer sets of eye movements, alternating taps and tones, facilitate information reprocessing</td>
</tr>
<tr>
<td>Average number of passes is 12–24</td>
<td>Average recommended number of passes of BLS is 24–40 (the number of passes is generally customized to the client’s response)</td>
</tr>
<tr>
<td>Sets are continued only as long as necessary to desensitize reactions to the target</td>
<td>There is no limit to the number of sets</td>
</tr>
<tr>
<td><strong>Treatment effect:</strong></td>
<td><strong>Comprehensive treatment effect:</strong></td>
</tr>
<tr>
<td>Reduction of the fear and anxiety related to the disturbing memory</td>
<td>Reduction in fear and anxiety</td>
</tr>
<tr>
<td></td>
<td>Replacement of negative emotions with positive ones</td>
</tr>
<tr>
<td></td>
<td>Emergence of insight</td>
</tr>
<tr>
<td></td>
<td>Change in body sensations</td>
</tr>
<tr>
<td></td>
<td>Surfacing of new behaviors</td>
</tr>
<tr>
<td></td>
<td>Negative events transformed to adaptive learning experiences</td>
</tr>
</tbody>
</table>
The procedure initially developed by Dr. Shapiro (1989a) has evolved to more closely resemble the standard protocol, with deviations as follows (follow the standard Assessment Phase as completely as possible):

**Assessment Phase**

1. Selection of a single memory and an image that represents the worst part of the memory/incident.
2. Identification of a negative belief (e.g., “I’m not safe,” “I should have done something,” “I have no control,” or “I am helpless”), which goes with the target memory or image.
3. Identify a desired positive cognition, such as “I’m safe now,” “I did the best I could,” or “It’s over.” Determine the validity of the client’s positive cognition (i.e., rate the VoC on a scale of 1–7).
4. Identify the associated emotions.
5. Determine the level of disturbance (i.e., rate the SUD on a scale of 0–10) based on the memory or image and the negative belief.
6. Identify the physical location of the body sensations.

**Desensitization Phase**

7. Instruct the client to focus on the image, the negative belief, and where he feels it in his body, and initiate a set of BLS (i.e., faster, but with only 12–24 passes; set of BLS).
8. After each set of BLS, instruct the client to, “Take a breath. (Pause) Let it go.” Then ask, “What are you noticing?” The clinician should note the response, and then gently return the client to the target, and reassess the SUD. After obtaining the SUD, instruct the client to “Just think of that,” and initiate the next set of BLS (i.e., 12–24).
9. Repeat this process until the client reports little or no disturbance (i.e., SUD = 0 or ecologically sound) and no new intrusive symptoms emerge.

Continue to Installation, Body Scan, and Closure Phases. See Chapter 6 for a complete transcript using EMD with a client.

**PRACTICAL TIPS TO REMEMBER**

**Practice, Practice, Practice**

*Practice, practice, practice* is this Primer’s mantra. In the EMDR Weekend 1 and 2 Trainings you were introduced to EMDR Therapy—but, because of time limitations, you may not have fully integrated its substance and protocol into your own therapeutic paradigm. Learning EMDR Therapy comes
from the *actual doing of it*. Even skilled clinicians who have conducted hundreds of sessions have the potential for learning something new every time they execute the process with a client. It is only from practicing EMDR that excellence and expertise can be derived; so the mantra *practice, practice, practice* cannot be overly emphasized.

### Follow the Script Verbatim

Newly trained EMDR Therapy clinicians are strongly encouraged to follow Dr. Francine Shapiro’s script verbatim in the Assessment Phase. Dr. Shapiro has chosen every word for a specific reason, and these words have been tested and validated over and over again in one context or another in session after session with clients presenting various mental health issues. It is important for the reader to understand the intent and implications of the wording of the well-researched protocol before implementing individual styles of eliciting the same information. In addition, it is highly beneficial for clinicians to follow the scripts provided for Phases 4 through 6. Clinicians who learned the script in the early days of EMDR Therapy may notice how it has been refined throughout the past 20 years.

If you have been recently trained or have decided to finally put your EMDR training to use, sit with a copy of the standard protocol in your lap as you implement the Assessment Phase with clients (see Chapter 3). Reading the script verbatim may feel unnatural at first, but you can expect to feel more at ease as you learn the procedural steps. Sitting with the pages in your lap and reading the script as it is written can also serve as good modeling for your client as he watches you work with something new on his behalf. As she becomes more familiar with the protocol and what words are required in each part, the clinician will most likely develop her own style for setting up the EMDR protocol. The words in the Assessment Phase absolutely necessary to optimize receiving the desired processing outcome have been *underlined* in this chapter and in subsequent ones for your recognition and convenience.

Consider logging onto the Trauma Recovery/EMDR Humanitarian Assistance Programs (TR/EMDR-HAP) website to contribute to a worthy cause. You may want to consider purchasing the laminated SUD/VoC Scale Chart or the EMDR Progress Notepad. These items may be purchased online at the TR/EMDR-HAP website (trauma-recovery.org). The worksheets can assist you in being more consistent and successful from client to client. The laminated chart may save time and also help the client to distinguish a belief from a feeling and to select a negative belief appropriate to his situation. It is not an uncommon reaction for a client to look like a deer caught in the headlights when asked, “What words go best with the picture that express your *negative belief* about yourself now?”
Know Your Client

Before you begin using the reprocessing phases, it is important that you know your client well. Know his strengths and weaknesses. Know his abilities and his limitations. Know his ego deficits. Know his coping mechanisms and strategies. Know his support system—or lack of it. Some clients may not be appropriate or ready for EMDR trauma processing. There could be situations, however, in which you will not have the luxury of waiting weeks to know your client before beginning reprocessing. Then it becomes imperative that you gain as much information as you can about your client in a brief period of time, particularly when situations or circumstances indicate a necessity of serious caution.

Stay Off the Tracks

The hallmark of EMDR reprocessing is facilitating a client’s flow of association and allowing the client to get to the end of the “track” on his or her own. After completion of the Assessment Phase, the clinician is encouraged to be very limited in what she says, such as “Take a breath. (Pause) Let it go.” “What are you noticing now?” “Good.” “Go with that.” “Notice that.” The clinician does not say much of anything else unless the client appears stuck in the process.

The most appropriate and easiest method to stay out of the way is by consistently maintaining a position of quiet neutrality. During the process, the clinician encourages the client by saying “Good” or “You’re doing fine.” Beyond this, the clinician must be careful not to physically or verbally express what he believes or thinks about a client’s responses between sets of BLS. It is imperative that the clinician allow the client to own the reprocessing of his traumatic event and not be encumbered by the therapist’s interventions, comments, or questions. Remember, the clinician is not the agent of change, but the client is.

Tracking the Client

It is important for the clinician to write down as much as possible of what the client says during the Assessment Phase, especially the exact wording of the client’s negative and positive cognitions and key words from his descriptions of traumatic events. Why? Because it is important to use exact wording when activating what the client says. If a client provides a negative cognition, such as “It’s my fault,” and a clinician reframes it as “I’m responsible,” the clinician may have inadvertently distorted what the client originally meant. In doing so, the clinician has also placed himself in the client’s process. Because the clinician reframed it that way, the client may begin to interpret it as “I’m responsible,” simply because the clinician said
it. “It’s my fault” and “I am responsible” may or may not mean the same to the client. To the degree that it does not, it can alter the direction of processing. During the remaining reprocessing Phases 4 through 6, clinicians often find it helpful to write down what the client says. However, if writing down what the client says during reprocessing slows, interrupts, or hinders in any way the client’s flow, stop writing and opt to listen and observe more closely what the client is experiencing in the moment.

Keep It Simple

In the early days of your EMDR experience as a clinician, try to keep it simple. Do not go straight from the training to your office and select the most challenging client to conduct your first reprocessing session. Select someone with a less complex trauma, such as a client who presents with a single-event trauma. Maybe someone has recently been involved in an automobile accident that relates to no other traumatic event in his life. As will be described in Chapter 4, when the three-pronged approach is discussed, multiple-event traumas are more comprehensive, will take a longer time frame to deal with, and require more skill than a client who presents with a single event. As a new EMDR clinician, you may not yet have the skill level required to deal with multiple-event traumas.

Power of Now

One of the most emphasized words in the EMDR protocols is “now.” Why? Because we are asking the client what he believes negatively about himself, what he wants to believe positively about himself, and what are the negative emotions and physical sensations that go with the event he is focusing on “now.” How is he being affected in the present by something that happened to him 2 months, 2 years, or 20 years ago? How is he being affected now?

The clinician may need to repeat the “now” over and over to a client. The client may get confused between how she felt “then” about an incident and how she feels “now” and ask questions that indicate her confusion. “Do you mean then or now?” And she could say, “Then it felt awful, but now it does not feel so bad.” If this happens during the Assessment Phase, the clinician may need to reevaluate whether or not the client has chosen an appropriate target. Remember, the clinician is looking to relieve the client of a memory that is charged with negativity. Use Figure 1.11 to help remember this important point.

One More Time

A good rule to remember during EMDR reprocessing with a client is that, any time something is positively reinforced with BLS, it strengthens the
focus of reinforcement. So, when a client reports a positive direction in the reprocessing, say “Go with that,” just one more time before returning to target. After the client reaches the SUD of 0, VoC of 7, and a clear body scan, say “Go with that,” one or more times to reinforce the positive treatment effect and/or to allow deepening of the positive cognition (Shapiro, 2001, 2009–2014). If the clinician is consistent with this rule, the success of the EMDR will be enhanced. In any case, it is important to continue BLS as long as positive material continues to emerge or strengthen in any part of the client’s reprocessing experience.

When reinforcing a positive effect during the Desensitization, Installation, and Body Scan Phases, the BLS will be faster and the length of the sets longer (i.e., 24–40 round-trip passes) than that during the Preparation Phase when using the calm (safe) place and other resource building exercises (i.e., slower 4–6 round-trip passes). As indicated earlier, slower and shorter sets are utilized in stabilization efforts so as to not activate any disturbing material prior to actual reprocessing with EMDR. The primary reason for utilizing faster, longer sets during Phases 3 through 6 is that negative associations may emerge at any phase. Faster, longer sets facilitate the resolution of the negative material, adaptive resolution, and generalization.

**Solo Run**

Client selection is an important part of the EMDR Therapy process but more so when a clinician is choosing clients for a first solo run. Clinicians may want to select clients with whom they have a strong client–clinician relationship. Pick the less complicated cases. Think of a client’s trauma as an
onion. How many layers are there? How thick? How thin? So, when looking at the onion, look for the one- or thin-layered skins. And go slowly.

If you are new to EMDR Therapy, select a client with more strengths than weaknesses, adequate coping mechanisms, and a supportive network of family and friends. Initially, you may also want to consider working with a client’s lesser issues to build up your experience and the client’s confidence in AIP during your learning process. For example, Sharon entered therapy 3 weeks prior. She had been sexually abused over a long period of time by an older brother who had an intellectual disability. Because Sharon was new to therapy and the clinician was new to EMDR, it was decided that her first reprocessing session would focus on her fear of dogs. It turned out that Sharon had been bitten by a stray dog at the age of 5 years. Because the session was so successful, they were able to continue using the process on the sexual abuse she experienced at the hands of her older brother.

Dr. Shapiro suggests first identifying the “touchstone” event when there may be one (2008). Before proceeding in this direction, however, one has to carefully discern whether or not it is possible for the client to attain successful processing of a touchstone event. This means that the client must be able to tolerate any level of disturbance that may arise. If the touchstone event is chosen for processing and the client becomes too overwhelmed by the experience, much time could be lost by having to “undo” the client’s newly created fear of the process. On the other hand, if you do not target the touchstone event and it arises as a feeder memory, it has the potential to be even more disturbing. The significance of completing a comprehensive history and obtaining informed consent becomes clearer here; that is, it is important for the client to be informed of the potential for accessing feeder memories during the reprocessing of any chosen target.

In this chapter, an attempt has been made to help refamiliarize the reader with basic concepts inherent in EMDR and/or to provide valuable updates to EMDR Therapy. Throughout subsequent chapters, case examples will be provided along with teaching points that attempt to explain the clinician’s strategies or to point out techniques prescribed by Dr. Shapiro during reprocessing.

SUMMARY STATEMENTS

1. EMDR Therapy is an integrative psychotherapeutic approach and is guided by the AIP model. The AIP model “provides the theoretical framework and principles for treatment and an explanation of the basis of pathology and personality development” (Shapiro, 2001). As an integrative psychotherapeutic approach, EMDR Therapy is distinct from cognitive behavioral therapy (CBT), experiential, and psychodynamic approaches, although it is not exclusive and may be informed by or used together with these approaches.
2. EMDR Therapy has eight distinct phases.
3. EMDR Therapy is a three-pronged approach addressing the past, the present, and the future.
4. BLS is not EMDR Therapy. It is only one component.
5. During the active reprocessing phases of EMDR Therapy, dual awareness should be maintained at all times: one foot in the present, and one foot in the past.
6. EMDR Therapy is a fluid, dynamic approach that entails the clinician using all her clinical skills. It is neither mechanistic nor a cookbook approach.
7. The heart of EMDR Therapy is the AIP model. As such, it is critical that the clinician have a clear understanding of it in order to proceed with EMDR practice.
8. Practice, practice, practice. This is how we learn the model.
10. Stay out of the client’s way. The reprocessing is about the client, not the clinician.
Eye Movement Desensitization and Reprocessing (EMDR) Therapy is an eight-phase protocol. Dr. Shapiro and the EMDR International Association (EMDRIA) are precise about what EMDR Therapy is and what it is not; and, if you eliminate one of the eight phases, it cannot be called EMDR Therapy. The intention of this chapter is to briefly touch on some of the eight phases and more extensively on others. An effort is made to enhance and expand on key areas that can assist the clinician in client selection, target selection, and adaptive resolution. Table 2.1 offers a description of the goals and objectives of each phase as described by Dr. Shapiro (2001, 2009–2014).

**PHASE 1: CLIENT HISTORY AND TREATMENT PLANNING**

The History-Taking and Treatment Planning Phase has a threefold purpose. The data collection that occurs in this phase provides all the information customarily acquired by most clinicians, as well as providing the client with the information needed for informed consent. This phase drives the client selection process and helps the clinician identify potential treatment targets that emerge from examining the positive and negative events in a client’s past, present, and future. This is the phase in which the clinician determines whether a client is able to tolerate reprocessing. These factors include client stability, integrative capacity, affect and distress tolerance,
### TABLE 2.1
Eight Phases of EMDR Therapy

<table>
<thead>
<tr>
<th>1. <strong>Client history</strong>— Take a general history from the client and develop an appropriate treatment plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has all the relevant client information been gathered (e.g., life experiences, childhood development, family of origin, cultural and gender issues, ethnic and religious influences, familial and peer relationships)?</td>
</tr>
<tr>
<td>Has risk or crisis assessment on the client been performed?</td>
</tr>
<tr>
<td>Has the client been evaluated for affect tolerance, integrative capacity, trust, and self-regulation?</td>
</tr>
<tr>
<td>Has the client’s history of attachment been assessed?</td>
</tr>
<tr>
<td>Have the client’s strengths and internal/external supports and resources been assessed?</td>
</tr>
<tr>
<td>Have the client’s selection and readiness been determined?</td>
</tr>
<tr>
<td>Have all the standard history-taking questionnaires and diagnostic psychometrics been administered?</td>
</tr>
<tr>
<td>Has the client been screened for dissociative disorders?</td>
</tr>
<tr>
<td>Have the client’s developmental deficits been identified?</td>
</tr>
<tr>
<td>Has the client’s level of complexity and resources to set the pace of treatment been determined?</td>
</tr>
<tr>
<td>Have needed skills and behaviors been identified?</td>
</tr>
<tr>
<td>What experiences have set the pathology for the client’s present symptoms?</td>
</tr>
<tr>
<td>Have potential targets and sequencing of targets (i.e., past, present, and future) been identified and secondary gains addressed?</td>
</tr>
<tr>
<td>If appropriate, has the client’s touchstone event(s) been identified?</td>
</tr>
<tr>
<td>Have the client’s current psychosocial factors been evaluated?</td>
</tr>
<tr>
<td>Has all relevant background information been obtained?</td>
</tr>
<tr>
<td>Is the client suitable for the EMDR reprocessing phases of treatment?</td>
</tr>
<tr>
<td>Is the client able to access identified experiences and maintain dual awareness so that reprocessing is able to occur?</td>
</tr>
<tr>
<td>Have safety and trust been established between the clinician and the client?</td>
</tr>
<tr>
<td>Is the client able and has agreed to provide the clinician accurate feedback in terms of internal experiences during the reprocessing of a memory?</td>
</tr>
<tr>
<td>Have medical considerations been assessed and addressed?</td>
</tr>
</tbody>
</table>

*(continued)*
### Eight Phases of EMDR Therapy

<table>
<thead>
<tr>
<th>Phase</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2. Preparation</strong></td>
<td>Introduce and prepare the client for EMDR Therapy.</td>
</tr>
<tr>
<td></td>
<td>Has the treatment plan been developed collaboratively with the client, and is it consistent with his treatment goals?</td>
</tr>
<tr>
<td></td>
<td>Are there any events a client is not ready to discuss?</td>
</tr>
<tr>
<td></td>
<td>Has an appropriate relationship been established with the client?</td>
</tr>
<tr>
<td></td>
<td>Has the client been formally introduced to EMDR Therapy?</td>
</tr>
<tr>
<td></td>
<td>Has the client been educated about the EMDR process?</td>
</tr>
<tr>
<td></td>
<td>Has the client's fears been assessed and addressed?</td>
</tr>
<tr>
<td></td>
<td>Has informed consent been established via the client's verbal understanding and agreement to continue with EMDR Therapy?</td>
</tr>
<tr>
<td></td>
<td>Has the client's stability been assured?</td>
</tr>
<tr>
<td></td>
<td>Can the client self-soothe?</td>
</tr>
<tr>
<td></td>
<td>Have coping strategies (i.e., stabilization/affect tolerance, train metaphor, stop signal, calm/safe place) been introduced?</td>
</tr>
<tr>
<td></td>
<td>Has BLS been introduced (i.e., type, speed, distance, seating arrangement)?</td>
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<tr>
<td></td>
<td>Have timing considerations been taken into account (e.g., client has an important meeting or clinician is going on vacation)?</td>
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<tr>
<td></td>
<td>Are there current life stressors in the client's life that may be exacerbated as a result of EMDR Therapy?</td>
</tr>
<tr>
<td></td>
<td>Again, is the client able to maintain dual awareness?</td>
</tr>
<tr>
<td><strong>3. Assessment</strong></td>
<td>Access, activate, and assess target using three-pronged approach for EMDR processing and primary aspects of memory (image, NC, PC, VoC, emotions, SUD, and body location).</td>
</tr>
<tr>
<td></td>
<td>Has a target image been obtained? If no image is identified, has the client answered the question, “When you think of the memory, what do you get?”</td>
</tr>
<tr>
<td></td>
<td>Have the negative and positive cognitions been identified?</td>
</tr>
<tr>
<td></td>
<td>Has the validity of positive cognition been rated using the VoC scale?</td>
</tr>
<tr>
<td></td>
<td>Have the relevant emotions been identified?</td>
</tr>
<tr>
<td></td>
<td>Has the level of disturbance been rated using Wolpe’s SUD scale?</td>
</tr>
<tr>
<td></td>
<td>Has discomfort or physical sensations experienced by the client been identified?</td>
</tr>
</tbody>
</table>
### TABLE 2.1  (continued)

| Four Phases of EMDR Therapy | 4. **Desensitization**—  
Reprocess selected targets (and all related channels of association) toward an adaptive resolution (SUD = 0). | Be sure to:  
Begin the reprocessing by bringing up the image, negative cognition, and location of negative physical sensations.  
Use a speed of BLS that is tolerable for the client, starting with about 20 passes and customizing the number of passes to the client’s response.  
Generally, the average is 24–40 passes (or 30 or more seconds) in length.  
Avoid talking, analyzing, summarizing, or clarifying.  
Return to target only after the end of a channel has been reached.  
Do not interrupt a client’s abreactive experience, but do provide periodic supportive statements to maintain dual focus.  
Use strategies for blocked processing and cognitive interweaves sparingly and effectively.  
Ask for a SUD rating only when all channels of association have been completely cleared or when you are unsure if the client is moving.  
Determine if the desensitization is complete before moving on to installation.  
Does SUD = 0?  
Check to see if ecological validity applies if SUD > 0 (i.e., greater than zero).  
Have all channels of association been fully processed? |
| 5. **Installation**—  
Recheck appropriateness and validity of positive cognition.  
Utilizing BLS, integrate positive effects when linked to original target (VoC = 7). | Does positive cognition still fit?  
Can the client easily pair the target memory and positive cognition?  
Add BLS (speed and frequency consistent with what is used in Phases 4 and 5). Customize to client’s response as needed.  
Does VoC = 7?  
Are there emerging blocking beliefs or feeder memories?  
Is ecological validity appropriate? |
<table>
<thead>
<tr>
<th>Phase</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>6. Body scan</strong>—</td>
<td>Complete processing of residual elements associated with traumatic memories by linking original event and positive cognition and check for bodily discomfort. Use BLS to clear any remaining physical disturbance. (Completed treatment = clear body scan.)</td>
</tr>
<tr>
<td><strong>7. Closure</strong>—</td>
<td>Appropriately close a complete or incomplete session.</td>
</tr>
<tr>
<td><strong>8. Reevaluation and use of the EMDR standard three-pronged protocol.</strong></td>
<td>Has the successful completion of relevant material been determined?</td>
</tr>
</tbody>
</table>

**TABLE 2.1 (continued)**

Eight Phases of EMDR Therapy

- **Is body scan clear? Has all residual disturbance associated with the target been fully processed?**
- **Are there unresolved negative physical sensations that need to be reprocessed?**
- **If needed, use sets of BLS (speed and frequency consistent with what is used in Phases 4 and 5) until the client reports clear body scan.**
- **Has the client been briefed as to what to expect after a complete or incomplete session?**
- **Has the client’s stability been ensured after EMDR processing (e.g., shifting states from a focus on the memory to full, present, grounded awareness to minimize difficulties between sessions)?**
- **Has the client been requested to keep a log?**
- **Does the client need stabilizing using the Calm (Safe) Place or other regulatory exercise?**
- **Has the client’s log been checked?**
- **Has the client’s SUD level been rechecked and memory fully reprocessed, if necessary?**
- **Has anything new emerged since the last session?**
- **Does the client need to complete the reprocessing of the memory targeted the last session to SUD = 0, VoC = 7, and body scan is clear or move to a new target?**
attachment history, readiness to change, and current psychosocial factors. The client’s clinical presentation aids the clinician in determining the need for titration of history-taking, as well as the need for additional resources. This phase of EMDR supplements the clinician’s normal history-taking procedures.

Informed Consent and Suitability for Treatment

In Phase 1, the client gives consent to the use of EMDR Therapy based on his appreciation and understanding of the facts and implications of possible treatment outcomes. In this first phase, the clinician begins to gather information pertinent to the client’s readiness, willingness, stability, and ability to engage in the EMDR process. The clinician will take a complete and thorough client history using whatever methodology she is comfortable with, identify the presenting problems, and establish treatment goals in the same way she might for clients with whom she will not be using EMDR Therapy. The next step is to utilize this information plus valuable data collected from risk or crisis assessments, depression inventories, diagnostic and dissociative evaluations, and the presence of internal and external supports, along with the client’s strengths and limitations, to assess a client’s suitability for treatment. See Appendix D for more information on EMDR Therapy and informed consent.

To begin an initial assessment of the client’s appropriateness for EMDR Therapy, the following questions need to be answered: Is the client ready for EMDR Therapy? Will the client benefit from EMDR Therapy? Is the client able to self-regulate? Finally, does the client consent to the use of EMDR Therapy? See Table 2.2 for the fourfold purpose.

### TABLE 2.2

**History-Taking and Treatment Planning**

<table>
<thead>
<tr>
<th>FOURFOLD PURPOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>• It is the result of the data collection that occurs in this phase, where the client obtains all the information needed for informed consent. It drives the process by which the client’s appropriateness and readiness for EMDR reprocessing (i.e., Phases 3–6) are evaluated.</td>
</tr>
<tr>
<td>• It helps the clinician identify potential treatment targets that emerge from examining the positive and negative events in a client’s past, present, and future.</td>
</tr>
<tr>
<td>• This is the phase in which the clinician begins to know the client, and develops an AIP-informed case conceptualization and treatment plan that guides Phases 2–8.</td>
</tr>
<tr>
<td>• Potential targets, including touchstone events, if available, are identified.</td>
</tr>
</tbody>
</table>
Client Selection Criteria

The client selection criteria are diverse and obtained from various sources. First, examine safety factors relevant to the client to assist in determining appropriate candidates for EMDR Therapy. For instance, does the client possess a sufficient level of trust? Before initiating EMDR reprocessing, it is essential to ensure that there is an adequate level of trust between client and clinician. For many clients, their trust reserves are often depleted by the time they get to EMDR treatment. In addition, the clinician may be asking the client to share intimate details of her life. Facts that she has never shared with anyone may emerge during EMDR Therapy. Although clients are not required to share all details with the clinician, this may occur or could be helpful from the client’s perspective. That is why it is important to build and establish adequate rapport with the client, sometimes in very short periods of time, to maximize the success of the EMDR processing. A client who has a history of severe abuse is screened more intensely than others to identify her appropriateness and readiness for this treatment as trust is likely to be more difficult to develop. The goal for the client is to trust enough to proceed safely with EMDR processing. The necessary levels of trust will vary with the complexity and the trauma experiences of the client.

Client’s Suitability and Readiness for EMDR Therapy

Dr. Shapiro (2009–2014) recommends checking the client’s stability, integrative capacity, affect tolerance and regulation, attachment history, and readiness to change before any reprocessing takes place.

1. Stability: Has the clinician assessed the client’s current level of psychosocial functioning? Has the clinician evaluated the client’s ability to control behavior and/or manage emotional responses? Has the clinician determined the availability of the client’s internal and external resources?

2. Integrative capacity: Does the client have the ability to stay present or to maintain dual awareness, present a coherent narrative, or to take in and utilize new information? Does the client have access to positive (integrated) memory networks?

3. Affect tolerance/regulation: Does the client have the ability to access and tolerate a positive and/or negative state? Does the client have the ability to manage his experience for a period of time? Can the client sustain high or varying levels of emotion throughout the EMDR process? Does the client have the ability to shift from one emotional state to another?

4. Attachment history: What is the consistency and duration of the client’s early relationships? What is the level of disruption, if any, of the client’s
early relationships? What is the client’s ability to establish and maintain relationships of any kind?

5. Readiness to change: Are there any external factors (e.g., child, spousal, employment, or legal demands) that may impede or interfere with or preclude a client’s successful treatment outcome? Have all complicating factors (e.g., limits, secondary/tertiary gains/losses) been identified? Does the client have a current and active issue with substance abuse or other compulsive disorders? Does the client have the capacity and motivation to change?

As the client’s needs and reactions to the treatment change after each session, the clinician needs to constantly reevaluate suitability and readiness, as well as benefits. This evaluation is a process, not a one-time event.

In addition, the clinician also needs to take into consideration the client’s responses to the following questions:

- Does the client have a medical condition that might preclude her as a candidate for the EMDR reprocessing phases (e.g., a stress-related illness, epilepsy or pseudoseizures, heart condition, high-risk pregnancy, withdrawal from substances)?
- Are there any contraindications for the use of eye movements (e.g., eye pain, detached retina, corneal scratches)?
- What is the age of the client?
- What medications does the client take that may impact the speed and generalization of the EMDR reprocessing phases (i.e., benzodiazepines)?
- Is the client inpatient or outpatient?
- Is the client a danger to others?
- Does the client have a history of violent or assaultive behavior?
- Is there a history of neurological impairment that may prevent the client from succeeding with the EMDR process?
- Is the client physically able to sustain intense emotion?
- Has the client been in counseling before? With whom? Why? How long? Does the client have a history of treatment failure?
- Does the client have a history of alcohol or drug abuse? If so, would an increase in use or relapse be life threatening? Is the client actively using alcohol or drugs or recently entered recovery?
- Has the client engaged in self-mutilation (e.g., cutting, burning, or picking)?
- Have indicators of poor psychological development been identified and addressed (e.g., years of unsuccessful psychotherapy, present memory lapses, depersonalization, derealization, somatic symptoms, flashbacks, intrusive thoughts, chronic life instability)?
- Does the client have impending legal proceedings that need coordination with an attorney?
In addition, the clinician may want to assess previous therapy that the client has had (i.e., reason, focus, length, quality), previous losses, and present relationships with significant others and children (Shapiro, 2006a). See Dr. Shapiro’s (2006a) EMDR: New Notes on Adaptive Information Processing With Case Formulation Principles, Forms, Scripts, and Worksheets for further assistance in taking a more thorough history of the client. Included in part of the booklet is an Intake Case Conceptualization Form. Dr. Shapiro suggests that the questions therein be incorporated into the Treatment Planning and History-Taking Phase to aid case conceptualization and management. This booklet can be purchased from the Trauma Recovery website (EMDR-HAP; http://trauma-recovery.org). See Appendix E for more information on trauma recovery. New Notes on Adaptive Information Processing With Case Formulation Principles, Forms, Scripts, and Worksheets was drawn from a preconference presentation called “Know the Why and How to Choose Your What: Some Essentials of the EMDR Model and Methodology” that Dr. Shapiro gave in 2006. This 3.5-hour audio recording may be purchased from Convention Media (www.conventionmedia.net).

Screening for Dissociative Disorders

While preparing a client for EMDR Therapy, it is important to screen her for a dissociative disorder. Familiarize yourself with the clinical signs of dissociative disorders and use of the Dissociative Experiences Scale (DES). See Appendix E for signs and symptoms of dissociative disorders and information on the DES. Screen every potential EMDR client for dissociative disorders as special preparation is needed to stabilize dissociative clients. This screening will take into consideration the number of years the client was involved with unsuccessful psychotherapy, past episodes of depersonalization and/or derealization, history of memory lapses, occurrence of flashbacks and intrusive thoughts, existence of Schneiderian symptoms (i.e., audible thoughts, hallucinated voices, thought broadcasting, thought insertion, thought withdrawal, delusion perception, and somatic passivity), and presence of somatic symptoms. Furthermore, if these symptoms are present, it will be necessary to lay special groundwork to aid in safely accessing the dysfunctionally stored material while maintaining client stability. For further information, the reader is also encouraged to refer International Society for the Study of Trauma and Dissociation (ISST-D) “Guidelines for treating dissociative identity disorder in adults, third revision” (2011; free full text is available from www.isst-d.org).

See the cautionary note in Table 2.3 about dealing with special-population clients with whom you have no expertise.
If your areas of expertise do not match the diagnoses or age of the clients who present as possible candidates for EMDR Therapy, it is your ethical responsibility to refer them on to someone who specializes in EMDR Therapy and those particular diagnoses (i.e., dissociative disorders, substance use disorders) or age groups (i.e., children, adults, seniors). EMDR Therapy is meant to be a treatment for the types of clients you normally see and does not make you an expert in areas beyond your specialization. If a clinician does not possess training in specialized populations, such as dissociation, eating disorders, children, sports or performance enhancement, or addictions, these clients should be referred to someone who has that specialized training.

**Client Willingness to Do EMDR Therapy**

Once the answers to these questions have been fully investigated by the clinician, assess the client’s willingness to continue treatment utilizing all phases of EMDR Therapy. Ask: “Is EMDR Therapy something that you might like to consider as a course of treatment?” In cases where an adequate level of trust has been established between the client and the clinician, EMDR reprocessing may be initiated early in the therapeutic relationship. It is optimal that the client also possesses a high level of comfort with the clinician. Therefore, ask “Are you comfortable with our starting the reprocessing at this time?” If the answer is affirmative, the clinician may move forward with embarking on the remaining phases of EMDR Therapy. It is also important for the clinician to be available for support and follow-up immediately after beginning reprocessing.

As the clinician, be careful about initiating EMDR reprocessing phases with a client and then leaving town, let alone the country, for an extended length of time. It may also be best that the client not be engaged in an extended trip shortly after beginning trauma processing. The clinician can also suggest that the client select a time for processing in which there is nothing particularly demanding on her schedule following the session.

**Assessment**

In the treatment planning stage of Phase 1, a closer look at the client’s presenting problems is undertaken. Once the client’s suitability for EMDR Therapy has been established, the clinician can better identify the negative events in the client’s past, present, and future that need targeting. The
questions that follow are typical of what a clinician may want to consider before implementing reprocessing with a client.

- What targets appear to have set the groundwork for the client’s presenting issue?
- What negative reactions does the client possess in the present that can be traced to experiences in his past?
- Which of these targets appear to have potential to fill in deficits in the client’s life and optimize a healthier level of functioning?
- Is the client able to access these identified experiences and process them to successful resolution?

In Phase 1, the clinician attempts to complete the client’s clinical picture by investigating and including all pertinent details before initiating processing of her traumas. Once a solid outline of these pictures begins to emerge, the clinician can begin to set targets for the treatment planning stage to determine possible interventions.

**Treatment Planning in EMDR Therapy**

EMDR treatment planning may be simple in the case of a single-event trauma, or it may be more complicated. A single-event trauma can be the easiest to process and often the most successful. It could be considered to be a one-layered onion. A multiple-event trauma is more comprehensive. This entails identifying the earliest dysfunctional memories associated with the client’s presenting problems or issues or what are called touchstone memories. In either case, the clinician also needs to identify present situations and experiences that trigger the dysfunction and the alternative future behaviors that ensure the success of therapy.

In the manuals for Weekend 1 (2009–2014) and 2 trainings (2009–2013), Dr. Shapiro presented a worksheet for the clinician to use as a checklist to ensure that necessary criteria have been evaluated before pursuing EMDR Therapy with a client. A modification of this worksheet appears in Table 2.4. In addition, treatment planning includes identification of needed resources or skills necessary for successful reprocessing with dual awareness and stability between sessions.

These questions will not be answered as briefly as the table might suggest, but be aware that all of them need to be considered in some fashion. It is up to the clinician to decide whether to simply check off each criterion met by the client. Alternatively, the clinician can rate each item on a scale of 1 to 3 to record the client’s level of appropriateness for EMDR Therapy in each criterion. In either case, this can be a valuable tool.
# TABLE 2.4
EMDR Therapy Selection Criteria

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>OK</th>
<th>PROBLEM</th>
<th>CONSULTATION NEEDED</th>
</tr>
</thead>
</table>

**Client Stability/Developmental Deficits/Ability to Manage Stress**

Client has been screened for
dissociative disorders (use
DES, SCID-D, or MID)

Indicators of poor psychic development have been identified:
1. Years of unsuccessful psychotherapy
2. Depersonalization and/or derealization
3. Memory lapses
4. Flashbacks and intrusive thoughts
5. Somatic symptoms

Chronic instability at home and/or work

Client's capacity to maintain dual awareness has been established

Secondary gain issues have been identified and appropriately addressed

Severity of possible newly activated issues considered

Client's capacity to understand and communicate

**Acute Presentations**

Caution and case consultations have been used for the following situations:
1. Life-threatening substance abuse
2. Serious suicide attempts
3. Self-mutilation
4. Serious assaultive behavior
5. Dissociative disorders

**Stabilization**

Adequate stabilization/self-control strategies are in place

(continued)
<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>OK</th>
<th>PROBLEM</th>
<th>CONSULTATION NEEDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client has adequate life supports (e.g., friend, relatives)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>If necessary, client has the viable means to dissipate disturbance during and/or after sessions</td>
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<tr>
<td>System issues that might endanger the client have been identified and addressed</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Client is able to call for help if indicated</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Medical Considerations**

General physical health, medical condition, and age have been considered

Current medications have been identified

Inpatient care has been considered or arranged

If needed, use of eye movements has been cleared by the physician

Any other neurological impairments or physical complications have been identified and addressed

**Time Considerations/Readiness**

Treatment has been timed around client's projects, demands, and/or work schedules

Availability of both clinician and client for support and follow-up has been ensured

Willingness and ability of the client to continue treatment has been assessed

Ninety-minute sessions, if possible, have been arranged

Legal obligations have been considered
Elements Pertinent to EMDR Therapy

There are other factors the clinician may also want to take into account during the History-Taking and Treatment Planning Phase of EMDR Therapy. The clinician may want to consider previous therapy the client has experienced. What was her reason for seeking therapy? How long did the therapy last, and what was the outcome? There could be a need to seek more information concerning the past and current state of the client’s relationships with the significant individuals in her life—parent, lover, spouse, boss, coworkers, children, and friends. How does the client self-soothe (e.g., relaxation, exercise, meditation, substances or other compulsive behaviors)? Table 2.5 provides a list of pertinent questions specific to EMDR.

Candidates for EMDR Therapy

Not everyone who walks into your office is a potential candidate for EMDR Therapy. In looking at both clients discussed subsequently, Isabella and Marie, as candidates for EMDR Therapy, the clinician might want...
to consider the criteria specified by Dr. Shapiro before proceeding to the processing stage.

Keep in mind that, as a clinician seeks answers to these questions, he is looking for patterns—clusters of similar events, responses, and symptoms (e.g., irrational negative beliefs, behaviors, emotions, body sensations, people, places, or things) and other parallels between the client’s past and present.

Case Example 2A: Isabella

Isabella came into the clinician’s office and stated that she was extremely disillusioned with her marriage and wanted to decide what to do about it. She stated that she “loved” her husband a great deal and that he was a wonderful man, but she was no longer “in love” with him. In her most recent past, she had become enamored and eventually became sexually involved with one of her male coworkers. She alleged no abuse in her childhood or her marriage. The rest of her history appeared unremarkable in terms of other traumatic events. She simply no longer loved her husband and longed for something more with another man.

Is Isabella a candidate for EMDR reprocessing phases? Consider the following:

1. **Symptoms**: When Isabella arrived, she was rushed and breathless. She was extremely apologetic for being late for her first appointment and talked hurriedly as she explained the situation with her husband and current lover. She stated that she was confused and frustrated and no longer loved her husband and was in a quandary as to what to do about it. She did not want to hurt or leave him but was opposed to living with a man with whom she could no longer experience emotional and sexual intimacy in the ways she did when they were younger.

2. **Initial causes**: It was not until she initiated a friendship with a coworker that she realized how isolated and lost she was in her marriage. She felt more like she was living with her brother than her husband.

3. **Past occurrences**: After starting up the friendship, Isabella realized that she had been unhappy in her marriage for a long time.

4. **Other complaints**: Isabella’s infidelity was a one-time occurrence for which she felt remorse.

5. **Constraints**: Isabella continues to be unhappy in her marriage, confused as to what to do, and remorseful for her infidelity.

6. **Desired state**: Isabella wants to be happily married.

Isabella did not appear to be an immediate candidate for EMDR reprocessing phases. After exploring her many options, the clinician and Isabella entered into the problem-solving process to find out what had occurred in
her marriage over the years that made her “fall out of love” with her hus-
band and what could be done to light a new fire under it. After a few weeks
of therapy, Isabella was asked to bring her husband, Antonio, to therapy
with her. He had no idea she was in therapy, nor did he know that she was
unhappy in their marriage. After a few months of counseling, their rela-
tionship was renewed and moved to a more intimate level. As you can see,
EMDR reprocessing phases did not appear to be an appropriate interven-
tion with this particular client or her husband.

Note: EMDR reprocessing might have been used with either of the two to focus on
issues that caused them to feel “separate and isolated” from one another later on
in their therapeutic process or to resolve the trauma of the affair that may have an
impact on Isabella’s or Antonio’s ability to deepen their relationship.

Case Example 2B: Marie

Marie had been involved in a car accident 2 months earlier. Since then, she
had not been able to get behind the wheel without experiencing feelings
that she associated with loss of control.

1. Symptoms: Marie reported feeling depressed and anxious. She had been
medicated for anxiety and depression for as long as she could remem-
ber. A history of both was evident from her other comments, but they
had become “more exaggerated after the accident.” She stated that she
was often nauseous and light-headed even at the thought of driving a
car. As a passenger, she reported being agitated and hypervigilant. She
could not ride in a car for long periods of time or tolerate busy intersec-
tions without experiencing a near panic within her. Whoever drives her
has to take long and complicated detours to avoid major intersections
along their route. Currently, the client only gets into the passenger side
of the car if she has to go to the doctor. She will not enter a car for any
other reason. As a result, she has not been able to work.

2. Initial cause: When she was 10 years old, Marie was involved in an acci-
dent in which her mother and younger sister were killed. This is the
touchstone memory.

3. Past experiences: When she was in college, a fire broke out in one of the
lower floors in her dorm. Marie was trapped on the seventh floor of the
dorm for 4 hours before it was safe for her to take the elevator to the
dorm’s lobby.

4. Other complaints: Since the accident, Marie becomes anxious and agitated
if she does not feel in complete control, especially while riding in a car.

5. Constraints: Low affect tolerance and inability to adequately self-soothe.

6. Desired state: She sought self-empowerment and peace behind the wheel.
Marie’s trauma was appropriate for EMDR Therapy. She had a history of previous events during which she felt out of control. The clinician taught Marie the Calm (Safe) Place exercise and other skills for managing acute episodes of anxiety before initiating reprocessing (i.e., Phases 3–6) for the automobile accident in which her mother and younger sister were killed and then the other subsequent occurrences where she similarly felt out of control. Many of her present symptoms and dysfunctions disappeared after these events were fully processed. Marie had been experiencing residue from these events every time she entered a busy intersection. After several months of successfully processing the car accident, dorm incident, and other disturbances where she previously felt out of control, Marie terminated and began living a more secure, stable existence. And she was able to get behind the wheel of a car once again.

Note: With clients having more complex presentations, it may be necessary to titrate the history-taking over a longer period of time.

PHASE 2: PREPARATION

While history taking and treatment planning lay the groundwork, the Preparation Phase sets the therapeutic framework and appropriate levels of expectation for the client (Shapiro, 2001). In this phase, the primary goal is to prepare the client to process a disturbing target utilizing EMDR Phases 3 to 6. Over the past few years, client preparation has been emphasized more heavily in trainings. It is often a “make or break” aspect of successful EMDR Therapy. The Preparation Phase may be brief or lengthy depending on the complexity of a client’s clinical landscape. It is about: (a) educating and communicating to the client what to expect before, after, and during the EMDR process (e.g., mechanics, procedures, outcome); (b) building confidence in the client in terms of safety, assurance, and the therapeutic alliance; (c) continuing the informed consent process; and (d) teaching coping skills (e.g., calm [safe] place, containment, resource development, relaxation) as needed to assure that the client can maintain dual awareness during reprocessing and stability during and between sessions.

Setting the Stage for Effective Reprocessing

It is during the Preparation Phase that the clinician begins to set the stage for effective reprocessing. There are specific tasks identified by Dr. Shapiro (2001) that the clinician does before initiating the reprocessing of disturbing material with the client: (a) safety within the therapeutic relationship is ensured; (b) EMDR theory is explained and the model is described; and (c) potential concerns, issues, and emotional needs are addressed. These tasks are identified in Table 2.6.
Maintaining a Safe Therapeutic Environment

Establishing sufficient rapport, trust, and safety is essential in the therapeutic relationship. The same is true of EMDR Therapy, but often the clinician may have a very short time to form this kind of bond with the client. As a result, a clinician’s demonstration of flexibility, respect, and accommodating attitudes toward the client’s sense of safety and need for reassurance becomes more pronounced. Because clinicians may implement reprocessing after a few weeks of first meeting a client, a sufficient level of trust and adequate bonding must take place before it is attempted.

Explanation of the EMDR Process and Its Effects

The importance of providing the client with a descriptive and informative explanation of reprocessing during these phases (i.e., Phases 3–6) cannot be stressed enough. Unfortunately, many EMDR-trained clinicians do not say more than, “I just learned this new technique. Let’s try it.” And, without hesitation, the clinician leads the client into setting up the procedural steps outlined in the Assessment Phase without telling the client what the
The acronym EMDR stands for or providing an adequate explanation of what is involved.

The client needs to be provided with a simple, general understanding of the theory behind EMDR Therapy and how his brain originally stores information. The amount of information supplied varies with the age of the client (i.e., children need far less information) and the expressed desire of the client for more or less information. EMDRIA sells a pamphlet called *EMDR Brochure for Clients* (2009), which can be used as an option for this process. It is also printed in Spanish and French (see Appendix E for more information on EMDRIA). In 2012, Dr. Shapiro wrote the book *Getting Past Your Past: Take Control of Your Life With Self-Help Techniques From EMDR Therapy*. This is an excellent resource about EMDR Therapy for clients and other laypeople.

Because clients frequently report feeling “stuck” in terms of emotions or body sensations, Dr. Shapiro’s (2001) explanation of how trauma gets locked into the central nervous system, gets triggered by internal and external stimuli, and results in a flood of intense emotional and physical sensations, can support clients’ understanding. In addition, it can be helpful to elaborate on how bilateral stimulation (BLS) helps to free the “stuck” information and allows the locked information to emerge to the surface, integrate, resolve, and flush out. However, this may be too much information for some clients. Use clinical judgment as to how much psycho-education to provide.

Dr. Shapiro (2001) also suggests describing the model in terms of connecting the target with adaptive networks. Figure 2.1 presents a graphic understanding of the theory about how the brain stores a disturbing event: (a) when a traumatic event occurs, the brain stores it in an isolated memory network and prevents it from linking up with more adaptive information. As a result, no learning can take place; (b) once the EMDR reprocessing has been initiated, appropriate links between the maladaptive and adaptive information occur, and shifts begin to emerge that allow learning to take place; and (c) if reprocessing has been successfully completed, all necessary links between memory networks have been addressed, learning has taken place, and the event is no longer disturbing.

It is important for the clinician to spend an adequate amount of time explaining to the client the possibilities and options regarding BLS. Several methods of BLS have been developed over the years, such as tapping, alternating sounds, or even the butterfly hug (Artigas & Jarero, 2005; Artigas, Jarero, Mauer, Lopez Cano, & Alcala, 2000; Boel, 1999, 2000). *(Note: The butterfly hug involves the client crossing her arms over her chest and lightly and alternately tapping her shoulders.)* Because *most* research to date has been done using eye movements, it has become the preferred means of BLS for most clinicians. Thus, it is important to inform the client of this as other options may be explored. De Jongh, Ernst, Marques, & Hornsveld (2013) address the use of other forms of BLS.
When assessing for the appropriate type of BLS to utilize with a client, it is optimal to assess and monitor her physical limitations. Does she suffer from a hearing deficit? Does she wear glasses? Does she have problems moving her eyes back and forth (i.e., side to side) in a brisk movement? Does she have mobility in her body to tap her own knees or shoulders? Because different types of BLS are used, check to see if the client can tolerate eye, audio, or tactile movement. Remember to take these options into consideration when assessing the proper stimulation for each client.

What effect does the BLS have? Although the mechanism of action is unknown at this time, there is a great deal of informed speculation as to how it works. What happens when we intentionally shift our focus back and
forth at an increased rate of speed? Does it cause us to process information, experiences, or trauma more efficiently? With more advanced computer technology becoming available, such as information from single photon emission computed tomography (SPECT) and computed axial tomography (CAT) scans, we are able to gain clearer understanding of how the brain works and how it may respond to BLS during EMDR reprocessing.

Calm (Safe) Place and Other Coping Strategies

Although these techniques will not be covered in depth in this Primer, there are various calming, soothing, relaxing, containing exercises with which the clinician may want to become more familiar. Several are described in the EMDR Therapy literature, and there are myriad options available to the clinician, including different breathing techniques, imagery, hypnosis, biofeedback, and somatic and muscle relaxation exercises. These maximize the likelihood that the client will be able to handle the level of disturbance that could arise before, during, or between reprocessing sessions. Some of these techniques may also be useful when closing down incomplete sessions. It is optimal for clients to be trained in some of these self-control techniques prior to implementing processing. It is also recommended that EMDR Therapy not be pursued if a client does not respond to or is unable to use any of these coping strategies. At the very least, it is strongly recommended that the clinician teach the Calm (Safe) Place exercise (see Appendix B), a mechanism for self-regulation. Once created by the client (with assistance or guidance from the clinician), the clinician can encourage the client to return to it before, during, or after a reprocessing session, especially if he is experiencing a high level of emotional disturbance. With more complex clients who display affect dysregulation, Resource Development and Installation (RDI; Leeds, 1998; Leeds & Shapiro, 2000) is suggested.

Clinicians can experiment with various techniques listed subsequently until it is determined that a client can tolerate or reduce levels of disturbance caused by the dysfunctionally stored material in her central nervous system. Although all clients need to be familiar with and use self-regulation techniques, some clients may be able to do it more easily on their own; so for them only a limited number of these techniques may be necessary for stabilization.

There is a broad range of possibilities that aid in the goal of successful processing and can also be used by clients in a session or between sessions for symptom reduction and relaxation:

To help prepare a client for processing:

1. Calm (Safe) Place (see Appendix B)
2. Sacred Space (see Appendix B)
3. Resource Development Steps (see Appendix C)
4. Mindfulness techniques
5. Other coping skills if more appropriate

For incomplete sessions or additional stabilization:

6. Lightstream Technique (Shapiro, 1991; see Appendix C)
7. Miller and Halpern’s Letting Go of Stress (1994)
8. Container (see Appendix C) and conference room techniques
9. Grounding, diaphragmatic breathing, and anchoring in the present exercises (see Appendix B)
10. Breathing shift (see Appendix C)
11. Spiral technique (see Appendix C)
12. Visualization
13. Guided imagery
14. Self-control and relaxation exercises
15. Four elements (i.e., air, fire, water, and earth) stabilization technique formulated by Elan Shapiro for use with terrorist victims in Israel (Shapiro, 2006a)

The utilization of the techniques during the Preparation Phase is often the client’s first introduction to BLS and provides her with a realistic peek into how a session may proceed during actual processing.

Calm (Safe) Place—Stabilization and Assessment

Dr. Shapiro (2001) prescribes the use of the Calm (Safe) Place exercise throughout the EMDR process. It assists in preparing a client to process traumatic events, to close incomplete sessions, and to help equalize or stabilize a client’s distress in session if the information that emerges is too emotionally disruptive. It has been redesignated calm (safe) place over the years because it was found that some clients have been traumatized to a high degree, making it ecologically impossible for them to imagine that a “safe” place can exist. The clinician can have the client create a calm place instead. Note: When utilizing this exercise with veterans or military personnel, the use of a “secure” place may be more appropriate. Table 2.7 provides a simple description of uses of this exercise.

The Calm (Safe) Place exercise also assists in preparing the client for processing in two important ways: (a) it serves to introduce the client to BLS in a comfortable way before it is used with disturbing material. If necessary and, according to the strengths and needs of the client, the clinician may suggest or name the type of place the client could create, such as a place of courage, a peaceful place, or a place for time out; and (b) it can be utilized to evaluate the client’s ability to shift from one positive state to
another without the intrusion of any negative associations. Both are helpful in evaluating a client’s readiness and appropriateness for EMDR.

As with any technique utilized with a client, it is important to use caution. Listed in the following are cautionary elements with which the clinician needs to be aware when using the calm (safe) place for self-regulation, symptom reduction, or relaxation (Shapiro, 2001).

1. The initial development of a calm (safe) place may be disturbing to the client and increase her levels of distress. If this does occur, reassure the client that it is not unusual for this to happen. Then assist the client in developing another calm (safe) place or initiate another self-regulating exercise. At other times, developing another calm (safe) place is unnecessary. Sometimes disturbance occurs because the clinician has used too fast or too many sets of BLS and the client has associated with the disturbing material. At other times, the client is trying to hold the image of the place rather than focusing solely on the “pleasant sensations in your body” as the script suggests. Because BLS will reduce the vividness of images, this is not surprising. In either case, the clinician should refresh the sensory aspects of the place through guided imagery until the client is able, once again, to experience pleasant sensations in the body. Then reinitiate BLS with the instructions, “Just focus on the

### TABLE 2.7
Use of Calm (Safe) Place—The Why and the How

<table>
<thead>
<tr>
<th>WHY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepares client for processing</td>
</tr>
<tr>
<td>Introduces and provides client with a positive experience with BLS</td>
</tr>
<tr>
<td>Temporary rest (i.e., relief or break) between sets</td>
</tr>
<tr>
<td>Technique to deal with dysfunctional material and high levels of disturbance that may emerge before, during, or after sessions</td>
</tr>
<tr>
<td>Aids in closing down a session</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>See Appendix B for the Calm (Safe) Place Script</td>
</tr>
</tbody>
</table>

**NOTE**

This exercise was originally adapted from a variation of a guided visualization included on Miller and Halpern’s (1994) “Letting Go of Stress” tape. In more complex presentations, Dr. Shapiro (2001) suggests substituting situations of “courage” or “strength” or other resourcing adjectives in this exercise for clients who may need to access positive affects between sessions. The result of this suggested change was the Resource Development Steps exercise found in Appendix C.
pleasant sensations in your body and allow yourself to enjoy them. Just
focus on these pleasant sensations and follow my fingers (or taps or
tones).” Be sure to use only a few (i.e., 4–6) slow sets of BLS and then
recheck the client’s experience.

2. Pairing the BLS with the development of the calm (safe) place has
the ability to bring some clients to high levels of negative affect very
quickly. For example, the client may be in the process of developing
a calm (safe) place in a meadow and suddenly the image of the rapist
appears as a dark figure overshadowing it. In a case like this, try again
to develop a place that continues to be calm (safe) to her, probably a dif-
ferent place, as the current image has been “intruded” on by distressing
material.

3. Negative associations may be activated if negative memories spontane-
ously link with the client’s calm (safe) place during its development.
For example, a client who happens to be a police officer is preparing to
reprocess a memory of seeing his partner shot in a shoot-out with a gang
member. On introducing BLS to his newly developed calm (safe) place
of a favorite location on the college campus he attended, a memory of
exchanging gunfire with a group of marauding student protesters on
a local college campus several years ago emerges. When this happens,
the clinician should assist the client in developing another calm (safe)
place.

4. Some clients may be unable to develop a calm (safe) place. In this case,
the clinician may need to utilize other strategies, many of which are
described in the Appendices, to shift out of states of disturbance. If
unable to use any coping strategies, the clinician should reevaluate
the client’s appropriateness for EMDR processing or she may need to
develop a more complex focus on treatment along with more advanced
stabilization.

5. Slow, short sets of BLS are utilized to reduce the risk that a client may
be activated by any negative associations.

Table 2.8, “Derailment Possibilities—Calm (Safe) Place,” provides some
cautions that if not heeded could keep “the train from leaving the depot.”

During the Preparation Phase, the clinician routinely reassesses the cli-
ent’s stability and provides coping strategies to enhance and strengthen
the client’s sense of calm, grounding, or safety before, during, and between
reprocessing sessions. The clinician may want to be equipped with a rep-
ertoire of stabilization and resource development interventions prior to
starting processing. Calm (safe) place, relaxation exercises, metaphors, anxi-
ety-control skills, stress-reduction strategies, and other resources can pro-
vide calm and safe means to assist a client in processing his most traumatic
experiences. For more complex trauma presentations, the use of Resource
Development and Installation (RDI) is recommended (see the following
section).
### TABLE 2.8
**Derailment Possibilities—Calm (Safe) Place**

*“Remember, this calm (safe) place is always available to you. Just let me know if you need to return to it at any time.”*

<table>
<thead>
<tr>
<th>Issue</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selecting a calm (safe) place or other resource that may be linked to a distressing or disturbing event. A client may select a place that is generally represented by calm (e.g., a meadow) but find that it is too closely associated with a traumatic event (e.g., being raped in a meadow as a teenager). If this becomes the case, the client needs to create another calm (safe) place.</td>
<td>Providing only one relaxation exercise or self-control technique to use between sessions. The clinician should attempt to provide the client with a calm (safe) place and a variety of other relaxation exercises to relieve any negative disturbance that may arise between sessions.</td>
</tr>
<tr>
<td>Providing only one relaxation exercise or self-control technique to use between sessions. The clinician should attempt to provide the client with a calm (safe) place and a variety of other relaxation exercises to relieve any negative disturbance that may arise between sessions.</td>
<td>Selecting a calm (safe) place. Again, it is important to “stay out of the way” and allow the client to identify and/or create his own refuge.</td>
</tr>
<tr>
<td>Forgetting to ask for and/or install the cue word. Strictly follow the Calm (Safe) Place Script word for word until you are familiar with the order, content, and intent of each step. The “cue” word is a crucial part of the Calm (Safe) Place exercise.</td>
<td>Selecting a calm (safe) place that is associated only with childhood can lead the client to a past focused/dissociated state and may fail to ensure present orientation and grounding.</td>
</tr>
<tr>
<td>Selecting a calm (safe) place that is associated only with childhood can lead the client to a past focused/dissociated state and may fail to ensure present orientation and grounding.</td>
<td>Selecting a calm (safe) place that is associated with an individual who may be part of the necessary reprocessing material (e.g., a church where the clergyman who molested the client still preaches). In this case, it would be appropriate for the client to visualize an entirely different calm (safe) place.</td>
</tr>
<tr>
<td>Selecting a calm (safe) place that is associated with an individual who may be part of the necessary reprocessing material (e.g., a church where the clergyman who molested the client still preaches). In this case, it would be appropriate for the client to visualize an entirely different calm (safe) place.</td>
<td>Doing sets of BLS that are too long or too fast. In order to avoid stimulating channels of association linked to disturbing material, it is important to do short, slow sets when utilizing BLS to stabilize the client.</td>
</tr>
<tr>
<td>Doing sets of BLS that are too long or too fast. In order to avoid stimulating channels of association linked to disturbing material, it is important to do short, slow sets when utilizing BLS to stabilize the client.</td>
<td>Reinstalling calm (safe) place or doing resourcing when it is unnecessary. It is not necessary to reinstall the calm (safe) place before every EMDR session. Simply remind the client of her cue word and her ability to elicit it at any point during the process (i.e., before, during, and after EMDR).</td>
</tr>
<tr>
<td>Reinstalling calm (safe) place or doing resourcing when it is unnecessary. It is not necessary to reinstall the calm (safe) place before every EMDR session. Simply remind the client of her cue word and her ability to elicit it at any point during the process (i.e., before, during, and after EMDR).</td>
<td>Continuing reprocessing with a client who obviously is unable to use self-control techniques to shift out of a state of distress. These clients may need to be evaluated for sufficient ego strength and self-soothing skills and may possibly need more frontloading in terms of stabilization before reprocessing can begin.</td>
</tr>
</tbody>
</table>
Resource Development and Installation (RDI), Dissociation, and Ego State Therapy

Although not covered at length in this Primer, a discussion of the Preparation Phase also needs to include RDI, dissociation, and Ego State Therapy. A brief description of each follows. Additional resources on these topics can be found in the Resources section (see Appendix E, “EMDR Therapy-Related Resources”).

Resource Development and Installation (RDI)

Clinicians use RDI as a prerequisite to prepare clients with more complex affect dysregulation (i.e., limited capacities to emotionally self-regulate) for EMDR. RDI (Korn & Leeds, 2002; Leeds, 1998; Leeds & Shapiro, 2000) was developed as a means of enhancing a client’s ability to alter her affective and behavioral states adaptively by heightening her access to functional memory networks. RDI provides a debilitated client who exhibits unstable behaviors (e.g., dissociation, mutilation or other self-injurious behaviors, addictions, eating disorders) a means of accessing, developing, and strengthening positive introjects and increasing affect regulation. Guidelines and protocol for EMDR RDI can be located in Appendix A in Dr. Shapiro’s (2001) basic text. Before proceeding to the Assessment Phase, consider what is needed to stabilize the client and whether the client has adequate affect regulation skills and adequate internal and external resources to safely and effectively reprocess the disturbing memories. Note: See Resource Development Steps in Appendix C. This is a resource development intervention similar to the Calm (Safe) Place exercise suggested by Dr. Shapiro (2001) to work with affect management and behavior change.

What Is Dissociation?

Realizing that you do not know how to recognize dissociation or deal with it adequately when it occurs in a session with a client is as important as knowing what dissociation is. Simply stated, dissociation is disconnection of things usually associated with each other. This can be a disconnection from the memories of an event and the attached emotion, knowledge, behavior, and/or sensation that happened as a result of a past or presently occurring event. It can also be a “disconnect” of various aspects of the self. Dissociation is often driven by overwhelming of the information processing and affect regulation systems. That is why it is important to keep a client within the therapeutic “window of tolerance” during treatment. Clients can and often do dissociate during traumatic events. Dissociation is a valid, automatic, and often critical defense mechanism during a traumatic event but can be problematic if it occurs during an EMDR session, particularly if the clinician does not recognize that it is transpiring or does not know how to ameliorate
its occurrence. Along with a thorough clinical assessment, it is highly suggested that, before initiating EMDR with a client, the clinician administer the DES (Bernstein & Putnam, 1986). For some highly dissociative clients, more robust clinical instruments may be necessary for thorough diagnosis (e.g., Structured Clinical Interview of Dissociative Disorders [SCID-D], Steinberg, 1994, or Multiscale Inventory of Dissociation [MID], Dell, 2006).

**Ego State Therapy**

In the late 70s, Watkins and Watkins developed Ego State Therapy. It employs family and group therapy techniques “to resolve conflicts between various ‘ego states’ that constitute a ‘family of self’ within a single individual” (Watkins & Watkins, 1997). Ego State Therapy techniques can be utilized in EMDR Therapy with clients who have complex posttraumatic stress disorders, dissociative disorders, performance enhancement difficulties, and problems associated with serious illness. Some clients enter therapy with dissociated parts that are unable to cope with the symptoms that have emerged as a result of their traumas. Hence, it becomes imperative in the history-taking to identify a client’s fragmentation and alienation, then define the appropriate ego state, and select the somatosensory and affect management strategies to help these challenging clients. Integrating ego-state techniques with EMDR Therapy can be highly useful and successful with clients possessing dissociative disorders (see Table 2.9).

**Container**

Usually introduced in the Preparation Phase, a container is an imaginary receptacle created through visualization, where a client places any residual images, feelings, beliefs, perceptions, urges or cravings, worries, thoughts, and other sensations left over from an EMDR reprocessing session for

| TABLE 2.9 |
| Cautionary Note |
| Dissociation is not a simple state, and clinicians who have not been formally and adequately trained to treat dissociative disorders or dissociative symptoms when they arise in sessions should immediately seek supervision or refer the client to someone who does have this training. EMDRIA-approved basic trainings do provide an overview of dissociation, but time constraints do not permit in-depth discussion. Note that many of the advanced EMDRIA-approved trainings do concern themselves with the subject of EMDR Therapy and dissociative disorders. (The ISST-D, “Guidelines for treating dissociative identity disorder in adults, third revision” [2011] may be downloaded from www.isst-d.org) |
safekeeping. This empowers the client to keep intrusive traumatic material at bay until she is able and willing to open it up again and continue to address issues that arise in therapy. The container helps keep the past in the past and the client fully functional in the present.

A container usually has the ability to be locked, sealed, tied, or otherwise secured; so the client makes a choice to open or not before the next session. The container is an important tool in EMDR Therapy. According to Murray (2011), its purposes are numerous: (a) It has the ability to enhance a client’s stability and affect tolerance; (b) it provides information as to the client’s ability to continue through to the Assessment Phase and reprocessing; and (c) it can be used to close down incomplete sessions or between sessions to manage any disturbances that may arise. Scripts for the Container exercise can be found in Appendix C and Murray (2011).

Addressing the Client’s Fears and Expectations

Client Expectations

The client can expect to be able to maintain a sense of safety and of being in control. These are critical for safe processing. If, during the reprocessing effort, the client indicates that he wants to stop, the clinician needs to honor his request. To do otherwise might seriously undermine treatment effects and the integrity of the therapeutic relationship. The clinician assists in helping the client maintain that dual awareness, reassuring him that the surfacing emotions and memories are transient and that he is in no real danger in the present.

Client Fears

It is in the Preparation Phase where the clinician addresses fears the client may have about the process and instills hope, however thin and tattered she may have perceived it to be. And it is this shred of hope that sets up the client’s potential for success in the EMDR process.

After an explanation of the EMDR theory, the clinician is encouraged to introduce metaphors (e.g., train or video) or analogies that may be used during the actual reprocessing of the client’s disturbing material. The client can then have familiarity with those metaphors if the clinician references them during the ensuing session. Other concerns or fears may be addressed at this time.

In summary, the clinician informs the client about the nature of EMDR and what he might expect as a result of EMDR reprocessing; establishes an adequate therapeutic relationship through bonding, rapport, and honesty; and ensures client safety, stability, and his ability to maintain his control over the process.

Caution: If the client cannot self-soothe, do not proceed to a trauma focus. Do more front-loading of stabilization and affect management skills to ensure the client is adequately stabilized and can tolerate any affect that may emerge before proceeding to the Assessment Phase.
Mechanics of EMDR Therapy

As previously mentioned, the clinician determines what type of BLS (e.g., eye movements, tactile, auditory) is to be used with the client and establishes a stop signal in the event that the client needs or wants to discontinue processing. In addition, the clinician needs to establish a comfortable seating position with the client, as well as the range, speed, and direction of the BLS.

Seating Arrangement

One of the elements emphasized during basic EMDR Therapy training is the seating arrangement between the clinician and the client. The suggested arrangement for clients with whom the clinician is utilizing hand movements to facilitate eye movements is what is called “two ships passing in the night.” In keeping with another concept, “staying out of the way,” the clinician positions himself in front of and off to the side of the client so that he is out of the client’s peripheral vision. If the clinician is utilizing one of the electronic forms of BLS, such as the EyeScan models (i.e., lightbar), AudioScan, or TacAudio Scan (see http://neurotekcorp.com), the clinician wants to be sure he is out of the client’s range of vision during the sets of BLS, while still visible to the client (if she chooses to turn her head) between sets.

Range, Distance, Speed, Direction, and Number of BLS Sets

Some clients cannot comfortably tolerate certain directions and speeds of eye movement. This is why it is important to find the best fit when proceeding with processing. In these cases, the range, distance, direction, speed, and number of sets of eye movements may be varied until a comfortable formula is found for the client. Hence, as the client holds his head stationary, the clinician demonstrates the centerline-to-centerline movement of fingers while also testing for distance, range, direction, and speed variance. These elements should be tolerably comfortable for the client.

The distance refers to the proximity of the clinician’s fingers from the centerline of the client’s face. The range should be tested prior to any reprocessing efforts with the client. The clinician facilitates this by holding two fingers approximately 12 to 14 inches from the client’s face and says, “Is this comfortable?” If not, the clinician continues to move her fingers out and asks the same question until the client reports a comfortable placement and distance.

Using two fingers as the focal point the clinician moves them from one side of the client’s range of vision to another. In place of fingers, the clinician could also use a pen, ruler, wand, finger puppet, or pointer to facilitate eye movements.

The clinician should also pretest the rate of speed of the eye movements by establishing a speed that is tolerably comfortable for the client. The clinician commences the eye movements, increasing in speed to determine the client’s ability to track. Allow the client to express any preferences in terms
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of distance, height, or speed before focusing on any disturbing material. When establishing an appropriate distance and speed, the clinician says, “Is this a comfortable distance and speed?”

The direction of the eye movements may vary from vertical to horizontal. Eye movements may also be diagonal, circular, or in a figure-eight pattern. The ease and speed of the eye movements should be evaluated frequently to ensure successful and complete reprocessing of the dysfunctional material.

The duration or the number of sets utilized should be determined by the client’s verbal and nonverbal feedback. The suggested number of initial passes (i.e., one round trip, centerline to centerline, shoulder to shoulder) ranges from 20 to 40. When actual processing has begun, the clinician should listen closely for any feedback from the client about the number of passes, speed, and distance. If the client reports discomfort or if the material does not seem to readily shift, adjustments in speed, distance, direction, and number of passes (i.e., eye movements, tones, and taps) may be necessary.

There is more than one type of eye movement available to the client as well as other forms of BLS if a client is unable to tolerate the eye movements. Although it has limitations in terms of speed, the two-handed approach entails a clinician holding a closed hand at each end of the client’s visual field and alternating raised fingers from end to end. The clinician may also use tapping and/or sounds as alternate forms of BLS.

Special caution and consideration should be given to clients who wear glasses, contacts, bifocals, or trifocals. In case of dryness or eye irritation, it can be suggested that the client have his contact lens case available in the event his contacts need to be removed in order to more comfortably continue reprocessing. It may be preferable for clients with contacts to utilize other forms of BLS. In the case of a client who wears glasses, give her the choice of tracking the eye movements with or without glasses or using other forms of BLS. In all cases, the clinician and the client should agree on at least two forms of BLS prior to reprocessing in case the mode of stimulation needs to be changed in the middle of the process (see E. Shapiro, 2011, for more information on the mechanics of eye movements).

**PHASE 3: ASSESSMENT**

As target selection has been accomplished in previous phases, assessment is simply the measurement and amplification of the targets already selected. This is the phase in which the components of the target are identified and baseline measures are taken. The order of the EMDR components (i.e., image, negative cognitions [NC], positive cognitions [PC], Validity of Cognition [VoC] scale, emotions, Subjective Units of Disturbance [SUD] scale, and body location) is specifically designed to access and stimulate the dysfunctional target material. Assessment should always be done in the order of the script because it moves from “seeing and thinking about it” to
“feeling it.” This is why a client’s level of distress may become increasingly more agitated during the Assessment Phase, and the clinician needs to be prepared to activate processing soon after completion of the assessment to ease his disturbance.

Identify, Assess, and Measure

The three words that Dr. Shapiro uses to represent this phase are identify, assess, and measure (2001). By consulting the treatment plan, the target memory for reprocessing is chosen; and the clinician assists and supports the client in identifying a specific pivotal picture and assessing its toxicity. This is accomplished by determining the negative and positive cognitions, and specific negative emotion(s) and body sensation(s) associated with the event. Then baseline measurements of the client’s responses to and progress within the phase are established and monitored (see Table 2.10; Shapiro, 2012).

Identifying the Target

The memory selected for reprocessing is identified in the first two phases of EMDR (see Chapters 3 and 4 for more information about target possibilities).

Identifying the Image

In order to assist the client in establishing a link between consciousness and the location where the memory is stored in the brain, the clinician assists the client in identifying an image (or picture) that best represents the entire incident.

<table>
<thead>
<tr>
<th>TABLE 2.10</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IDENTIFY</strong></td>
<td><strong>ASSESS</strong></td>
</tr>
<tr>
<td>Target</td>
<td><strong>Image</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Negative cognition</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Positive cognition/Desired state</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Specific emotion(s)</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Location of body sensation:</strong> “Where do you feel it (i.e., the disturbance) in your body?”</td>
</tr>
</tbody>
</table>

*The SUD measures the level of disturbance of the entire memory.*
or the “worst” (i.e., most upsetting) part of it. It does not matter whether the image (or picture) is clear or distinct. In fact, it is not unusual for the image to present as blurred or fragmented. If there is no image (or picture), the clinician instructs the client to focus on the event (incident or experience).

Assessing the Negative and Positive Cognitions, Emotions, and Location of the Physical Sensations

Along with the memory to be identified and treated (i.e., the target) and the image (or picture) that represents it, the clinician assists the client in identifying the negative self-belief or statement (i.e., negative cognition), the desired direction of change (i.e., positive cognition) verbalized by the client, and the emotions and location of the physical sensations associated with it.

1. When the client voluntarily or involuntarily stimulates stored information associated with the identified image (or picture) of the specific traumatic event, perceptions may come to the surface that could distort what a client perceives in the present. These perceptions are explicitly expressed in an negative cognition identified by the client (e.g., negative, self-referencing, generalizable, irrational, dysfunctional, and possessing emotional resonance). For example, shame and self-hatred can be explicitly expressed in the negative cognition, “I am not good enough.”

2. The positive cognition is a positive reflection of what the client would like to believe about herself (i.e., desired direction of change) as she focuses on the image (or picture) of the targeted event and on the opposite side of a personal issue or theme indicated by the negative cognition. For example, “I am a failure” versus “I am able to succeed.”

3. As the client focuses on the image (or picture), she is asked to name the specific emotional sensations that also emerge (i.e., the shame and self-hatred described earlier).

4. The clinician asks the client to initiate a body scan to determine the location of the physical sensations associated with the disturbance. For example, “Where do you feel it in your body?”

Measuring the VoC and the SUD

The VoC scale is used to measure the positive cognition for current validity as the client thinks of the incident and to ensure that it is attainable and not a result of wishful thinking on the part of the client. It is rated to provide a baseline measurement as to how true (i.e., “How true do those words feel?”) and how believable the cognition feels to the client (i.e., is it wishful thinking on the part of the client?). The VoC scale is shown in Figure 2.2.

Table 2.11 briefly explains the why, how, and cautions of the VoC scale.

The SUD scale is a measurement of the gut-level of emotional disturbance being experienced by the client. The SUD scale is shown in Figure 2.3.
When measured during the Assessment Phase, assesses on a gut level the validity of a client’s positive cognition now as he thinks about the image (or picture) or event (incident, experience; i.e., how strongly a client believes his selected positive cognition). The measurement of the VoC scale at this point during the process helps a client to see “light at the end of the tunnel.”

When measured in the Installation Phase, determines what further work may need to be done before the installation of the positive cognition is considered completed (e.g., continuing sets of BLS until VoC = 7, identifying and processing blocking beliefs, feeder memories, ecological validity).

When measured in the Installation Phase, assesses the appropriateness of the positive cognition (e.g., If the VoC does not increase after a few successive sets, the clinician may need to reevaluate the appropriateness of a chosen positive cognition and if another positive belief would be a better fit).

When measured in the Installation Phase, increases the self-efficacy of the client as validity of a positive cognition continues to increase.

“**When you focus on the image (or picture) (or if no picture, event) how true do those words _____ (e.g., ‘I am safe.’) feel to you now on a scale from 1 to 7, where 1 feels completely false and 7 feels completely true?”**

“**On a scale from 1 to 7, how true do those words _____ (e.g., ‘I am competent.’) feel to you now?”**

**NOTE**

It is important to ensure that a client’s positive cognition is appropriate and possible. A red flag for this risk is when the client reports an initial VoC rating of 1. If this occurs, the client may be engaging in wishful or magical thinking which is indicative of a positive cognition that will be almost impossible to achieve. Consider the case of a client who physically abused his five year old son within the past three months. His positive cognition is, “I am a good father.” This statement is clearly untrue. No matter how one thinks about it, a good father does not beat up a young son. No matter his remorse, there is no way for this father to achieve this desired belief within the near future. In this instance, “I can learn from my mistakes and be a good father” may be a far more appropriate positive cognition.
Neutral/No Disturbance | Highest Disturbance
---|---
0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10

**FIGURE 2.3** Subjective Units of Disturbance scale.

**TABLE 2.12**
Subjective Units of Disturbance—The Why and the How

<table>
<thead>
<tr>
<th>WHY?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helps the clinician and client determine which memories need to be targeted.</td>
</tr>
<tr>
<td>Rates the intensity of a client’s disturbance.</td>
</tr>
<tr>
<td>When used in the Desensitization Phase, assesses the degree of change in a client’s level of disturbance and determines when desensitization is complete (SUD = 0 or ecologically valid).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOW?</th>
</tr>
</thead>
<tbody>
<tr>
<td>“From 0, which is neutral or no disturbance, to 10, which is the worst disturbance you can imagine, how disturbing does it feel to you now?”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NOTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The clinician should be cognizant of which emotion(s) a client is rating and ensure that the client is rating negative not positive emotions. It is also important for a client to name the emotion(s). If more than one emotion is named, however, the level of disturbance is always based on the entire incident, not the emotions alone.</td>
</tr>
<tr>
<td>The SUD does not specifically measure the intensity of an emotion but, rather, the level of disturbance of the event (incident, picture). A person may feel some sadness but not be disturbed by it (SUD = 0). The client may experience no residual emotion but still feel disturbance related to a body sensation (e.g., arousal when she thinks of the sexual abuse).</td>
</tr>
</tbody>
</table>

Table 2.12 briefly explains the why, how, and cautions of the SUD scale.

These scales benefit both clinician and client in that they provide an indicator of the client’s progress during the EMDR process. The components of the Assessment Phase are considered to be the stepping stones to adaptive resolution, and Chapter 3 has been entirely dedicated to stressing its importance.
PHASE 4: DESENSITIZATION

When Does It Begin?

By the end of the Assessment Phase, the train is now loaded and ready to start down the first level of reprocessing associations. The goal of the Desensitization Phase is to reprocess every level of association identified along the track until the level of disturbance is down to a 0. The “active” reprocessing phases of EMDR Therapy (i.e., reprocessing and desensitization) begin when the clinician instructs the client, “Concentrate (or Focus) on that image (or picture) (do not describe the image/picture) and those words _____ (repeat the client’s negative cognition, ‘I am _____’). Notice where you feel it in your body, and follow my fingers (or alternative form of bilateral stimulation).” (Note: The clinician does not refer back to all aspects identified in the Assessment Phase—only the image or incident, the negative cognition, and where it is felt in the body.) Once these instructions are given, the reprocessing is initiated and continues with subsequent sets of BLS until the SUD is 0, VoC is 7, and body scan is clear. The clinician begins the agreed-on form of BLS. After an initial set of about 20 passes (i.e., 15 to 20 seconds), the process comes to the first stop along the track when the clinician stops the BLS and says, “Take a breath. (Pause) Let it go. What are you noticing?” The client will provide a brief description of what he is experiencing, and the clinician will simply say, “Go with that (‘Notice that,’ ‘Be with that.’)” and resumes BLS. The train continues down the track, linking into more adaptive information.

Table 2.13 highlights the why and how of desensitization.

There are two important aspects of the Desensitization Phase (i.e., returning to target and checking the SUD level) that are implemented at specific times after the initial reprocessing begins. Figure 2.4 provides a simplified flow of the Desensitization Phase of EMDR Therapy.

<table>
<thead>
<tr>
<th>TABLE 2.13</th>
<th>Desensitization—The Why and the How</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WHY?</strong></td>
<td></td>
</tr>
<tr>
<td>Addresses a client’s disturbing imagery and other sensory details, cognitions and thoughts, emotions, and body sensations. Elicits insights and appropriate associations, including linkage of the memory to adaptive information.</td>
<td></td>
</tr>
<tr>
<td><strong>HOW?</strong></td>
<td></td>
</tr>
<tr>
<td>Repeated sets of BLS are used with appropriate variations and changes of focus as needed until a client’s initial reported SUD lowers to a 1 or 0.</td>
<td></td>
</tr>
</tbody>
</table>
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Desensitization and Reprocessing Begins. “Focus on that image (or picture) and those words, (repeat the client’s negative cognition). Notice where you feel it in your body and follow my fingers.” Clinician reprocessing begins with a set of BLS. She ends each set with, “Take a breath. Let it go. What are you noticing now?” The client reports what he is noticing. Go to A.

A Continue with additional sets of BLS and the client report. If something new or distressing surfaces, repeat A. If nothing new or distressing surfaces or the client’s reports are neutral or positive for two or more consecutive sets of BLS, go to B.

B Go back to target. Ask the client, “When you go back to the original experience, what are you noticing now?” The client reports what he is noticing. Say, “Go with that,” and implement another set of BLS. Go to A and continue with sets of BLS until nothing new or distressing surfaces or the client’s reports are neutral or positive for two or more consecutive sets of BLS. It may be necessary for the client to return to target (B) several more times before all the negatively associated material has been accessed and reprocessed. If, after going back to target and doing another set of BLS, the client reports nothing new or distressing, go to C.

C Check the SUDs. Ask the client, “When you bring up the experience, on a scale of 0 to 10, where 0 is no disturbance and 10 is the highest disturbance you can imagine, how disturbing does it feel to you now?” If the client’s SUD = 1 or greater, check for a feeder memory or blocking belief, and go to A. If the client’s SUD = 0, go to E. If the client’s SUD > 0 or 1 and nothing is shifting, go to D.

D Implement another set of BLS. If still no change, ask the client “Where do you feel it in your body?” and implement an additional set of BLS. If still no change, ask the client, “What keeps it a _?” or “What prevents it from being a 0?” If still no change, the clinician should be alerted to check for ecological soundness or validity. If the client’s SUD = 0 or ecological soundness has been established, go to E.

Note: The clinician is cautioned against considering ecological soundness when the VoC is moderate or high.

E Implement another set of BLS. If the SUD continues to equal 0 (or ecologically valid), proceed to the Installation Phase.

FIGURE 2.4 Desensitization flow chart.

What About Reprocessing?

The title of the Desensitization Phase may prove inadequate as it does not describe all that it entails. It may be more appropriate to consider this the Desensitization Phase of the Reprocessing Phases. Desensitization or removal of the disturbance associated with the initial target is actually only a side benefit of this phase. The positive cognition restructuring (e.g., “I am bad” to “I am good”); integration of perception (i.e., from that of the 3-year-old who experienced the original trauma to that of the 30-year-old who is processing the trauma); new insights or “Aha” experiences; and positive changes in previously reported emotional and physical sensations are
significant as well. The typical outcome of the desensitization represents the removal of the disturbing material, whereas reprocessing is the actual reprocessing of the material and includes the association or linkage with adaptive information. Resultant restructuring of the cognition, spontaneous emergence of insights, and other positive shifts usually do not occur without this important component.

**Purpose of the Desensitization Phase**

The primary purpose of this phase of the EMDR treatment protocol is to: (a) identify, reprocess, and flush out the dysfunctionally stored material associated with the original target and all channels of association (i.e., images, cognitive, emotional, or physiological nodes that link with other past experiences); and (b) desensitize the emotional impact of the memory. As the processing of the information unfolds, the clinician can observe shifts in client awareness; progression of insights; and noticeable changes in the original target information in terms of image, affect, thoughts, sounds, sensations, or beliefs.

**Associative Processing**

Clients may report different aspects of the memory. They may mention changes in imagery (e.g., an angry face changes to a happy or neutral face). A new memory could emerge. A change in the presenting image can occur; details in the presenting image may unfold (e.g., the most terrifying moment of the traumatic event being targeted emerges); or a single image that represents a disturbing aspect of an event may change (e.g., intrusive thoughts, flashbacks, recurring nightmare images). Clients sometimes notice auditory and cognitive changes. They may also experience a diminishing negative emotion, indicative of the memory becoming less toxic and thus desensitized. Each of these shifts is processed completely as it emerges. Once fully processed, the client can be instructed to reaccess the original target.

The general tendency during the course of the reprocessing, whether the client is reporting new or shifting information, is for the disturbance to be less disturbing with each successive set. Even if this is not the case and the disturbance increases instead, reprocessing may still occur. The client may have accessed or experienced another aspect of the memory, and it is being metabolized at a different level. It is a safe assumption that, as the disturbance lessens progressively from set to set, the targeted channel is being cleared of dysfunctional debris.

In between sets of BLS, it is imperative that the clinician listen carefully to what the client reports so that the next focus of reprocessing can be adequately identified, and the clinician’s next intervention can be
strategically orchestrated. When one channel of association has been addressed and exhausted, as indicated by two neutral or positive reports in a row, the client is instructed to return to the original target to discern the presence of new channels needing processing. Each of these channels is linked psychologically to the other. Although the client focuses on the target, the information can be shifted in different ways. It may be linked by shifting images, thoughts, sounds, tastes or smells, insights, sensations, or beliefs. New memories, emotions, and changes in body sensations may also shift the information in various ways. This is what Dr. Shapiro (2001) calls associative processing. Depending on which of these manifests, the clinician will decide what action may be taken. Remember, desensitization of these channels cannot be completed until the dysfunctional material associated with the targeted event has been eliminated. Table 2.14 provides an outline of the possible changes in focus between sets identified by Dr. Shapiro (2001), examples (where applicable), and the clinician’s response under the circumstances.

Evaluating Channels of Association

In the Desensitization Phase, each line of association that emerges during the reprocessing of the client’s disturbing material may be evaluated at several levels. Is the progression or sequential processing that is occurring therapeutically relevant? When can a clinician assume that a channel has been cleared out? What does the clinician need to do when it is determined that an end of a channel has been reached? What happens after retargeting the original incident and no new associations, emotions, sensations, thoughts, or images emerge? Table 2.15 is designed to answer these questions and more.

End of Channel?

When associations appear to have reached the end of a channel or when nothing new or disturbing appears after two or more successive sets of BLS, the clinician redirects the client back to the original target. “When you focus on the original event (incident, experience), what are you getting now?” (Or “What are you noticing now?”) A new set of BLS is initiated regardless of whether the client reports negative or positive associations. Even if the client reports positive images or reports “nothing,” which is quite often the case, continue the BLS for at least two sets. It is not unusual for unexpected channels of association to open up at this point in time. If this happens, simply reprocess the material in the usual manner and redirect the client once again to the original target after the channel appears to have been completely cleared of dysfunctional material. (Note: When the clinician says, “What do
### TABLE 2.14
**Associative Processing**

*Clients tend to report their experiences in terms of changes in imagery, tastes or smells, sounds, sensations, thoughts, and emotions.*

<table>
<thead>
<tr>
<th>CHANGE IN</th>
<th>EXAMPLE</th>
<th>IF THEY EMERGE... BECOMES THE FOCUS OF THE NEXT SET (i.e., “Go with that.” Add BLS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TASTES OR SMELLS</td>
<td>The smell of aftershave or the taste of tobacco left behind after father’s molestation of daughter</td>
<td>Taste or smell If it fades and no new associations, return to original target</td>
</tr>
<tr>
<td>IMAGERY</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>New memory</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One memory</td>
<td>The memory of her father opening the door</td>
<td>Memory</td>
</tr>
<tr>
<td>Several memories</td>
<td>The memories of the molestation and breakfast with the family the next morning</td>
<td>Most disturbing memory</td>
</tr>
<tr>
<td>All memories are equally disturbing</td>
<td>Both memories above are highly disturbing.</td>
<td>Last memory to appear</td>
</tr>
<tr>
<td>Endless stream of associated memories (i.e., 10–15)</td>
<td>Bits and pieces of multiple molestations stream through client’s consciousness</td>
<td>Return to original target after each shift</td>
</tr>
<tr>
<td>Transient memory</td>
<td>Memory of her first sexual encounter with a boyfriend.</td>
<td>If needed, retarget after presenting memory has been completely reprocessed.</td>
</tr>
</tbody>
</table>

(continued)
TABLE 2.14  (continued)  
Associative Processing

Clients tend to report their experiences in terms of changes in imagery, tastes or smells, sounds, sensations, thoughts, and emotions.

<table>
<thead>
<tr>
<th>CHANGE IN</th>
<th>EXAMPLE</th>
<th>IF THEY EMERGE...BECOMES THE FOCUS OF THE NEXT SET (i.e., “Go with that.” Add BLS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Image changes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative image emerges</td>
<td>Father yelling</td>
<td>Negative image Early in session: Target a set or two to see if it strengthens; readdress the original issue as soon as possible</td>
</tr>
<tr>
<td>Neutral or positive image emerges</td>
<td>Father singing softly to himself while gardening or sitting silently on his rocking chair in the evenings</td>
<td>Later in session: Continue until strengthening ceases</td>
</tr>
<tr>
<td>Two images emerge, one positive and one negative</td>
<td>Father singing and yelling</td>
<td>Negative one</td>
</tr>
<tr>
<td>Incident unfolds</td>
<td>Frame-by-frame scenes of the molestation emerge chronologically</td>
<td>Client focuses on each scene in separate sets until resolution is achieved</td>
</tr>
<tr>
<td>Appearance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Image itself changes in appearance</td>
<td>Father appears to be getting bigger and bigger</td>
<td>Changes in appearance. If client states that the image is “blurry,” ask the client to concentrate on it</td>
</tr>
<tr>
<td>Image disappears, disturbance remains</td>
<td></td>
<td>Tell the client to, “Just think of the incident” and concentrate on physical sensations. Continue the sets until the disturbance is resolved</td>
</tr>
<tr>
<td>SOUNDS AND THOUGHTS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Negative statement or idea</strong></td>
<td>“I am a total failure.”</td>
<td></td>
</tr>
<tr>
<td><strong>Mismatch</strong></td>
<td>Client reports thinking of something funny</td>
<td></td>
</tr>
<tr>
<td><strong>Positive thought</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If positive thought emerges</td>
<td>“I am a success.”</td>
<td></td>
</tr>
<tr>
<td>If no change in positive thought</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If positive thought strengthens</td>
<td>“I am a failure.”</td>
<td></td>
</tr>
<tr>
<td>If both a positive and negative thought emerge at once</td>
<td>“I can be successful at some things.”</td>
<td></td>
</tr>
<tr>
<td><strong>Insights</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Become progressively more adaptive.</td>
<td>The clinician instructs the client to, “Think of that.”</td>
<td></td>
</tr>
<tr>
<td><strong>SENSATION AND AFFECT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>New emotion</strong></td>
<td>“I am feeling unusually sad.”</td>
<td></td>
</tr>
<tr>
<td><strong>Shifting body sensations</strong></td>
<td>“My stomach is beginning to cramp.”</td>
<td></td>
</tr>
<tr>
<td><strong>Physical sensations</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### TABLE 2.15
Evaluation of Association

<table>
<thead>
<tr>
<th>IDENTIFY, EVALUATE, AND MEASURE</th>
</tr>
</thead>
</table>

**Evaluate associations for…**
- Progression (i.e., disturbance is more or less disturbing)
- Other aspects of the memory being experienced
- Any change in image, sounds, smells, beliefs, emotions, or sensations

**A channel of association has been cleared when…**
- The client experiences no disturbance
- The associations have reached a reasonable stopping point or
- Nothing new emerges after two consecutive sets of BLS

**When enhanced associations cease…**
- Instruct client to retarget the original incident by saying, “When you focus on the original event (incident, experience), what are you noticing now?”
- Wait for client’s response and then initiate another set.
- Process emerging channels.
- After each channel has been cleared, instruct the client to return to the original target.

**When the original incident has been retargeted and no new associations, emotions, sensations, or images emerge after two consecutive sets of BLS…**
- Recheck the client’s SUD level.
- If the client reports a SUD equal to 0, it is considered to be desensitized; and the installation of the positive cognition may begin.
- If SUD becomes stuck at 1 or 2, focus on the body sensation and add BLS.
- If there is still no change, ask, “What makes it a ___?” or “What prevents it from becoming a zero?” Once identified, add BLS. If still no change, probe for additional blocking beliefs or feeder memories.
- If there is a *feeder memory*, first say, “Just notice that” and add BLS. If it does not resolve, then target it directly beginning with Phase 3. When resolved, return to the current target and complete reprocessing.
- If a response indicates the presence of a *blocking belief* (e.g., “If I get my hopes up too high, the other shoe will drop.”), first say, “Go with that” and add BLS to see if the blocking belief clears on its own. If the SUD continues to be greater than 0 (or not yet ecologically valid), implement the full EMDR reprocessing (i.e., Phases 3–6) on the memory where the client came to believe the blocking belief.
- If the client’s response seems appropriate given the circumstance (e.g., “It’s difficult to feel totally safe knowing the rapist is out on bond.”), first say, “Go with that” and add BLS to see if there is any change. If the SUD continues to be greater than 0, the level of disturbance may be considered ecologically valid. Initiate the Installation Phase.
TABLE 2.15  (continued)
Evaluation of Association

<table>
<thead>
<tr>
<th>IDENTIFY, EVALUATE, AND MEASURE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If the client has arrived at the end of a channel and time is running out...</strong></td>
</tr>
<tr>
<td>Go directly to the Closure Phase. Do not return to target as this may open up a new channel of association with a yet untapped disturbance.</td>
</tr>
<tr>
<td><strong>If the client makes a statement that reflects a blocking belief limiting further progress...</strong></td>
</tr>
<tr>
<td>Acknowledge the statement and do at least two sets of BLS to see if it will clear on its own. The clinician can also ask, “Do you remember where (or when) you learned that?”</td>
</tr>
<tr>
<td>If necessary, using floatback identify the memory associated with the origination of the limiting/blocking belief and add repeated sets of BLS before returning to target. If the limiting statement/blocking belief continues to impede full desensitization, it may require reprocessing of the associated memory (using Phases 3–6) before returning to the Desensitization Phase of the original memory. Before advancing to the Installation Phase, examine all SUD levels higher than 0 for ecological validity. Accept the limitation only if it appears reasonable and has ecological validity.</td>
</tr>
</tbody>
</table>

you notice now?” and the client says, “Nothing,” it is important for the clinician to question the client by asking, “What does ‘nothing’ mean?” or “Where did your mind go as you were noticing nothing?” Or, “Do you notice ‘nothing’ or ‘numbness’ in your body?” Sometimes, “nothing” may mean that the client is experiencing a condition of numbness, has dissociated, or simply can no longer access the memory. At other times, “nothing” may reflect clients’ misperception that whatever is in their awareness is not relevant. The answer the client gives will depend on what the clinician does (i.e., continue processing, return to target, or utilize a strategy to unblock the processing).

Only when the client reaches a point at which no new associations, images, sensations, thoughts, or emotions come to the forefront will the clinician ask the client, “Focus on the original event (incident, experience). On a scale of 0 to 10, how disturbing does it feel to you now?” If the client answers, 0, the original target is said to be desensitized. Transcripts of client sessions, which include the Desensitization Phase, are provided in Chapter 6.

What happens if the SUD reported by the client is more than 0? Consider the following:

**Clinician:** From 0, which is neutral or no disturbance, to 10, which is the worst disturbance you can imagine, how disturbing does it feel to you now?

**Client:** It feels like a 2.
The clinician implements another set of BLS.

Clinician: How disturbing does it feel to you now?
Client: It’s the same.
Clinician: Where do you feel the 2 in your body?
Client: In my head.

When a client initially reports a SUD > 0, the clinician’s first line of action is to have the client focus on where the client feels it in her body.

Clinician: Where in your head?
Client: My forehead.

It does happen that a client will report a sensation in her head that is not necessarily of a physical nature. Instead of questioning whether it is cognitive or physical, just ask the client the same question as mentioned previously. You do not risk leading the client away from an important component of her processing in asking this question. Do not try to lead a client during reprocessing. Remember that what is being processed is about her, not you.

Clinician: (Change direction of eye movements) Go with that. Take a breath. (Pause) Let it go. What comes up for you now?

The phrase, “Let it go,” is intentionally stated this way as it vaguely refers to “letting go” of the breath and the memory.

Client: It’s the same.
Clinician: What emotions are you feeling?
Client: I’m feeling a little wary.

The client has reported a low-grade negative emotion. If the client had reported a more positive emotion at this time, the clinician could redirect the client to assess negative emotions if they remain.

Clinician: What keeps it from being a 0?
Client: I don’t deserve to be happy.

The client’s response reveals what is called a blocking belief. The clinician could ask, “Do you remember when you first learned this, or first had...
that thought?” If there is time, the experience(s) creating the belief should be processed. If not, this information will need to be carried over to another session and be targeted with an associated memory for the full EMDR reprocessing (i.e., Phases 3–6). Once resolved, return to the current target and complete Phases 4 through 8.

**Clinician:** (Change direction of eye movements) Go with that. Take a breath. (Pause) Let it go. What are you getting now?

If the client still reports no change, the clinician will need to check for ecological soundness. The clinician does not proceed beyond the Desensitization Phase of EMDR unless the client’s SUD is 0 or ecological soundness has been validated (see Chapter 1 for explanation of ecological soundness).

**When to Return to Target?**

Table 2.16 provides a more comprehensive understanding of the why and how of returning to target. Table 2.17 provides guidelines for returning to target (i.e., the original incident or event) and taking the client’s SUD level.

Returning to target has the potential of activating another channel of association. Therefore, if there is insufficient time to reprocess new material, the clinician is advised to close down a session as incomplete rather than returning to target.

<table>
<thead>
<tr>
<th><strong>TABLE 2.16</strong>&lt;br&gt;Going Back to Target—The How and the Why</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WHY?</strong></td>
</tr>
<tr>
<td>To discern whether or not there are additional channels of dysfunctional material that need to be reprocessed when there is no change after two consecutive sets of BLS</td>
</tr>
<tr>
<td>To reorient the client to the target if the client or the therapist is confused about where the processing has gone in relationship to the target</td>
</tr>
<tr>
<td>To commence the Installation Phase</td>
</tr>
<tr>
<td>To complete the body scan</td>
</tr>
<tr>
<td><strong>HOW?</strong></td>
</tr>
<tr>
<td>After a client has come to the end of a channel of association: “When you go back to the original memory (incident, experience), what are you noticing now? [Pause as the client provides a response.] Go with that.”</td>
</tr>
</tbody>
</table>
### TABLE 2.17
Desensitization Phase—When to…

<table>
<thead>
<tr>
<th>Return to original target if . . .</th>
<th>Take a SUD (0–10) if…</th>
</tr>
</thead>
<tbody>
<tr>
<td>An end of channel is identified by repeated neutral or positive responses by the client.</td>
<td>After returning to target and doing two more sets of BLS, the client still reports neutral or positive material.</td>
</tr>
<tr>
<td>After at least two consecutive sets of BLS, the client reports no change.</td>
<td>Client’s progress is being checked.</td>
</tr>
<tr>
<td>The associations reported by the client are too vague or unrelated to the original target.</td>
<td>The end of the desensitization is identified (SUD equals 0).</td>
</tr>
<tr>
<td>If the client reports a SUD greater than 0, then do the following in order: Focus on client-reported location of body sensation and add BLS. Ask what prevents it from being a 0. If identified, do BLS. Search for feeder memories or blocking beliefs using direct questioning, floatback, or affect scan. Consider ecological soundness. Explore further for additional feeder memories or blocking beliefs.</td>
<td></td>
</tr>
</tbody>
</table>

#### Change Characteristics of BLS if:

- Client reports a headache, dizziness, or nausea.
- No shift in information is reported or observed.

...then change direction or change type of BLS

...then change length and speed or change type of BLS

---

**What to Do If the Subjective Units of Disturbance (SUD) Becomes Stuck**

What happens when the SUD level becomes stuck at a 1 or 2?

1. Ask the client, “Where do you feel it in your body now?” and add BLS.
2. If the SUD is still not equal to 0, the clinician may check for blocking beliefs by asking the client, “What keeps it a _____?” or “What prevents it from becoming a zero?” If a blocking belief is identified, the clinician adds BLS until the blocking belief has been completely reprocessed.
3. If the SUD is still not equal to 0, the clinician may probe for additional blocking beliefs or feeder memories. Note that blocking beliefs may be spontaneously processed (i.e., an EMDR reprocessing session within an EMDR reprocessing session) or may be the target in a subsequent reprocessing session (i.e., “Where did you learn that belief?”). As mentioned previously, additional blocking beliefs may be uncovered using direct questioning, floatback, or affect scan techniques.

4. If SUD is still not equal to 0, the clinician may check for ecological soundness (Shapiro, 2009–2014).

How Long Does It Last?

The Desensitization Phase in some instances may last no longer than 10 minutes or may span over numerous sessions. Some sessions can move smoothly from start to finish without the clinician saying anything more than, “Take a breath. (Pause) Let it go. What are you noticing now?” followed by, “Go with that” or words of encouragement, such as “Good. You’re doing fine.” This is what is called spontaneously reprocessing. At times, you may experience other sessions that are full of verbal and nonverbal cognitive interweaves (see Chapter 5) every step of the way. Just like every client, each session is unique. Anything can and will happen. Go with the flow, keep out of the way, and let whatever happens, happen. This is a good EMDR mantra for both the clinician and the client.

When to Proceed to the Installation Phase?

Remember, the rule of thumb for this stage is that the SUD level is reduced to a 0 before proceeding to the Installation Phase. Does this always happen? Not necessarily. We need to allow for ecological validity in some instances. What keeps it from being a 0? In others words, is this response most appropriate for this client under her particular circumstances? See Figure 2.5 for a graphic picture of the Desensitization Phase.

Table 2.18, “Derailment Possibilities—Desensitization,” has been compiled to demonstrate to the clinician the potential obstacles to unobstructed processing.

Taking a Break

At the end of a set of BLS, when the clinician says, “Take a breath. Let it go,” the clinician stops the eye movements (or other form of BLS) and asks the client, “What are you getting now?” or “What comes up for you now?” This is essential to maintain dual attention and is done for several
Target/Node Reprocessing Desensitization

[FIGURE 2.5 Desensitization phase.]

- Channels of Association
- Dysfunctionally Stored Material
- Reprocessing
  - Observed Shifts
  - Awareness
  - Progression of Insights
- Desensitization Complete
  - SUD = 0
  - VoC = 7

Associative Processing
- Imagery, new memory, image changes, incident unfolds, appearance changes, and changes in sounds, sensations, and/or emotions
Initiating bilateral stimulation without instructing the client to bring up the image, negative cognition, and body sensations.
When initiating desensitization, use the words above in the order presented to initiate reprocessing for a client.

Instructing the client to “stay” focused on the image/target.
As the image/target is a starting point, the clinician instructs the client to “Just let it go wherever it goes,” thus allowing associations to spontaneously emerge. The client may get confused and try to hold on to the target and have difficulty getting started as a result. Prior to initiating desensitization and reprocessing, the clinician may say to the client, “The image is a starting point, not a staying point. Focus on the image for a few moments and then release to allow other associations to spontaneously emerge.”

Providing or repeating the description of the image or any details of the memory being processed.
This is contraindicated in the protocol. Repeating back details of a client’s memory is an intrusion into his processing. When referring to the event, refer to the “original incident or experience.” If the client cannot remember where he started in the beginning, give as little detail as possible.

Failing to closely observe the client’s nonverbal cues during the BLS.
The clinician should closely observe any changes in expression, breathing, skin tone, posture, etc., during the BLS to help determine the length of the set.

Failing to listen to what a client says between sets.
The clinician should listen attentively in order to identify the client’s next focus for processing (e.g., a client’s last statements, another aspect of a client’s experience, or possibly a new target).

Asking the client to focus on: (1) the emotions identified during the Assessment Phase; (2) the physical sensations described by the client (e.g., a deep pain in the pit of my stomach); (3) a sensation in place of an image; or (4) “All that.”
Always instruct the client to bring up the picture, the negative cognition, and where (not what) he feels it in his body. Do not repeat the details.

(continued)
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reasons: (a) during BLS, information pertinent to the targeted traumatic event is stimulated. Stopping the processing allows time for the dysfunctional information to drop off and adaptive information to be consolidated; (b) this brief interruption allows the clinician to reevaluate the client’s progress and to judge if reprocessing has taken place; (c) during this break, the client’s concentration and intensity of focus is interrupted, and the client is given permission to rest, reorient, and verbalize what happened during the set. It also provides the client with a sense of empowerment; and, finally, (d) it provides the client with an opportunity to verbalize her internal process and understand whatever changes have taken place more readily (Shapiro, 2001).

PHASE 5: INSTALLATION

What Occurs?

When all channels of association revealed throughout the reprocessing are completely cleared (i.e., SUD = 0 or ecologically valid), the clinician can embark on the Installation Phase. It is during this phase that the positive cognition is linked to the original event (incident or experience). Installation occurs when the positive self-assessment established by the client is fully integrated with the targeted information. To allow this, the clinician rechecks the current appropriateness, applicability, and validity of the positive cognition reported in the Assessment Phase. Table 2.19 provides a clearer view of the why and how of the Installation Phase.

Table 2.20, “Derailment Possibilities—Installation,” has been compiled to demonstrate to the clinician the potential obstacles to the installation process.

Evaluate Appropriateness of Original Cognition

Because so much baggage is shifted or lost and new insights are being boarded at the various stops during the “train ride,” what the client originally wanted to believe about herself may now be different. She may need
Eight Phases of EMDR Therapy

A stronger positive cognition to complete the process. It may have gone from, “It’s over. I am safe” to “I am a powerful person.” The fact that a more powerful and appropriate positive cognition surfaced after desensitization was complete is indicative that the client has moved further along the information-processing track.

To provide the client with an opportunity to evaluate the appropriateness of the original positive cognition, the clinician asks, “When you bring up that original incident, do the words _____ (e.g., ‘I am competent.’) still fit, or is there another positive statement you feel would be more suitable (or appropriate)?” It is imperative that the client choose the cognition that resonates the most with her as she focuses on the original target. If you help the client to identify a positive cognition at this stage, do so cautiously. Remember, the process belongs to the client; and the clinician needs to keep her distance from the “moving train.” The clinician does not want to impede or derail the “train” with any attempts to be helpful.

### TABLE 2.19
Installation—The How and the Why

<table>
<thead>
<tr>
<th>WHY?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sets the desired direction of change.</td>
</tr>
<tr>
<td>Stimulates the appropriate alternative and adaptive neuro networks.</td>
</tr>
<tr>
<td>Offers therapist/client a baseline from which to assess a client’s progress.</td>
</tr>
<tr>
<td>If a better positive cognition fails to materialize before or during desensitization, provides an opportunity for the client to give a positive statement that can be used for rapid installation.</td>
</tr>
<tr>
<td>Improves a client’s self-esteem and installs generalized self-enhancement as his train moves further down the track.</td>
</tr>
<tr>
<td>May increase generalization to other associated memories or present triggers that will be targeted as part of the treatment plan.</td>
</tr>
<tr>
<td>Ensures “enhanced integration of the cognitive reorganization” (Shapiro, 2001).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOW?</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Focus on the original event (incident, experience). Do those words _____ (e.g., ‘I am competent.’) still fit, or is there another positive statement you feel would be more suitable?”</td>
</tr>
<tr>
<td>“Focus on the original event (incident, experience) and those words _____ (e.g., ‘I am competent.’). From 1, which is completely false, to 7, which is completely true, how true do they feel now?”</td>
</tr>
<tr>
<td>“Hold them together.” Initiate BLS utilizing standard long/fast sets that are typical of all reprocessing phases.</td>
</tr>
</tbody>
</table>
TABLE 2.20
Derailment Possibilities—Installation

“Do the words (repeat positive cognition) still fit or is there another positive statement you feel would be more suitable?”

“Focus on that event and those words ____ (repeat selected positive cognition). On a scale from 1 (completely false) to 7 (completely true), how true do they feel to you now?”

“Hold them together.” Initiate BLS.

“On a scale from 1 to 7, how true do those words ____ (repeat selected positive cognition) feel to you now?”

Failing to check if the positive cognition is still appropriate before completing installation.

The clinician should always check the appropriateness of the positive cognition identified by the client in the Assessment Phase. Be open for the possibility that a more appropriate or powerful positive cognition may have emerged spontaneously during successive sets of desensitization. The client should use the positive cognition that is most meaningful and acceptable to him.

Failing to ask the client to pair the selected positive cognition with the original memory.

Linking the original memory (or its current manifestation) with the positive cognition strengthens the associative bond between the two. In the event the memory (e.g., being snubbed at a birthday party by her peers) is triggered in the future, it may be accompanied by a stronger, more adaptive response (e.g., “I am worthy”).

Instructing the client to focus on the original image (or picture).

The installation of the positive cognition requires that a client focus on the entire memory or event rather than the original starting image (or picture). This question is asked in a more general form because the original image may have disappeared or has been replaced by another that is more appropriate.

Instructing the client to focus on the body by saying, “Where do you feel it in your body?” or “What keeps it a (SUD level)”? or “What prevents it from being a 0?”

Asking these questions indicates that the clinician is confused by the order of the phases. The order is: (1) Desensitization (SUD = 0; check for blocking beliefs or feeder memories if SUD still > 0); (2) Installation (check for appropriateness and install positive cognition); and (3) Body Scan (i.e., “What is happening in the body now?”).

Asking for the SUD after the completion of the Installation Phase.

This is a common occurrence. Again, it is important to remember the order of the phases of treatment. Installation only occurs after the completion of the Desensitization Phase, and the SUD level is checked and established in the former.

(continued)
Validity of the Positive Cognition

During this phase, the positive effects of the chosen cognition identified are being linked and can be fully integrated with the target memory. Imagine that the client chooses the original positive cognition. The baseline measurement has already been established. Has the VoC changed? To assess, the clinician asks, “As you focus on the incident, how true do the words _____ (e.g., ‘I am competent.’) feel now on a scale of 1 to 7, where 1 is completely false, and 7 is completely true?” If the VoC does not increase after repeated sets, the positive cognition will need to be rechecked and, possibly, a substitute may be considered.

Link to Original Target

Once an appropriate positive cognition is chosen, it is linked with the original target. At this stage of the process, the original target is likely to be quite different than it was when reprocessing began. Clients often describe it as cloudy, in the distance, untouchable, foggy, unclear, or far way. The client is asked to hold the event in mind while repeating the positive cognition silently to
herself in this way: “Focus on the event, and hold it together with the words _____ (e.g., ‘I am competent’).” Successive sets of BLS follow. Because the Installation Phase is still part of reprocessing, the length and speed of the set are similar to those determined in the Desensitization Phase.

**When Is Installation Complete?**

Like desensitization, installation continues until there are no longer changes and the VoC continues to be a 7. Continue to do BLS as long as the VoC of 7 is strengthening and becomes more adaptive. When it is a 7 and further BLS no longer causes it to shift in a functional way, the clinician then implements the body scan.

**How to Discern the Presence of a Blocking Belief**

If the VoC does not rise to a 7, it is a signal for the clinician to look for blocking beliefs or emerging associations that need to be addressed, such as “If I don’t have this problem, I won’t know who I am.” The clinician checks for a blocking belief by asking the client, “What keeps this from going to a 7?” Or “What is the worst thing that would happen if this went to a 7?” If a blocking belief arises, implement another set of BLS and say “Go with that.”

If the client insists on sticking with his blocking belief and it seems without much content and the VoC is nearly a 7, the clinician can proceed to the body scan. If the blocking belief has some punch and does not improve with successive sets of BLS, the clinician will need to assess for ecological soundness (see Chapter 1 for definition of ecological soundness). There are occasions when the blocking belief becomes a target for a full EMDR reprocessing (i.e., Phases 3–6). It is not until the earlier memories behind the blocking belief are successfully reprocessed at the next session(s) that the reprocessing of the original target can be completed. Once the earlier memory has been successfully processed, the clinician needs to reevaluate the original target and complete the installation.

**PHASE 6: BODY SCAN**

Dysfunctionally stored material often manifests itself somatically. After having successfully installed the client’s positive cognition, the clinician asks her to reassess her body from head to toe for residual body tension, tightness, unusual or unfamiliar sensations, or even positive changes that might still be present. Table 2.21 presents the why and how of the body scan.

In implementing a body scan at this juncture, the clinician is looking for residual blocking beliefs or other material (e.g., major areas of resistance,
associated networks containing dysfunctional information that might not be fully integrated). The amelioration of the cognitive, emotional, and physical sensations will increase the probability of a positive treatment effect.

The client is asked to focus on the original targeted event, the positive cognition, and any identified physical discomfort. The clinician continues with successive sets of BLS until the tension has been lifted. This is what the clinician says to initiate a body scan: “Close your eyes and keep in mind the original event (incident, experience) and the words _____ (i.e., positive cognition), ‘I am competent.’ Then bring your attention to the different parts of your body, starting with your head and working downward. Any place you find any tension, tightness or unusual sensation, tell me.”

If the physical sensations do not dissipate, first switch to diagonal eye movements and add another set or two of BLS. This often helps to move somatic material. If the physical sensations still do not shift, another channel or other associated networks of information may be present and will need to be processed before the current session will be considered complete. Positive sensations that emerge are reinforced with shorter sets (i.e., 4–6) of BLS. It is not unusual for a client to report an obvious injury when scanning her body (e.g., pain in the back from a ruptured disk or upset stomach from something she had for lunch). When these types of bodily discomforts are reported, continue the body scan in the prescribed manner. There may be chronic or acute problems showing up physiologically that are affecting her psychologically as well. In these instances, three things can

<table>
<thead>
<tr>
<th>TABLE 2.21</th>
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</thead>
<tbody>
<tr>
<td>Body Scan—The Why and the How</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WHY?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluates and addresses any residual body tension, tightness, or unusual sensations.</td>
</tr>
<tr>
<td>Opens or reveals other channels of association that may be appropriate for reprocessing.</td>
</tr>
<tr>
<td>Highlights major areas of resistance.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOW?</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Close your eyes and keep in mind the original event (incident, experience) and the words _____ (i.e., positive cognition), ‘I am competent.’ Then bring your attention to the different parts of your body, starting with your head and working downward. Any place you find any tension, tightness or unusual sensation, tell me.”</td>
</tr>
</tbody>
</table>
happen: (a) the discomfort may dissipate or remit completely; (b) the client may remember another incident that had not been anticipated by either the clinician or the client, which will need to be reprocessed at the next session (e.g., a pain in the lower back may cause a memory of being molested at age 5 years to emerge); or (c) there is no change, because the bodily discomfort is unrelated to the current processing.

The key point to remember during the body scan is that the reprocessing of the dysfunctional material is not considered complete until the body scan is clear (i.e., free of residual negative associated sensations). Do not proceed to the next target until it is clear. If there is not enough time in the session to ensure the completion of this phase, either extend the session or close it down and address anything that is not completed at the next session.

Table 2.22, “Derailment Possibilities—Body Scan,” has been compiled to demonstrate to the clinician the potential obstacles to the Body Scan Phase.

<table>
<thead>
<tr>
<th>TABLE 2.22 Derailment Possibilities—Body Scan</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Close your eyes and keep in mind the original event (incident, experience) and the words _____ (repeat selected positive cognition). Bring your attention to the different parts of your body, starting with the top of your head and working downward. Any place you find any tension, tightness, or unusual sensation, please tell me.”</td>
</tr>
</tbody>
</table>

Failing to do a body scan.
No reprocessing is considered complete or successful without the inclusion of the body scan.

Failing to pair the negative body sensations with the original event (incident, experience) and/or the installed positive cognition.
Follow the script as prescribed.

Instructing the client to focus on the original picture/image.
A body scan is facilitated by having the client focus on the original event (incident, experience) rather than the image (or picture) targeted in the Assessment Phase.

Concluding a body scan when the client still reports residual physical sensations.
The body scan is not complete until the client reveals no tension or associated negative sensations.

Failing to initiate successive sets when the client continues to report negative physical sensations.
Successive sets of BLS should be continued until all negative physical residue has been desensitized.

(continued)
### TABLE 2.22 (continued)
**Derailment Possibilities—Body Scan**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performing a body scan when there are only a few minutes left in a session.</td>
<td>The clinician should ensure that the client does not end a session with high levels of disturbance or in the middle of an abreaction. A body scan always has the potential for setting off new channels of dysfunctional information (e.g., fears, resistance) that may take more than a few minutes to reprocess. Ensure that the client leaves the office in a stable condition.</td>
</tr>
<tr>
<td>Asking the client, “Is everything okay?”</td>
<td>A body scan evaluates and addresses residual body tension. The clinician facilitates processing by refraining from asking questions or making comments.</td>
</tr>
<tr>
<td>Asking the client questions about what is revealed during a body scan (e.g., “Did you find any tightness in your chest?”).</td>
<td>The clinician should refrain from asking or asking as few questions as possible.</td>
</tr>
<tr>
<td>Requesting a descriptive appraisal of any body sensations the client may report (e.g., “How much does it hurt?”).</td>
<td>As it does not provide any useful information, the clinician should refrain from asking these kinds of questions.</td>
</tr>
<tr>
<td>Asking for body sensations only.</td>
<td>At this point, channels of association, blocking beliefs, feeder memories, or negative emotions may still emerge. As the client scans her body, just let whatever happens, happen.</td>
</tr>
<tr>
<td>Initiating a body scan before the completion of desensitization and installation.</td>
<td>The body scan should only be performed after all other parts of the process have been fully completed.</td>
</tr>
<tr>
<td>Naming the body parts as the client scans down his body.</td>
<td>The client should be encouraged to scan down his body by his own design and at his own pace.</td>
</tr>
<tr>
<td>Encouraging the client to do the body scan with her eyes open.</td>
<td>Eyes should remain closed during the scanning of the body and then open for the BLS during the body scan.</td>
</tr>
<tr>
<td>Failing to strengthen any positive physical sensations that arise.</td>
<td>Successive sets should always be done to strengthen these positive physical sensations.</td>
</tr>
</tbody>
</table>
PHASE 7: CLOSURE

Levels of Closure

The Closure Phase of EMDR Therapy refers to either properly shutting down an incomplete session or ending a completed session. This phase also includes debriefing the client after each session, instructing him or her to maintain a log between sessions, and giving guidelines for in-between sessions. Regardless of whether the session is complete or incomplete, the primary goal of this phase is to ensure that the client is returned to “a state of emotional equilibrium” (Shapiro, 2001) by the end of the session (i.e., to ensure the client’s stability at the end of a session and between sessions). At this point, all processing has stopped, and the client is directed to focus on or access neutral or other positive networks that are not associated to the targeted network.

Strategies for Closing Sessions

Strategies for closing down completed and incomplete sessions are different.

Completed Session

A session is complete when SUD = 0, VoC = 7, and the body scan is clear (see Figure 2.6). When a session has been successfully completed, the clinician indicates to the client that it is time to stop and provides encouragement and assurance by saying, “You have done very good work today. How are you feeling?” In addition, the clinician debriefs the client by further asking, “As you review your experience in our session today, what positive statement can you make to express what you have learned or gained?”

Incomplete Session

As Figure 2.6 depicts, a session is considered incomplete if one of the standard procedural steps has not been completed (i.e., SUD is greater than 0, VoC is less than 7, or no clear body scan). When it is necessary to close

\[
\text{Completed Target Session} = \text{SUD} = 0 + \text{VoC} = 7 + \text{Clear body scan}
\]

\[
\text{Incomplete Target Session} = \begin{cases} 
\text{SUD} > 0 & \text{(SUD} = 0) + \text{VoC} < 7 \\
\text{SUD} = 0 + \text{VoC} = 7 + \text{No clear body scan} 
\end{cases}
\]

FIGURE 2.6 Formulas for completed and incomplete target sessions.
down an incomplete session, do not: (a) recheck the SUD or VoC levels; (b) refer back to the positive cognition; or (c) do a body scan. If the clinician feels that she is at a good stopping point, she notifies the client, asks the client’s permission to stop, and tells the client why. For instance, “We are near the end of our time together, so we need to stop. Are you okay with that?” It is at this juncture that the clinician may suggest containment, stress reduction, progressive breathing, relaxation exercises, or the Lightstream Technique to help return the client to her normal functioning. Remind the client of her calm (safe) place. As additional processing may take place between sessions, it is important that the client be stabilized before leaving the clinician’s office. Assure the client that she can call between sessions, if needed. Once the client is stabilized, encourage and debrief the client in the same manner described earlier for completed sessions.

Table 2.23 presents the why and how of complete and incomplete closure.

<table>
<thead>
<tr>
<th>Closure: Complete or Incomplete—The Why and the How</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHY?</td>
</tr>
<tr>
<td>Returns a client to a state of emotional equilibrium to ensure stabilization between sessions.</td>
</tr>
<tr>
<td>Assures that the client no longer has “one foot in the past” but instead is fully oriented to “here and now.”</td>
</tr>
<tr>
<td>HOW?</td>
</tr>
<tr>
<td>Do this by providing client with detailed instructions at the end of each session...</td>
</tr>
<tr>
<td>Instruct the client to use a variety of relaxation techniques (e.g., Calm [Safe] Place, Sacred Space, Lightstream Technique) to assist her in maintaining a relative state of calm.</td>
</tr>
<tr>
<td>“I suggest we do a relaxation (or a container) exercise before we stop.”</td>
</tr>
<tr>
<td>Or “I suggest we _____ (fill in the blank).”</td>
</tr>
<tr>
<td>Remind the client that disturbing images, thoughts, or feelings may continue between sessions and that these disturbances are indicative of further processing. Instruct the client to keep a log of any disturbing memories, dreams, thoughts, or situations that arise between sessions as these disturbances may be the target of future sessions. Provide the client with realistic expectations as to what may surface in terms of negative or positive responses between sessions.</td>
</tr>
<tr>
<td>“Processing may continue after our session. You may or may not notice new insights, thoughts, memories, physical sensations or dreams. Please make a note of whatever you notice. We will talk about that at our next session. Remember to use the self-control techniques as needed.”</td>
</tr>
</tbody>
</table>
The clinician may need to use her own clinical judgment in determining whether special attention needs to be focused on a client to minimize the opening of new negative channels of association or whether the client has the ability to manage any negative emotions that arise as a result of continued reprocessing between sessions. In this case, the clinician may suggest to the client the use of the Calm (Safe) Place exercise, container, and/or relaxation exercises to utilize between sessions. The clinician may also want to assign the client homework to help manage whatever comes up in the interim, such as practicing self-control techniques and using the trigger, image, cognition, emotion, and sensation (TICES) grid.

These are the instructions that Dr. Shapiro (2011) provides for closing down all reprocessing sessions: “Processing may continue after our session. You may or may not notice new insights, thoughts, memories, physical sensations, or dreams. Please make a note of whatever you notice. We will talk about that at our next session. Remember to use self-control techniques as needed.” Table 2.24, “Derailment Possibilities—Closure,” outlines some common oversights when it comes to the Closure Phase of treatment.

**Assessment of Client’s Safety**

Regardless of whether the session is complete or incomplete, Dr. Shapiro (2001) suggests that the clinician remind and instruct the client in these key points as she leaves an EMDR reprocessing session:

1. End the reprocessing using the Calm (Safe) Place exercise, the Lightstream Technique, or other containment strategies to return the client to a more present-focused, functional state of mind.

2. Additional processing may occur between sessions; additional disturbing material in the form of images, thoughts, or emotions may arise.

3. It is important to instruct the client to keep a log or journal of negative material (i.e., situations, thoughts, emotions, dreams) that may arise between sessions. The act of writing provides the client with an emotional distancing technique. The negative material collected in the log may serve as targets for future sessions (see Appendix C under TICES Log). Although having the client keep a log between sessions is an ideal practice, some clients may be resistant. Just remember, it is neither necessary nor critical to the rest of the process.

4. To ensure client stability, encourage the client to utilize visualization and relaxation techniques between sessions. If she needs to write down something disturbing in the TICES log in between sessions, instruct her to use one of the self-control techniques that she was taught following entry into the log. Once she has written something in her log, it helps her to externalize the initial disturbance (or “container” it).
TABLE 2.24  
Derailment Possibilities—Closure

**INCOMPLETE SESSIONS**

Provide the client with a reason for stopping (i.e., “We are almost out of time, and we will need to stop soon.”).

“We can put it away now.”

“It can be put in a box until next time.”

“We can let it go for now.”

Provide encouragement and support for what the client has accomplished (i.e., “You have done some good work today, and I appreciate the effort you have made. What feels like the most important things you have learned about or for yourself today?”). If the client gives a positive response, do a set of BLS to reinforce. If not, then do a relaxation or container exercise.

**Initiating a complete session closure when the session is incomplete.**

When a session is incomplete, it is the clinician's responsibility to debrief the client and to return him to an adequate level of equilibrium before he leaves the office. Adequate closure techniques (e.g., Lightstream, Calm (Safe) Place exercise, visualizations) need to be agreed on before reprocessing commences in the event that the client continues to demonstrate high levels of disturbance.

**Failing to use relaxation, visualization, container, calm (safe) place, etc.**

Maintaining client stability between sessions is extremely important and easily facilitated by these techniques. Therefore, it is the clinician's charge to attempt to bring the client back to a state of relative calm and mastery before completely closing down a session. Clients should be encouraged to use these self-control techniques to dissipate any disturbance that may emerge between sessions. Here is a list of potential client consequences as a result of insufficient closure:

1. Client is destabilized between sessions, experiencing emotional lability.
2. Client does not feel “present” and grounded, indicative of dissociation.
3. Client experiences flashbacks or other intrusions from the memory network between sessions.
4. Client may notice an increased urge or inclination to use maladaptive coping strategies that may be related to the memory or memory network being reprocessed (e.g., a client in recovery who is reprocessing childhood trauma that is also associated with beginning to use substances may find herself having increased cravings for alcohol).
5. Client may become more reactive to present triggers associated with the memory being reprocessed.
6. Client may experience increased dissociation between sessions.

*(continued)*
TABLE 2.24  (continued)
Derailment Possibilities—Closure

Continuing with EMDR reprocessing if the client is unable to completely eliminate moderate levels of disturbance with the self-control techniques presented previously.
If the client is unable to eliminate moderate levels of disturbance using self-control techniques, EMDR reprocessing should be postponed until the client is able to tolerate high levels of disturbing material. More front-loading is indicated.

Going back to target, negative cognition, body, or checking for a SUD level prior to ending a session.
It is important to find a neutral place for the client to stop. Having a client refocus on any of these components will risk bringing up additional disturbing or distressing material or activating another negative channel of association. Again, shifting states for a client is necessary for closing a session; and some type of relaxation exercise or self-control technique is preferable.

Encouraging the client to focus on distress and then using BLS to bring the client to her calm (safe) place.
The purpose of closing down a session is to bring the client back to complete equilibrium at the end of every session.

Doing additional BLS after the client has been brought back to his safe place.
Doing so may stimulate more negative material or activate another channel of association.

Instructing the client to focus on her distress (e.g., incompetency, fear of snakes, belief that she is unlovable).
One of the purposes of closing down an incomplete session by invoking a relaxation response or container is to provide an opportunity to shift states and terminate reprocessing. Having a client focus on her distress may activate more disturbing material or open another negative channel of association.

FOR ALL SESSIONS
“The processing we have done today may continue after the session. You may or may not notice new insights, thoughts, memories, or dreams. If you do, just notice what you are experiencing. Take a snapshot of it (what you are seeing, feeling, thinking, and the trigger), and keep a log. We can work on this new material next time. If you feel it is necessary, call me.”

Neglecting to perform any closure at all.
It is important for a client to know what to expect after each session and what is normal and what is not. That is, a client should know that additional processing occurs regularly between sessions and is evidenced by any disturbing images, thoughts, or emotions that may emerge and that these

(continued)
are healthy signs of continued processing. Even if a client experiences little or no obvious processing, the clinician should not fail to perform debriefing and closure at the end of each session. Ending a session in this way can provide the client with a sense of accomplishment and self-efficacy. So, regardless if little or no processing has been completed within a session, debriefing and closure should always be conducted.

**Failing to debrief the client at the end of every EMDR session.**
Decompensation may occur with any client, especially one who may be suicidal. Failing to debrief a client of the possibilities increases this danger. It is important that the clinician provide the client with realistic expectations (negative and positive) about between-session processing. This information helps the client to better maintain a sense of equilibrium.

**Failing to provide adequate time at the end of a session to conduct the required closure.**
Conduct a 50- to 90-minute session allowing for adequate processing and time at the end of the session to facilitate appropriate closure.

**Allowing the client to leave the office with an unresolved abreaction.**
If a client's trauma is insufficiently processed at the end of a session, the clinician should inform the client that she may continue to experience high levels of distress after a session. The clinician should make concerted attempts to bring the client back to a balanced state of equilibrium and also assess whether it is safe for her to drive home.

**Forgetting to inform the client that he can call in between sessions as needed.**
The clinician should inform a client of his availability during the preparation phase of EMDR and at the end of an incomplete session.

**Debriefing with the client about the specifics of her EMDR session.**
Processing continues regardless of what the status of the sessions is at the end (i.e., complete or incomplete), and resolution is still possible in the interim (i.e., between the current and subsequent sessions) even if the session is incomplete.

**Failing to ask the client to maintain a TICES log.**
By having the client keep a log or journal of any negative thoughts, situations, dreams, and memories helps him to cognitively distance himself from the same by the simple act of writing it down on a piece of paper. The client is asked to take a snapshot of anything negative that emerges in the interim. This may or may not be used as a target in a subsequent session.

**Using a relaxation or self-control technique that has not previously been introduced to the client.**
It is more efficient to use a technique during closure with which the client has been previously successful than to experiment with something new.
5. It is important for the clinician to provide the client with reasonable and realistic expectations of what might be the negative and positive reactions that a client could encounter before, during, and after a session.

What Can Happen After a Session?

Dr. Shapiro (2001, 2009) sums it up in this statement to the client, “Processing may continue after our session. You may or may not notice new insights, thoughts, memories, physical sensations, or dreams. Please make a note of whatever you notice. We will talk about that at our next session. Remember to use one of the self-control techniques once a day and after each time you write something in your log.”

PHASE 8: REEVALUATION

Reevaluation is an ongoing process of assessing the reprocessing of relevant material before, during, and after EMDR processing sessions. Reevaluation is conducted at the beginning of the next session following an EMDR Therapy session to determine if: (a) the treatment effect has held; (b) any other relevant channels of association have emerged; (c) any new experiences stimulated dormant networks; and (d) any new changes need to be implemented to be successfully integrated into a client’s life.

Reevaluation is also conducted before terminating treatment to ensure: (a) the client is able to integrate into his larger social systems; and (b) all relevant material has been completely processed. Has each individual target been resolved? Has ecological validity been determined? Has all associated material been reprocessed in terms of past, present, and future? Has the client experienced adequate assimilation with a healthy social system?

What Has Changed and What Is Left to Do?

In the next scheduled session, the clinician elicits information as a follow-up to the client’s previous EMDR reprocessing. What has changed? What have you noticed since your last session? What images, emotions, thoughts, insights, memories, or sensations have emerged, if any? Have you noticed changes in symptoms or behaviors? What were your responses to these changes? Have new dreams or other material surfaced as a result? What are your reactions and responses to triggers?

In addition to reevaluating what has changed in the client’s life since the previous EMDR session, the clinician will also reassess the specific target work that was done. Has the individual target been resolved? Instruct the client to bring up the memory or trigger targeted in the previous session and say, “What image, if any, comes up?” or “What represents the worst of it as
you think of it now? What thoughts about it come up? What thoughts about yourself? What emotions? What sensations? And, on a scale of 0 to 10, how disturbing is it to you now?” If the memory was completely reprocessed at the end of the last session (i.e., SUD = 0, VoC = 7, and body scan is clear) and the memory continues to hold no disturbance, the next memory or trigger in the treatment plan can be targeted using Phases 3–6. If the reprocessing was incomplete in the prior session, resume at the appropriate phase of reprocessing. Once all phases are completed (i.e., SUD = 0, VoC = 7, and body scan is clear), the client is ready to tackle the next traumatic memory or trigger.

The clinician is encouraged to ask the client these questions regardless of whether the previous session was complete or incomplete. The questions are solicited to ensure the resolution of the targeted issue, the presence of ecological validity, and the determination of whether associated material has been activated that must be addressed in the current or subsequent sessions, and the existence of resistance on the part of the client.

**Resuming Reprocessing in an Incomplete Session**

If an event from the previous session was not fully processed (i.e., SUD > 0, VoC < 7, and lack of a clear body scan), the clinician will resume the processing of the unfinished target (see Table 2.25).

The aforementioned script is prescribed by Dr. Shapiro for resuming an incomplete session. Notice that the script focuses on the worst part of the memory now, the emotions, SUD level, and body sensations. No mention is made of the negative or positive cognition or VoC. The clinician begins the session in this manner because the original image/picture may or may not have been resolved in the past session. By focusing on what is the worst part “now,” the clinician allows the client’s next channel of association to emerge spontaneously. It is possible that the negative cognition may have changed since the process began. In the Assessment Phase, the clinician determined how the memory was stored initially when implementing the Assessment Phase (i.e., the clinician determined what the worst part was in terms of image [or picture], NC, PC, VoC, SUD, and location of the body sensations). In subsequent sessions, the goal is to access memories as they are currently stored, which most likely have changed since the previous session. To begin the reprocessing again, the clinician says, “Focus on that the image (or picture) and where you feel the sensations in your body” and initiates a set of BLS.

**Reevaluation of Treatment Effects**

Have new aspects of the memory or other earlier associated memories emerged during the interim between this session and the last that need to be addressed? This is also the time to refer to the client’s log or journal to assess changes in behavior or the way he is responding to the world.
TABLE 2.25
Resuming Reprocessing in an Incomplete Session

Use a target memory if SUD > 0, VoC < 7, or body scan is not clear as reported from a previous session:

Reaccess the memory.
Clinician: Bring up the memory we have been working on. What is the image that represents the worst part of it as you think about it now? Or ask, What is the worst part of the memory as you think of it now?
When resuming the processing of an unfinished target from a previous session, the clinician is not required to identify the negative and positive cognitions or the VoC.
Client: Okay. It is not as intense as before, but I do still see my brother shaking the axe at me threateningly.

Identify the client’s current emotions around the event (incident, experience).
Clinician: What emotions are you experiencing now?
Client: Now that I focus on it, I can feel the fear intensify.

Identify the current level of disturbance (i.e., SUD).
Clinician: On a scale of 0 to 10, how disturbing does this event (incident, experience) feel to you now?
Client: It’s about a four.

Identify location of physical sensations associated with the event (incident, experience).
Clinician: Where do you feel it in your body?
Client: In my chest.

Resume desensitization and reprocessing.
Clinician: Focus on that memory, where you feel the sensations in your body, and follow my fingers (or implement BLS of choice).

Use if the target memory is SUD = 0, VoC < 7, and the body scan is not clear:
Complete Installation Phase and body scan.

Use if target memory is SUD = 0, VoC = 7, and body scan is not clear:
Complete the body scan.

In all cases, follow procedural steps through the Closure Phase.
Note: The negative cognition is not re-referenced.

Reevaluation of treatment effects takes place at the beginning of each session following an EMDR reprocessing session. After a brief evaluation of changes in how the client acts, feels, senses, or believes, instruct the client to focus on the finished target from the previous session to see if treatment has held and ask, “On a scale of 0 to 10, how disturbing is it to you now?” If the
treatment effect appears to have held (i.e., SUD = 0), proceed with processing other appropriate targets. If the client reports something other than a 0, reprocessing of the disturbing material is in order, unless it is determined that there is ecological validity.

Reevaluation and Treatment Planning

Reevaluation focuses on integrating each session into the client’s full treatment plan. The clinician assesses how the prior reprocessing session has impacted the client’s internal responses and behaviors and how it may have affected individuals with whom the client interacts. This determination allows the clinician to assess what attention needs to be directed toward the client’s interpersonal system issues.

The Reevaluation Phase is much more than just a reassessment of previously targeted material to see if treatment has held or additional processing is required. Reevaluation also requires the clinician to actively integrate each targeting session within the client’s overall treatment plan and calls for the clinician to assess appropriate targets and outcome in terms of the three-pronged approach (i.e., the client’s past, present, and future). The client’s stability and functioning between sessions is evaluated to determine if additional Phase 2 stabilization and resourcing may be needed prior to the resumption of reprocessing. In this regard, Dr. Shapiro (2001) states that attention must be paid to four factors: (a) resolution of individual target; (b) addressing associated material that may have been activated within a target; (c) reprocessing of all necessary targets in all three prongs; and (d) adequate assimilation accomplished within a healthy social system.

Not only do individual EMDR sessions need to be reevaluated, the clinician also needs to reassess whether the appropriate targets and subsequent outcomes have been attained in relation to the three-pronged protocol (i.e., past, present, and future). A treatment plan structured within EMDR Therapy is not complete until all childhood trauma has been processed utilizing all three stages of the protocol. Whether working on past, present, or future targets, or single- or multiple-event targets, the clinician is constantly reevaluating the successful processing of targeted material to ensure that all dysfunction has been reprocessed and that treatment effects continue to be maintained.

Final Reevaluation Stage

The final reevaluation stage of EMDR Therapy will conclude with whatever follow-ups are necessary to determine when it is appropriate for a client to terminate therapy. It is important to remember that the treatment effect may not be generalized to every possible disturbance experienced by the client. It is possible that other issues may arise in the future and that clients may come back to therapy at a later date in an attempt to resolve these issues.
Then there is what Dr. Shapiro (2001) calls a natural unfolding process, which may indicate that the process continues even after therapy has concluded. When this happens, it is not an indication that the EMDR treatment process was a failure. The unfolding of new disturbing material is an opportunity for learning at a different level. Life is a dynamic process, and learning takes place on a minute-by-minute basis even after therapy has concluded.

So another reevaluation is made prior to the client terminating therapy. In this instance, the clinician will evaluate to discern if the client’s symptoms have been reduced or eliminated in a manner that is ecological to the client. In terms of a comprehensive treatment approach, the clinician may make a systematic evaluation of the overall progress of the client in resolution of main themes and detect whether the client has successfully integrated treatment gains into their current life context.

Before termination is considered complete, the clinician may:

**Past**
1. Ensure that any primary events identified during the course of treatment have been resolved.
2. Scan for other unresolved memories by having the client focus on each of his previously identified negative cognitions or scan chronologically through his life for the same.
3. Reevaluate any events that may have emerged during the processing of a primary target.
4. Identify any cluster memories that have not been resolved through the generalization effect.

**Present**
1. Reprocess (i.e., Phases 3–6) any current stressors—conditions, situations, people—that continue to evoke any maladaptive behaviors.
2. Identify and address residual sources of maladaptive patterns of response (e.g., physical sensations, urges) that may be a by-product of second-order conditioning.

**Future**
1. Ensure all triggers have been reprocessed with desired outcomes or potential changes in the future.
2. Discern whether a client has been successfully able to integrate positive changes from the reprocessing and apply these changes in a positive way in his daily life (E. Shapiro, 2011).

**Pivotal Points in the Reevaluation Phase**

Table 2.26 presents a summary of pivotal points that Dr. Shapiro (2001, 2008, 2009) has identified for reevaluation to take place. Reevaluation is a dynamic and continuous process. Table 2.27, “Derailment
Possibilities—Reevaluation,” provides some common mistakes made during the Reevaluation Phase of treatment.


### TABLE 2.26
**Summary of Reevaluation Phase**

<table>
<thead>
<tr>
<th>Global inquiry:</th>
<th>What has the client noticed since the last session?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reevaluate the state of the client’s life since the last session.</td>
<td>What has changed?</td>
</tr>
<tr>
<td>Say, “Tell me what you have noticed different in your life since our last session?” and ask these questions:</td>
<td>“Have you noticed any changes in how you respond to the issue we have been working on?”</td>
</tr>
<tr>
<td></td>
<td>“Have you noticed any insights? Dreams? Changes in behavior or symptoms?”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Target specific:</th>
<th>Reevaluation of previously targeted material:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reevaluate targeted material processed during the previous session.</td>
<td>Has the memory targeted in the prior session been resolved? Does it require further processing?</td>
</tr>
<tr>
<td></td>
<td>Has the new information been appropriately and adequately integrated by the client?</td>
</tr>
<tr>
<td></td>
<td>Have additional targets emerged as a result of previous processing?</td>
</tr>
<tr>
<td></td>
<td>Have other memories or negative cognitions arisen that were not identified in the History-Taking and Treatment Planning Phase?</td>
</tr>
<tr>
<td>Say, “As you think about the event (incident, experience) we focused on during our last session, what are you noticing now?” and ask these questions:</td>
<td>“What has changed or what is different about the incident now?”</td>
</tr>
<tr>
<td></td>
<td>“Any new insights or thoughts?”</td>
</tr>
<tr>
<td></td>
<td>“Any new connections?”</td>
</tr>
<tr>
<td>And, then say, “When you think of the event (incident, experience), on a scale from 0 to 10, how disturbing is it now?”</td>
<td>Reevaluation occurs during critical or pivotal points in treatment.</td>
</tr>
</tbody>
</table>

| A final reevaluation will end with an extensive follow-up period. | Have all appropriate targets and their subsequent outcomes been attained in terms of past, present, and future? |
| | Have feeder memories that emerged been processed? |
| | Is the client ready to conclude BLS? |
TABLE 2.27
Derailment Possibilities—Reevaluation

“Tell me what you have noticed different in your life since our last session.”
“Any changes in how you respond to the issue we have been working on?”
“Any new insights?”
“Any dreams?”
“Any changes in behavior?”
“Any change in your symptoms?”

Only performing a final reevaluation.
Reevaluations are important to complete at the start of every session that has been preceded by EMDR reprocessing. Reevaluation continues to inform the treatment planning process.

Failing to reevaluate at the beginning of each session.
At the beginning of each session (after the first reprocessing session), the clinician checks with the client to see if the treatment effects from the previous session have been maintained by having the client reaccess the target from the previous session. The clinician reviews the client’s responses to determine if further reprocessing is needed. Revaluation is performed for two reasons: (1) unforeseen ramifications of the treatment effects may have emerged that need attention, and (2) new targets may have arisen. The treatment can be determined to be successful only after sufficient reevaluation of previous reprocessing and any resulting behavioral effects. Every EMDR reprocessing session (i.e., Phases 3–6) should be integrated into a complete treatment plan.

Targeting new material before previous targets have been fully reprocessed.
Previous targets need to be fully integrated before initiating reprocessing with a new target. Exceptions may be seen in the event of feeder memories or blocking beliefs that impede processing. In these cases, “EMDR reprocessing within EMDR reprocessing” may need to be done.

Failing to complete any form of reevaluation.
Reevaluation is the eighth phase of EMDR Therapy, and the process is not considered complete without it. Even in the event of single-event traumas, reevaluation needs to be performed. One to three follow-up appointments may be necessary to evaluate treatment effects. In terms of a multiple-event trauma, there may be many reevaluation sessions.

Failing to integrate the targeting sessions with the overall treatment plan.
During the Reevaluation Phase, Dr. Shapiro (2001) suggests that the following questions be asked and answered to ensure complete integration of the targeted material with the overall treatment plan: (1) has the individual target been resolved?; (2) has associated material been activated that must be addressed?; (3) have all the necessary targets been reprocessed to allow the client to feel at peace with the past, empowered in the present, and able to make choices for the future?; and (4) has an adequate assimilation been made within a healthy social system?
SUMMARY STATEMENTS

1. EMDR Therapy is an eight-phase integrative treatment approach… it is not one or two phases—it is eight.

2. Know your client. Know your client well.

3. There must be an adequate level of trust between the clinician and client for EMDR processing to be successful.

4. If your areas of expertise or specialization do not include the client’s diagnosis, it is the clinician’s ethical responsibility to refer the client to a professional who is appropriately trained. This applies if the client is new. If not, get the appropriate supervision.

5. It is not necessary for the clinician to know all the details about a client’s trauma. What is important is that the clinician allows the client to process the trauma without interference. Stay out of the client’s way. Stay out of their process.

6. If a sufficient level of trust or bonding has not been established, do not undertake EMDR processing.

7. The explanation of the model that supports EMDR Therapy is presented in a way that fosters instilling hope and understanding in terms of how a client begins to comprehend his coping and defense mechanisms.

8. Do not implement EMDR reprocessing (i.e., Phases 3–6) unless the client is ready.
ASSESSMENT PHASE

Back to Basics

It is only after the clinician has obtained an adequate history, has determined that the client is an appropriate candidate, and has prepared the client for Eye Movement Desensitization and Reprocessing (EMDR) Therapy that the Assessment Phase can begin. This phase entails two elements. First, the clinician and client confirm the previously selected target memory (i.e., identified target as part of the overall treatment plan); identifying the image (or picture); and its cognitive, emotional, and physical components. Second, baseline measurements are established in terms of total disturbance and the credibility of the positive cognition (i.e., how possible is it given the circumstances?).

The components of the standard EMDR procedure remain consistent whether the clinician is targeting single- or multiple-event traumas, past traumas, present triggers, or future events. In all cases, the clinician will be trying to identify targets that encompass the past, present, and future.

Variations of the EMDR procedural steps are used in specific and special situations (e.g., phobias, obsessive compulsive disorder, and chronic pain). These variations, however, still incorporate the main ingredients of the EMDR procedural steps. Many of these protocols can be found in
Dr. Shapiro’s (2001) book *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols and Procedures, Second Edition*. These variations will not be covered at this time. Instead, this Primer will be focusing on the standard EMDR protocol to ensure that the clinician has a grasp of all that it entails. Scripted protocols for basic and special situations (Luber, 2009a), special populations (Luber, 2009b), man-made and natural disasters (Luber, 2015a), anxiety and mood-related conditions, and trauma- and stressor-related conditions (Luber, 2016b) are available as well.

**How Much Do You Need to Know?**

After completion of the first two phases (i.e., History-Taking and Treatment Planning and Preparation), the clinician then proceeds to the Assessment and Desensitization (and Reprocessing) Phases. A common question that clinicians may ask is, “How much do I need to know about the memory itself?” The answer is that the clinician needs to know only what the client wants to reveal or even less. This is the beauty of EMDR Therapy. The clinician is not required to know all the painful details of a traumatic event in order for the process to be successful. The clinician can encourage the client to provide only a brief description of the disturbing event (e.g., “My uncle chased me with a dead bird”), explaining that it is not because you do not want to listen, but that it is unnecessary for you to know it all for him to process successfully.

Many clients who come to our doors have told their stories several times to previous clinicians. If there is sufficient information for the Assessment Phase, the clinician probably has enough detail for the client to bring her traumatic memory to a successful resolution without unnecessary retraumatization. Reprocessing is the client’s internal process. What she wants and needs us to know can only be revealed by her when she is willing, able, and ready.

**TARGET ASSESSMENT**

In order to facilitate appropriate information processing and achieve psychological change through healthier associations, it is imperative that a client make connections to the appropriate targets to gain access to the dysfunctional material that drives a client’s current pathology.

**Effective EMDR Therapy Equals Effective Targeting**

The Assessment Phase begins by confirming the specific target that the clinician and client previously agreed upon as part of an extensive treatment plan. In selecting the target, the clinician considered whether it was the most effective for resolving the client’s issue. An effective target leads
the way to the dysfunctionally stored material and, thus, the dysfunctional memory networks. Targets generally emerge during a thorough evaluation of the client’s presenting problems. From the client’s responses to the questions in the History-Taking and Treatment Planning Phase, the clinician is able to help identify salient targets for the client. As stated earlier, in your initial interviews with the client, watch and listen for behavioral, emotional, cognitive, and physical cues; the duration of the presenting issue; how the problem manifests in the present; and what the client needs to be more adaptive in the future. In addition, determine whether the client possesses adequate affect tolerance and stability to process the negative states and access anything positive that may arise during the EMDR process.

If a client presents with a single disturbing or traumatic event, target selection is simply a matter of identifying the worst part of the event. The clinician, however, will also identify any present triggers and future template whenever appropriate. With multiple disturbances and traumatic incidents, target identification and selection become more complicated.

Characteristics of Effective Targets

The target should be as specific as possible and can be an image (or picture), complete or partial memory of an event, sight, sound, taste, touch, dream, metaphor, fantasy, or recurring thought or fear that something is going to happen. A target should be concrete rather than abstract. Simply targeting “fear of flying” is too diffuse or vague. However, the specific target of experiencing extreme turbulence in an airplane 33,000 feet above the ground during a violent storm is more concrete and a more appropriate target for EMDR reprocessing. There may also be a number of obstructions to the memory network that could be targeted. Table 3.1 describes these obstructions and how to deal with them.

Table 3.2 represents possible obstacles when selecting appropriate targets for processing.

How Is the Memory Encoded?

In assessing how a memory is presently encoded in the client’s memory network, Dr. Shapiro (2001) suggests asking questions such as, “What image (or picture) represents the incident (i.e., representative)?” or “What image (or picture) represents the worst part of the incident (i.e., most disturbing)?” or “When you focus on the incident, what do you get (i.e., if no picture)?” In essence, the clinician is asking the client, “How is it stored now?” This does not include inquiries at this point about what the client feels and believes about herself. Emerging information may be in the form of tastes, sounds, or smells.
Take the example of Jennifer who reported being molested by her English teacher when she was a sophomore in high school. The teacher in question had requested that she stay after school one afternoon to help him prepare some special handouts for his class the next day. While helping him, this teacher came up behind her, nudged his head into her hair, kissed her on the neck, and fondled her. Jennifer let out a faint cry and ran from the room. She ran down the hall and out the side door of the school where she found her brother waiting to give her a ride home. Jennifer never told anyone of her experience outside of therapy. She is a junior now and is encountering difficulties relating to boys her own age and men in authority positions.
Jennifer had never experienced anything like this before. She indicated that her childhood was uneventful. She felt that she had lived a relatively normal life until this point. So, when she asked the client what part of this particular trauma she wanted to work on, the clinician stated it in this way, “What image (or picture) represents the entire incident?” Her answer was, “The car ride home. I felt so ashamed.” The clinician asked the question in this manner because it was: (a) a one-time event; (b) she had a clear memory

**TABLE 3.2**

<table>
<thead>
<tr>
<th>Derailment Possibilities—Target Selection</th>
</tr>
</thead>
<tbody>
<tr>
<td>“What image (or picture) represents the event (i.e., representative)?” Or “What image (or picture) represents the worst part of the event (i.e., most disturbing)” or “When you focus on the event, what do you get (i.e., if no picture)?”</td>
</tr>
</tbody>
</table>

**Considering the image (or picture) of the incident as the target rather than the memory**

The target includes an image (or picture) that represents the worst part of the event. It is a “freeze frame” picture that encapsulates what happened at the time of the event. It is the image (or picture) that immediately overwhelms a client with fear, dread, anger, sadness, and so on, when he focuses on the event. If no picture, the target may be accessed through another sensory aspect of the memory (e.g., sound, smell, taste) that is the most disturbing.

**Selecting a target that is too vague or diffuse**

The target should be more specific than general (i.e., an event where the client experienced extreme disturbance while flying as a passenger in an airplane vs. fear of flying).

**Selecting a target unrelated to the presenting symptom(s)**

A target should be related to the presenting symptoms as they are indicative of dysfunctionally stored material.

**Unless a more recent experience(s) is causing the client’s intrusive symptomology, selecting a target memory that is not a relevant, earlier experiential contributor**

As most pathology is forged by relevant, earlier life experiences, these events should be processed first. If not, processing may become derailed by feeder memories.

**For multiple event traumas, not clustering the events together**

In this case, multiple events should be clustered together; and a representative incident should be selected for each cluster.

**Not targeting each present trigger separately**

Due to second-order conditioning and previously paired association, it is possible that each may have become independently disturbing.
associated with the event; and (c) there appeared to be no other parts to the memory that might have been as disturbing. Alternately, the clinician could have asked, “What is the worst part of this memory?” The client might have replied, “When he came up behind me.” In this case, the clinician would have targeted both the worst part and, if they did not emerge spontaneously during the processing, any remaining disturbing fragments (e.g., the ride home).

**Appropriateness of the Target**

In assessing the appropriateness of the selected target, it may be helpful to ask the following question: Does the image or event identified by the client represent a single incident that will potentially gain access to the dysfunctionally stored information? Refer to Figures 3.1 to 3.6 to see how the individual blocks of the procedural steps build a powerful tool to assist the client in activating his natural healing process.

As many clinicians can attest, single-incident trauma is generally not the type of case that they deal with on a day-to-day basis with their clients. Target selection with clients having complex posttraumatic stress disorder (C-PTSD) or other complex psychological profiles requires a different approach from that described earlier for single traumatic or disturbing events. In these cases, several clinical aspects may require treatment, and each target needs to be identified and fully processed to obtain positive treatment effects.

A multiple-trauma victim may be asked to cluster his traumatic incidents into groups of like events. He is then asked to choose an incident that

![Image](image.png)

**FIGURE 3.1** Stepping stones to adaptive resolution: image and picture.
is representative of the group to serve as the target. Some clinicians may use historical time lines or genograms to elicit the same type of information from the client. Others may arrange and treat them in chronological order. Some will arrange them in chronological order, but treat the most disturbing event first and then proceed chronologically to treat what remains. Dr. Shapiro (2006a) developed a Treatment Planning Guide (TPG), which attempts to identify and address past, present, and future events, incidents, issues, and desired outcomes associated with the presenting problem.

ASSESSMENT OF COGNITIONS

Elements of Negative and Positive Cognitions

In terms of the train metaphor, the negative cognition represents the obstacle on the track that keeps a client from resolving or learning from a past experience; and the positive cognition helps a client take a glimpse down the tracks to see what may be possible. As the train traverses down the track, negative images, thoughts, emotions, physical sensations, and other psychic debris are unloaded; and more positive aspects of the same are loaded until the train reaches its final destination.

The negative belief often pops up spontaneously as the client focuses on the memory. The negative cognition (NC) is another indication of how the memory is stored. If not, it is optimal or suggested to take time assisting clients in the selection of the most appropriate cognitions, particularly the negative. The selection of appropriate cognitions predicts greater success in accessing the dysfunctionally stored material surrounding the event. When the proper cognitions are identified, “all roads should lead to Rome.” That is, all memory networks lead to resolution of the trauma. Accurate cognitions also assist the generalization and resolution of other traumatic memories existing in the same domain in the client’s system.

The negative and positive cognitions share common components, such as:

- Self-referencing (i.e., typically using an “I” statement);
- Stated in the present because they still exist in the present;
- Focusing on the presenting issue;
- Generalizable to other related events;
- Concrete, rather than abstract.

The negative cognition is a self-denigrating or self-limiting irrational belief, whereas the positive cognition represents a shift in self-perception that opens up new possibilities for the client. Negative cognitions aid in eliciting associated affect. When the client focuses on the disturbing event and the words, “I am unsafe,” the client can still feel fear, confusion, and shame in the present. Positive cognitions provide marked evidence of the
client’s desired direction for change, for instance, “I am safe now” or “I am free of fear, confusion, and shame.” As a desired goal, positive cognitions are initially somewhat believable and acceptable. If the cognitions are totally unbelievable, they may need some modifications (e.g., “I am safe” vs. “I am beginning to believe I am safe”).

Both the negative and positive cognitions are self-referencing and stated in the present tense and, therefore, are usually, with some exceptions, preceded by an “I” statement. Both are generalizable. That is, they can be related to clusters of similar events or areas of concern. The negative cognition focuses on the client’s presenting issue, whereas the positive cognition focuses on the client’s desired direction of change. For example, “I am a bad person” could be a presenting issue, and “I am a good person” might be the desired direction of change. Table 3.3 provides a simple view of the purpose of cognitions in the standard procedural steps.

What Is a Cognition?

It is important to know what cognitions are not, as well as what they are. Cognition involves conscious intellectual activity, such as thinking, reasoning, and remembering. For the purposes of EMDR Therapy, cognitions are beliefs. Negative cognitions are not feelings, such as “I am scared.” They are not true statements. In the case of a driver who ran a red light and crashed into another car, the statement, “I was not in control” would be true and an inappropriate negative self-referencing belief if targeting the actual event. Table 3.4 provides a more extensive view of how to and how not to structure negative and positive cognitions.

Teasing Out Negative and Positive Cognitions

How do you elicit effective negative and positive cognitions without putting words into the client’s mouth? When assisting the client in forming her negative and positive cognitions, the clinician might say, “What words

<table>
<thead>
<tr>
<th>TABLE 3.3 Purpose of Cognitions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NEGATIVE</strong></td>
</tr>
<tr>
<td>Highlight irrationality (or dysfunctional) of belief for client</td>
</tr>
<tr>
<td>Stimulate dysfunctional material</td>
</tr>
<tr>
<td>Establish a baseline from which to measure progress</td>
</tr>
</tbody>
</table>
### TABLE 3.4
Characteristics of Negative and Positive Cognitions

<table>
<thead>
<tr>
<th>WHAT THEY ARE</th>
<th>WHAT THEY ARE NOT</th>
<th>WHAT THEY ARE</th>
<th>WHAT THEY ARE NOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-referential (i.e., usually preceded by an “I”)</td>
<td>Statements of simple emotion (e.g., “I am afraid or angry”)</td>
<td>Self-referential (i.e., usually preceded by an “I”)</td>
<td>Absolute statements—words like never and always are inappropriate (e.g., “I will always be in control”)</td>
</tr>
<tr>
<td>Stated in the present</td>
<td>Accurate descriptions of disturbing circumstances, social references, attributes of others or client (e.g., “My father molested me”)</td>
<td>Stated in the present</td>
<td>Magical thinking (e.g., “I am a good father.” when the father has recently been caught molesting his child)</td>
</tr>
<tr>
<td>Focuses on the presenting issue</td>
<td>Blatant overgeneralizations (e.g., “I am the worst person in the world”)</td>
<td>Focuses on the presenting issue</td>
<td>EMDR processing cannot make a silk purse out of a sow’s ear. However, one can say, “I can atone for my behavior.” Or “I can learn to be a good father”</td>
</tr>
<tr>
<td>Reflects a belief (i.e., cannot be a simple statement of emotion or a description of circumstances)</td>
<td>Description of fact (e.g., “My mother was scary.” or “My mother despised me”)</td>
<td>Ecologically sound (i.e., it is possible under client’s circumstances)</td>
<td>Negations of negative thinking (e.g., “I am not guilty”)</td>
</tr>
</tbody>
</table>

(continued)
<table>
<thead>
<tr>
<th>Characteristics of Negative and Positive Cognitions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NEGATIVE COGNITIONS</strong></td>
</tr>
<tr>
<td><strong>WHAT THEY ARE</strong></td>
</tr>
<tr>
<td>Often irrational and/or dysfunctional</td>
</tr>
<tr>
<td>Generalizable to related events</td>
</tr>
<tr>
<td>Cannot be removed if true or installed if false</td>
</tr>
<tr>
<td>Concrete rather than abstract</td>
</tr>
<tr>
<td>Interpretive rather than descriptive</td>
</tr>
<tr>
<td>Elicits associated affect</td>
</tr>
</tbody>
</table>
go best with that image (or picture) that express your negative belief about yourself now? I am ______.” This reminds the client to frame the belief in the present. The clinician is silently saying, “I am what? Please fill in the blank.” The client may still attempt to frame her beliefs in different ways, such as “I cannot succeed” for the negative belief or “I can succeed,” or “I will succeed” for the positive belief. All are correct.

What if the client says, “I am not successful at my job?” Is this an acceptable negative cognition? This particular cognition only pertains to the client’s job. Should the negative cognition (as well as the positive cognition) be generalizable to other areas in the client’s life where she might feel she does not succeed? What would be a better cognition, and how would you tease it out? How about, “What does this make you believe about yourself in general?” The statement, “I cannot succeed,” has a stronger potential for generalizing to all areas of the client’s experience and becoming a more appropriate negative cognition. The corresponding positive cognition may become, “I am a success” or “I can learn to be successful” or even “I can be successful in some ways.”

What if a client’s response to the clinician’s elicitation of a negative cognition is, “I have failed?” In some instances, depending on the client’s target, this may be a true statement. The clinician can respond with, “When you focus on (repeat description), what negative belief do you have about yourself? What does that say about you as a person?”

If a client responds to the negative cognition question with an emotion (e.g., “I am scared”), the clinician can respond by saying, “What negative belief about you goes with that fear?” Or the clinician can reframe the client’s response by saying, “In your worst moment, what negative belief do you have about yourself now when you focus on the event?” In either case, the clinician may be able to elicit an appropriate negative cognition.

Watch for wishful thinking. For instance, a client frames the negative cognition as “I am not perfect” and the positive cognition as “I am perfect.” In ordinary life, no one is perfect. In this instance, the clinician might say, “Does that mean you believe _____ (fill in the blank) about yourself” to help the client reframe the cognitions in a more realistic way.

Sometimes a client may generalize his response when the clinician elicits the negative and positive cognitions to his entire life or to another memory. In this event, the clinician may want to remind the client that he is framing his response around the image (or memory, if no picture) being focused on at the moment.

When a client focuses on the image (or picture) representative of the worst part of the memory being processed and cannot easily provide a negative or positive self-referencing belief, the clinician can offer several general negative cognitions as a demonstration of what is being asked, such as “So, for example, I’m wondering if it is more like ‘I’m not safe,’ or ‘I can’t trust,’ or ‘I’m not good enough,’ or ‘It’s my fault?’ Do any of those seem to fit?” The clinician should always offer at least three or four
suggestions and draw from the informational plateaus most likely to fit the situation being presented. This is to give examples, not to put words into the client’s mouth. In these cases, it is important for her to verbally and/or nonverbally indicate to the client that he has permission to choose or reject anything offered as an alternative by the clinician (Shapiro, 2001). If the client still is unable to provide a negative belief, the clinician could hand him the list of cognitions available in the training manual or the laminated Subjective Units of Disturbance (SUD) or Validity of Cognition (VoC) scale placard sold online by Trauma Recovery/EMDR-Humanitarian Assistance Programs. The front side of the placard illustrates the SUD scale and the VoC scale in more graphic detail as a visual aid for children and adults. The other side provides a sample list of negative and positive cognitions. Use this strategy sparingly as it is important for the client to self-generate a negative or positive cognition if possible.

Sometimes clients will provide an emotional response rather than a belief-oriented one. If the client reports an emotional statement, the clinician may respond, “What negative belief about you goes with the _____ (repeat the emotion)?” (Shapiro, 2001).

In working with a client setting up the protocol, he may express more than one negative cognition at a time, such as, “I am unlovable and unworthy.” When this happens, ask him to “Focus on the image (or picture). Which negative belief resonates the most with the image (or picture)—worthiness or lovability?” Every negative belief opens up another maladaptive memory network, so the clinician intentionally will limit the negative cognition to 1 per target during the Assessment Phase. Others may emerge during the reprocessing, and that is okay.

At other times, the client may provide negative and positive cognitions which are not parallel, such as “I am unworthy” (NC) and “I am lovable” (PC). How would you tease out which negative semantic theme the client associates with the image (or picture)? You could say one of the two things. First, you might say, “If you would like to believe, ‘I am lovable’ as you focus on the image (or picture), what does that make you believe negatively about yourself now? What is the flip side of ‘I am lovable?’” Or you might say, “What is the flip side of ‘I am unworthy’ for you?”

Some clinicians believe the negative and positive cognitions need to be perfectly parallel to be effective. If the client says his negative cognition is, “I am bad,” his positive cognition needs to be, “I am good.” Some conclude the cognitions only need to be similar. So what does that mean? Here are some examples:

<table>
<thead>
<tr>
<th>IMAGE (OR PICTURE) INCIDENT</th>
<th>NEGATIVE COGNITION</th>
<th>POSITIVE COGNITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rape</td>
<td>I am dirty</td>
<td>I am okay</td>
</tr>
<tr>
<td>Assault</td>
<td>I am in danger</td>
<td>I am fine</td>
</tr>
</tbody>
</table>
Dr. Shapiro (2001) states that the positive cognition is generally a 180° shift from the negative cognition. In any case, the clinician assures that the positive cognition expresses a positive self-assessment that verbalizes the same thematic schema or issue conveyed in the negative cognition.

There are also clinicians who advocate that negative and positive cognitions do not necessarily have to be parallel or compatible. For example, Ralph was involved in an automobile accident where his hand was severed. His negative cognition is “I am unsafe,” while his positive cognition is, “I can be whole again.” There continues to be diversity of belief as to whether the compatibility of the negative and positive cognitions is necessary for more complete processing of the target. Some clinicians believe the process works better when the cognitions are parallel. Others say it does not matter. Use of clinical judgment is required in all cases where the cognitions do not match. In this Primer, it is urged that the clinician only accept a positive cognition that is on the same informational plateau (i.e., responsibility/defectiveness, safety/vulnerability, or power/control [or choice]) as the negative cognition.

Especially under the pressure of processing past trauma, many of our clients are unable to come up with these beliefs. Some cannot distinguish a belief from a feeling. Some just cannot think that quickly on their feet. And some simply go blank. Rather than retraumatize them further by thinking they cannot process correctly, simply offer a range of examples as described above, or say, “Here’s my ‘cheat sheet.’ Focus on the trauma and see if any of the beliefs on the left side of the placard resonate.” If the client selects more than one negative belief, ask her to pick the one that resonates the most as she focuses on the image (or picture). Even with the use of the laminated SUD/VoC scale, allow the client to come up with a corresponding positive cognition. If she cannot, ask her to look at the negative cognition she selected off this placard and ask if the positive cognition horizontal to it fits. If it does, she can go with that. Note: Again, use the placard only as a method of last resort or as a teaching tool. If time allows, the clinician may probe further, if necessary, to assist the client to come up with a negative cognition of her own. “What makes this image (or picture) the worst part?” Have a therapeutic discussion about what the image (or picture) means to the client. Help the client put his feelings into words. Take as much time as needed to tease out an appropriate negative cognition.

Can the protocol be continued without assessing for a negative cognition? Dr. Shapiro (2001) states “when the thoughts, emotions, or situation appear to be too confusing or complex, it is appropriate to continue without the negative cognition.” In all cases, the clinician attempts to elicit a negative cognition. Information gathered in the Assessment Phase can assist the clinician in drawing out an appropriate negative cognition from the client that resonates with the targeted memory. The existence of a negative cognition allows for more complete accessing and processing of the dysfunctional information attached to the targeted event.

See Table 3.5 for a more complete listing of negative and positive cognitions. The negative cognitions usually cluster around themes of
<table>
<thead>
<tr>
<th>Responsibility/defectiveness</th>
<th>POSITIVE COGNITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am not good enough</td>
<td>I am good enough/fine as I am</td>
</tr>
<tr>
<td>I don’t deserve love</td>
<td>I deserve love; I can have love</td>
</tr>
<tr>
<td>I am a bad person</td>
<td>I am a good (loving) person</td>
</tr>
<tr>
<td>I am incompetent</td>
<td>I am competent</td>
</tr>
<tr>
<td>I am worthless/inadequate</td>
<td>I am worthy; I am worthwhile</td>
</tr>
<tr>
<td>I am shameful</td>
<td>I am honorable</td>
</tr>
<tr>
<td>I am not lovable</td>
<td>I am loveable</td>
</tr>
<tr>
<td>I deserve only bad things</td>
<td>I am deserving good things</td>
</tr>
<tr>
<td>I am permanently damaged</td>
<td>I am/can be healthy</td>
</tr>
<tr>
<td>I am ugly/my body is hateful</td>
<td>I am fine/attractive/lovable</td>
</tr>
<tr>
<td>I do not deserve</td>
<td>I can have/deserve…</td>
</tr>
<tr>
<td>I am stupid/not smart enough</td>
<td>I am intelligent/able to learn</td>
</tr>
<tr>
<td>I am insignificant/unimportant</td>
<td>I am significant/important</td>
</tr>
<tr>
<td>I am a disappointment</td>
<td>I am OK just the way I am</td>
</tr>
<tr>
<td>I deserve to die</td>
<td>I deserve to live</td>
</tr>
<tr>
<td>I deserve to be miserable</td>
<td>I deserve to be happy</td>
</tr>
<tr>
<td>I am different/I don’t belong</td>
<td>I am OK as I am</td>
</tr>
<tr>
<td>I have to be perfect (out of inadequacy)</td>
<td>I am fine the way I am</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Responsibility/action</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I should have done something*</td>
<td>I did the best I could</td>
</tr>
<tr>
<td>I did something wrong*</td>
<td>I learned (can learn) from it</td>
</tr>
<tr>
<td>I should have known better*</td>
<td>I do the best I can (I can learn)</td>
</tr>
<tr>
<td>*What does this say about you?</td>
<td>(e.g., Therefore, I am . . .)</td>
</tr>
<tr>
<td>I am shameful/I am stupid/I am a bad person</td>
<td>I am fine as I am</td>
</tr>
<tr>
<td>I am inadequate/weak</td>
<td>I am adequate/strong</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Safety/vulnerability</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I cannot trust anyone</td>
<td>I can choose whom to trust</td>
</tr>
<tr>
<td>I cannot trust myself</td>
<td>I can learn to protect myself</td>
</tr>
<tr>
<td>I am in danger</td>
<td>It’s over; I am safe now</td>
</tr>
<tr>
<td>I am not safe</td>
<td>I am safe now</td>
</tr>
<tr>
<td>I am going to die</td>
<td>I am safe now</td>
</tr>
<tr>
<td>It’s not OK (safe) to feel/show my emotions</td>
<td>I can safely feel/show my emotions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Control/power (or choice)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I am not in control</td>
<td>I am now in control</td>
</tr>
<tr>
<td>I am powerless/helpless</td>
<td>I now have choices</td>
</tr>
<tr>
<td>I cannot get what I want</td>
<td>I can get what I want</td>
</tr>
</tbody>
</table>

(continued)
responsibility/defectiveness (i.e., self-worth/shame or action/guilt), safety/vulnerability, or power/control (or choice). Some of these negative and positive cognition combinations were cited by Dr. Shapiro (1995, 2001, and 2009–2013).

It is not unusual for a client to have difficulty selecting a positive cognition. If this happens, do not spend an excessive amount of time on the process. What is most important is the client having a positive EMDR experience. Remember, he will have another chance to provide a positive cognition in the Installation Phase, so complete the protocol without a positive cognition, if necessary. It may or may not slow down the processing, but the processing probably will not be halted because of it.

### Informational (Cognitive and Emotional) Plateaus

The negative and positive cognitions rendered by clients are often organized into the following themes:

**Responsibility/Defectiveness or Responsibility/Action**

**Safety/Vulnerability**

**Power/Control (or Choice)**

These informational plateaus are generally processed in this order.

In the earlier case of Jennifer, the negative and positive cognitions might be elicited as follows:

**Clinician:** Jennifer, what words go best with that image (or picture) that express your *negative* belief about yourself now?

**Jennifer:** I did something bad.
Clinician: What does that make you believe about yourself now?

Jennifer: That I am bad.

Clinician: When you bring up that image (or picture) what would you like to believe about yourself now?

Jennifer: Well, I guess, that I am good.

In assisting clients to formulate cognitions that will optimally aid resolution of their trauma, you can use the checklist below to ensure that all components of each cognitive level have been considered (see Table 3.6).

See Figure 3.2 to identify the completion of the cognitive part of the Assessment Phase.

Table 3.7 outlines the common mistakes made by the clinician that may derail successful reprocessing.

| TABLE 3.6 |
| Criteria for Negative and Positive Cognitions |

<table>
<thead>
<tr>
<th>NEGATIVE COGNITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-referential (i.e., usually preceded by an “I”)</td>
</tr>
<tr>
<td>Stated in the present</td>
</tr>
<tr>
<td>Focuses on the presenting issue</td>
</tr>
<tr>
<td>Reflects a belief (i.e., cannot be a simple statement of emotion or a description of circumstances)</td>
</tr>
<tr>
<td>Often irrational and/or dysfunctional</td>
</tr>
<tr>
<td>Generalizable to related events</td>
</tr>
<tr>
<td>Cannot be removed if true or installed if false</td>
</tr>
<tr>
<td>Concrete rather than abstract</td>
</tr>
<tr>
<td>Interpretive rather than descriptive</td>
</tr>
<tr>
<td>Elicits associated affect</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>POSITIVE COGNITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-referential (i.e., usually preceded by an “I”)</td>
</tr>
<tr>
<td>Stated in the present</td>
</tr>
<tr>
<td>Focuses on the presenting issue</td>
</tr>
<tr>
<td>Ecologically sound (i.e., it is possible under client’s circumstances)</td>
</tr>
<tr>
<td>Generalizable to related events</td>
</tr>
<tr>
<td>The word “not” is not used in the statement</td>
</tr>
<tr>
<td>Reflects a positive and desired direction of change</td>
</tr>
<tr>
<td>Not clinician imposed</td>
</tr>
<tr>
<td>Does not contain words like “always” or “never”</td>
</tr>
<tr>
<td>Concrete rather than abstract</td>
</tr>
<tr>
<td>Possesses emotional resonance</td>
</tr>
<tr>
<td>Often elicits positive emotion</td>
</tr>
</tbody>
</table>
ASSESSMENT OF THE VALIDITY OF COGNITION (VoC)

VoC Scale

The SUD and the VoC are emotional and cognitive rating scales designed and utilized by the clinician to provide a baseline measure for client and clinician alike. The VoC is a 7-point Likert scale, which provides a baseline (or pretreatment) measure of strength (i.e., truth) of a client’s positive cognition while focusing on the target memory. It is assessed at the beginning of the process after the positive cognition is defined and reassessed in the Installation Phase to see if the original cognition is still appropriate.

Prior to initiating reprocessing, the VoC usually needs to be at least a 2 to be considered a workable cognition. It is very difficult for a client to go from “total disbelief” to “total belief.” If a client reports an initial VoC rating of 1 (i.e., completely false), the clinician assesses whether it is unrealistic, improbable, or impossible to achieve (i.e., red flag). The clinician must evaluate the ecological soundness of the cognition in terms of the client and the event. Therefore, the clinician assesses the suitability and degree of success the client may experience in assimilating a positive cognition with a low VoC level. In some cases, the client’s positive cognition may simply be titrated to raise the VoC level. For instance, a 1 rating for, “I am in control,” could be changed to “I can learn to have better control,” thereby rendering the VoC at least a 2 (see Figure 3.3). If a client reports a VoC of 1, the clinician may ask, “Is this possible for you to get to?” If the client says, “Yes,” let it alone. If the client says, “No,” the clinician may say, “Let’s see if we can change this just a little to come up with a belief that is attainable.”
### TABLE 3.7
Derailment Possibilities—Negative and Positive Cognitions

<table>
<thead>
<tr>
<th>NEGATIVE COGNITIONS (NC)</th>
<th>(Negative self-statement associated with an event)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“What words go best with that image (or picture) that expresses your negative belief about yourself now?”</td>
<td></td>
</tr>
<tr>
<td>If no picture,</td>
<td></td>
</tr>
<tr>
<td>“What words go best with that event (incident, experience) that expresses your negative belief about yourself now?”</td>
<td></td>
</tr>
</tbody>
</table>

**Accepting a statement that does not meet all the requisite criteria**

The negative cognition should be negative, irrational, self-referential, presently held, reflect a client’s presenting issue, resonates with his associated affect, and generalizes to other like events.

**Investigating the negative (or positive) cognition using the Socratic method or in any other complex manner**

Always follow the script above, which directly links the negative belief to the image (or picture).

**Asking for the negative cognition without a clear reference to the targeted image (or picture)**

It is important that the client focus on the original targeted image (or picture) as she develops an appropriate negative cognition. Otherwise, the “train” may not get out of the station.

**Accepting more than one negative cognition at a time (e.g., I am unsafe and helpless) during the Assessment Phase**

Each cognition may open a different associated memory network. It is important to find the negative cognition that resonates best with the image (or picture) at hand.

**Accepting a statement that is a description of what the client is feeling (e.g., “I am sad”)**

A negative cognition is a belief—not a thought, emotion, or physical sensation.

**Automatically suggesting (or imposing) the negative (or positive) cognition to a client**

Suggesting a negative cognition to a client should be performed judiciously and only after a client’s failed attempts to come up with one on his own. And it should be performed in such a way to openly indicate to the client that it is fine to reject or accept the clinician’s suggestions. Do so cautiously as imposing negative or positive cognitions on a client may have a detrimental effect despite a clinician’s attempt to do so delicately and unobtrusively.

**Automatically handing the client a list of negative (or positive) cognitions**

It is important to allow the client to discover her own negative self-talk. Offer the list only as a possible last resort.

(continued)
TABLE 3.7 (continued)
Derailment Possibilities—Negative and Positive Cognitions

Asking for the negative cognition in reference to the past
Elicit the negative belief that resonates best with the image “in the now.”

Accepting a statement that is factually true (e.g., “I was powerless”)
In the case where an adult presents with issues of childhood sexual abuse, this is a truthful description of a past condition and which EMDR processing cannot change.

Accepting a statement that relates the specifics of an event or a description of circumstances (e.g., “I failed my licensure exam three times”)
Negative cognitions represent a statement or belief only about oneself (e.g., “I am a failure”) not other people, places, or things.

Accepting a statement that references the misfortunes of a client’s earlier life experiences
Often clients verbalize statements, such as “Life was unfair” or “My coach did not like me.” When this occurs, simply say, “What does that say about you as a person?” or “What does that make you believe about yourself now?” EMDR processing does not have the ability to change traumatic or distressing life events. However, it may alter what a client negatively believes about himself as a result of these events.

Accepting a statement that is too diffuse or disruptive
It may be appropriate to omit the negative cognition if an issue appears to be too diffuse or disruptive (i.e., too confusing, too distressing, too difficult) to a client’s process. Particularly in the earlier stages, ineffective and inefficient processing effects may occur when any of the components of the standard protocol are utilized, so omitting the negative cognition for any reason should be the exception.

Pressing a client for the negative cognition when his thoughts, emotions, or situation seem to be too confusing or complex
In this instance, it is appropriate to continue without the negative cognition.

<table>
<thead>
<tr>
<th>POSITIVE COGNITIONS (PC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Positive self-statement associated with desired direction of change)</td>
</tr>
</tbody>
</table>

“When you bring up that image (or picture), what would you prefer to believe about yourself now?”

Accepting a statement that does not meet all the requisite criteria of a positive cognition
A positive cognition should be self-referential, focus on desired state or direction of change, believable, generalizable to like events, and be compatible but not necessarily identical with the negative cognition.

(continued)
Investigating the positive cognition using the Socratic method or in any other complex manner
Always follow the script above which directly links the preferred positive belief to the image (or picture).

Automatically suggesting (or imposing) a positive cognition in lieu of using the question as stated above
See same for negative cognition above.

Accepting a statement that is not compatible or is not on the same informational plateau (i.e., responsibility/defectiveness, responsibility/action, safety/vulnerability, or power/control (or choice)) as the negative cognition
The positive cognition represents a client’s desired state and is generally a 180° shift from the negative cognition. Developing compatible negative and positive cognitions most often helps facilitate a smoother process in terms of realigning other like incidents for processing within the cluster, using fewer cognitive interweaves, and ensuring the integration of a completed VoC and clear body scan as the train approaches its final stop. For more complex presentations, the clinician may need to accept the cognitions that a client provides (i.e., the best she can do in the moment) despite their incompatibility. The important point is not causing a client undue distress by trying to make the cognitions fit. If a client cannot come up with a compatible positive cognition, accept the one she gives or abandon the development of the positive cognition altogether. The client is provided another opportunity for its development in the Installation Phase.

Accepting a statement that is a negation of the negative cognition (e.g., “I am not a failure” or “I am not to blame”)
Statements such as these do not stimulate or directly link to the positive information that is stored in the client’s neuro networks as strongly and efficiently as more positive statements, such as “I can succeed” or “I did the best I could.” Whenever possible, a positive cognition should represent a self-assessment with implications for a brighter future.

Accepting a statement that is absolute or one that uses “always” or “never”
A positive cognition must be reasonable and realizable.

Asking for the positive cognition in reference to the past
Elicit the positive belief that resonates best with the image (or picture) and what a client would like to believe about himself “in the now.”

Accepting a statement without a reference to the self and/or a magical connotation (e.g., “They did the best they could” or “My mother is good”)
EMDR processing does not have the ability to change actual events of the past or the personality attributes of a client or others.
If a client reports a VoC of 5, 6, or 7, the clinician may begin to wonder if the client is measuring the level of validity in his head. In this case, direct the client to focus on his gut and say, “Is this in your head or gut?” If the client says, “head,” instruct the client to “close your eyes and bring up the event. How true does _____ (repeat client’s positive cognition) feel now?”

**ASSESSMENT OF EMOTIONS**

**Emotion**

The next step in the Assessment Phase is the identification of the negative emotion(s) associated with the event or issue. This is simply where the client identifies the emotion(s) she is currently feeling when thinking about the original event (incident, experience) and the negative cognition. Let us go back to Jennifer and see what emotions she was able to recognize. “Jennifer, when you bring up the incident and those words, ‘I am bad,’ what emotion(s) do you feel now?” “Fear, anger, confusion.”

In this case, we want to know what Jennifer feels now as she focuses on the incident and her negative cognition, not when it happened. She may not
be feeling the same emotions that she felt at the time the incident happened; and, in her case, she was able to identify more than one emotion. She was afraid her teacher might approach her again. She was angry at what he did and confused about what to do and how to feel about it (see Figure 3.4). If the client identifies only one emotion, the clinician does not need to probe for more. The clinician should accept the client’s answer and move on.

**ASSESSMENT OF CURRENT LEVEL OF DISTURBANCE**

**Subjective Units of Disturbance (SUD) Scale**

The SUD scale was originally developed by Joseph Wolpe and is an 11-point Likert scale (i.e., a unidimensional scaling method developed by Rensis Likert) utilized in EMDR Therapy to measure a client’s subjective experience of how distressing an event feels for her at the present moment. It is meant to measure the level of disturbance of the entire memory. The SUD is taken after the client has identified what emotions she is feeling during the Assessment Phase and again as the Desensitization Phase appears to be
nearing completion to indicate whether processing is complete and resolution of the disturbance has been achieved. It can also be used at the end of a channel of association to determine the client’s level of progress. The SUD level should also be assessed as a gut-level feeling by the client.

To determine a client’s initial SUD level, the clinician simply asks, “From 0, which is neutral or no disturbance, to 10, which is the worst disturbance you can imagine, how disturbing does it feel to you now?” Note that the client has not been redirected to the original incident or to her negative cognition. The SUD follows the elicitation of emotion but refers to the entire incident. As such, the clinician is asking how the client feels now with regard to the old incident or “How are you feeling now?” (e.g., fear over initiating the process) or “How disturbed are you now?” The SUD is a baseline measurement that helps the clinician to know the client’s level of disturbance. It also provides information to the client as to how the process is progressing.

It is not unusual for clients to experience a range of different emotions during a reprocessing session. The SUD does not reflect the level of disturbance with each emotion. It is a measure of the total disturbance.

During the Desensitization Phase when a client reports a SUD level of 0, the clinician may assume that the client’s memory has been totally desensitized. Often, the SUD level at the end of a session does not reach zero. The client’s original target may not be fully processed (leading to SUD = 0) at the end of the session, but the SUD will most likely have decreased to some degree.

These scales can be confusing to a client, especially since one measures his progress by decreasing in value and the other by increasing in value. If a client questions this, the clinician may provide him with a plausible and simple explanation. “Well, if you think of it in this way, it makes it easier to understand. The EMDR standard protocol is set up in a way so as to decrease the negative emotional charge of your trauma and to increase the charge to your desired direction of change” (see Figure 3.5).

Table 3.8 lists common mistakes made by clinicians with regard to the Validity of Cognition (VoC) and Subjective Units of Disturbance (SUD).

**ASSESSMENT OF PHYSICAL SENSATIONS**

**Body Sensations**

The final question that you will ask Jennifer is, “And where do you feel it in your body now?” She might respond, “In my stomach.” The somatic component is an important piece of the client’s traumatic jigsaw puzzle. The clinician is asking the client where she is feeling the disturbance in her body when she evokes a disturbing image (or picture) with the negative cognition. Jennifer most likely had a physical reaction while the event was occurring. She might have felt it in her stomach then or maybe not. She might have felt
it in her stomach whenever she brought the incident up or maybe not. What is important is where she feels it in her body while she is currently focusing on the event. We do not need or want to know what she was feeling before, during, or after the event in her body. We need to know where she feels it in her body now when setting up the last of the Phase 3 procedural steps.

The significance of body sensations in the Assessment Phase cannot be overemphasized. When a client is focusing on a traumatic memory, the emergence of physical sensations may be associated with emotional tension (e.g., tight muscles or rapid breathing), physical sensations stored at the time of a traumatic event (e.g., physically feeling the pain where a perpetrator hit the victim in the jaw), or negative cognitions.

Notice that the clinician says, “Where do you feel it in your body now?” In doing so, the clinician is making an assumption that the client is feeling it somewhere in their body, even if they say, “Nowhere.” It is inappropriate to say, “What do you feel in your body?” or “How do you feel it in your body?”

As you can see, the body’s physical responses to a trauma are an important aspect of the treatment. When the clinician asks the client, “Where do you feel it (the disturbance) in your body now?” there is a clear assumption that there is physical resonance to dysfunctional material (Shapiro, 2001). Later, when we cover the reprocessing phases, the clinician will see that,
### TABLE 3.8
Derailment Possibilities—Validity of Cognition (VoC) and Subjective Units of Disturbance (SUD)

#### VALIDITY OF COGNITION (VoC)
(Provides a baseline and ensures that the positive cognition is possible)

“When you think of that image (or picture), how true (or believable) do the words (positive cognition) feel to you now on a scale of 1–7, where 1 feels completely false and 7 feels completely true?”

**Asking for the VoC on a 0–7 scale**
The correct scale is 1–7.

**Eliciting a VoC that is in reference to a general event**
VoC should be in reference to the image (or picture) previously identified.

**Obtaining the VoC by asking a question other than the one stated above**
Do not ask, “How true is it today?”

**Proceeding without the client actually understanding the significance of the VoC**
If the client appears confused by what he is asked, the clinician may say, “Remember, sometimes we know something with our head; but it feels differently in our gut. In this case, what is the gut-level feeling of the truth now of [clinician states the positive cognition], from 1 (completely false) to 7 (completely true) as you think of the image?”

**Automatically accepting a VoC of 1**
Before proceeding to the next assessment step, it is appropriate for the clinician to assess the positive cognition in terms of potential flaws in ecological validity, logic, and applicability. The positive cognition should be appropriate and valid with a client’s present environment. Although a client may be able to successfully assimilate a positive cognition with such a low VoC rating, it is often an indicator of the unsuitability of the positive cognition. In some cases, it may be best to suggest an intermediate positive cognition, such as “I am learning that I have choices” to replace the positive cognition that was rated with a VoC of 1 “I have choices.”

**Asking for the VoC without pairing it to the image (or picture)**
The initial words are “When you focus on that image (or picture) (i.e., original image or picture), how true do those words (repeat positive cognition) feel to you now?”

**Failing to repeat the exact words used by a client to describe her positive cognition in reference to the image (or picture) (e.g., I am okay vs. I am fine as I am)**
It is imperative that the clinician repeat the positive cognition exactly as the client has given it to her. The clinician should write down the cognitions so they may be easily accessed when needed.

(continued)
TABLE 3.8  (continued)
Derailment Possibilities—Validity of Cognition (VoC) and Subjective Units of Disturbance (SUD)

Failing to check with the client regarding the trueness of the positive cognition on a “gut” level for an initial VoC of 5 or above
If a VoC appears to be too high, it may be because: (a) they know it is true; (b) but do not feel it is true; and (c) they are not pairing it to the disturbing image (or picture). Depending upon the outcome, the clinician may need to assist the client in further teasing out the appropriate negative and positive cognition.

During the Installation Phase, failing to regularly check for the VoC after each set
Unlike Desensitization Phase measurement of the SUD scale, the clinician checks the VoC regularly if changes continue to occur in the Installation Phase.

SUBJECTIVE UNITS OF DISTURBANCE (SUD)
(Provides baseline measurement of client’s subjective experience of how distressing an image/event feels)

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

Asking for the SUD on a scale of 1 to 10
Correct scale is 0 to 10.

Asking for the SUD before obtaining the positive cognition, VoC, and Emotion(s)
Again, follow the exact order of the Assessment Phase.

Assigning the SUD to the emotion(s) (e.g., sadness, fear, or anger) identified in the Assessment Phase
The SUD is evaluated on the total disturbance level.

as long as physical sensations linger, the reprocessing is considered incomplete. Residual tension and atypical physical sensations must be absent for reprocessing to be complete (see Figure 3.6).

As stated earlier, it is important to mimic Dr. Shapiro’s words as closely as possible when assessing the components of the client’s targeted memory in preparation for EMDR processing. Her script for the Assessment Phase procedure is followed precisely in this Primer as well.

CASE EXAMPLES

The following cases are composites of clients and events. Where appropriate, notes have been inserted to serve as teaching points.
Note: If this is the first time a client has experienced EMDR reprocessing, it is a good practice to introduce the client to it by saying, “When a disturbing event occurs, it can get locked in the brain with the original picture, sounds, thoughts, feelings, and body sensations. EMDR reprocessing seems to stimulate the information and allows the brain to reprocess the experience. That may be what is happening in rapid eye movement (REM) or dream sleep—the eye movements (tones, tactile) may help to process the unconscious material. It is your own brain that will be doing the healing, and you are the one in control” (Shapiro, 2001). If the client ends up having multiple reprocessing sessions, you can say, “Just let whatever happens, happen.” And you might remind the client to distance himself from the trauma by saying, “To help you ‘just notice’ the experience, imagine riding on a train or watching a video; and the images, feelings, and thoughts are just going by.”

Case Example 3B: Terry

Terry, a 40-year-old male, suffered from severe anxiety and depression and a phobia of dead animals, especially birds of any kind. When Terry first arrived, he was sluggish and disoriented. His wife joined him in sessions
for the first couple of times because she acted as his historian. He had lost track of the last few years in terms of doctors, medications, and episodes. He was scared but knew he needed something more than talk therapy for him to get better. As part of his history, the clinician discovered that his mother had married many times during his childhood and usually to very abusive men. Because of this, Terry had experienced what seemed to him lifetimes of trauma before he graduated from high school.

When Terry arrived to begin EMDR reprocessing, he was visibly shaken. “I’m scared,” he said. “I’m afraid it is not going to work.” Because of his discomfort with reprocessing, it was decided to start with a less disturbing memory, that of being chased with a dead bird by his Uncle Roger.

It is important for the clinician to provide the following instructions to the client prior to the initiation of the Assessment Phase. If provided prior to the Desensitization Phase: (a) the client has to pull himself out of the memory in order to listen and understand the clinician’s instructions and (b) the clinician has interrupted any access the client has just established with the targeted memory.

Often we will be doing a simple check on what you are experiencing. I need to know from you exactly what is going on with as clear feedback as possible. Sometimes things will change and sometimes they won’t. There are no “supposed to’s” in this process. So just give as accurate feedback as you can as to what is happening without judging whether it should be happening or not. Just let whatever happens, happen. [Remember to tell the client about the STOP hand signal.]

Here is how the protocol of Terry’s fear of dead birds was set up:

Clinician: Last week, Terry, you stated that you wanted to start with the memory of your uncle chasing you with a dead bird. Can you elaborate briefly?

The briefer, the better. The clinician does not necessarily need to know the details. It is about the client being able to resolve his trauma as completely as possible. The focus is on the client spending time processing the event rather than describing all the details of it. If the clinician already knows enough about the memory, the client will not be asked to elaborate at all.

Terry: I must have been around 3 years old. I was playing in the yard when I spotted a strange-looking “thing” in the yard. It turned out to be a dead bird. I always was a curious kid. Because I wanted to know what it was and what it did, I ran to Uncle Roger and showed him the dead bird. Uncle Roger immediately took the dead bird away from me, thrust it into my face, and began to chase me with it.
Clinician: What image (or picture) represents the worst part of the incident?

Once a client has revealed a traumatic memory, the clinician asks him for a single image (or picture) as the initial focus, an image (or picture) that represents a link to neurological and dysfunctional material.

Terry: It was his evil laugh. He chased me and laughed hysterically.

The sound that the client has selected is very concrete (e.g., “his evil laugh” rather than “always being treated cruelly by my uncle”). This is an important element of an effective target. Terry’s sensory access to the memory is a sound, his uncle’s evil laugh, rather than an image or picture. The clinician should adapt the standard script appropriately.

Clinician: Terry, what words go best with that sound that express your negative belief about yourself now?

Terry: I am in danger.

This is an excellent negative cognition. It is irrational (or dysfunctional), negative, and self-referencing. It is stated in the present and focuses on the client’s presenting issue. And it can be generalized to other traumatic events in which the client may feel unsafe. It also reflects the associated affect of fear identified later by the client.

Clinician: When you bring up the sound, what would you like to believe about yourself now?

Terry: I am not in danger.

This positive cognition is not acceptable or effective. The way it is stated, it is simply a negation of the negative cognition as it appears above. A negative (i.e., “no,” “not”) within a positive statement does not bring the client to his desired direction of change. This is when it becomes necessary for the clinician to tease it out without putting words into the client’s mouth, if at all possible.

Clinician: How can you phrase that in a more positive direction?

Terry: Oh, I don’t know. How about, “I am safe?”

Does this cognition fit the criteria for a positive cognition? Yes, it does. It is a positive, self-referencing belief. It reflects the client’s desired direction of change. It is generalizable to other areas of the client’s life. And it provides clear indication of a positive associated affect. In addition, the positive cognition in this instance matches the theme in the negative cognition. Both deal with the theme of safety.
Note that the cognitions are not perfectly parallel in this example (i.e., “I am in danger” and “I am safe”). They are comfortably similar, and this is okay. It is important to use the client’s words, not what we think the client’s words ought to be.

Clinician: Good. Terry, when you focus on the sound, how true do those words, “I am safe,” feel to you now on a scale from 1 to 7, where 1 feels completely false and 7 feels completely true?

Terry: Two. It does not feel very true.

Clinician: When you bring up that sound and those words, “I am in danger,” what emotion(s) do you feel now?

Terry: Fear! Total fear!

Clinician: From 0, which is neutral or no disturbance, to 10, which is the worst disturbance you can imagine, how disturbing does it feel to you now?

Terry: It’s an eight.

Clinician: Where do you feel it in your body now?

Terry: In my gut.

A client’s bodily response to trauma is an important aspect of treatment and provides a valuable addition of information apart from the verbalizations provided by the client (Shapiro, 2001). When a client is asked where the body sensation is located in his body, what that clinician is really asking is, “Where does the dysfunctional material physically resonate in your body?”

Sometimes it may be difficult for a client to identify where he feels the disturbance in his body. When this is the case, the clinician can assist the client in assessing body sensations by referring them back to their original SUD level. For example, if the client reported a SUD level of 9, the clinician might say, “You reported a 9 as the level of disturbance. Where do you feel the 9 in your body?” If the client is still having difficulty, say “Close your eyes and notice how your body feels. Now I will ask you to think of something; and, when I do, just notice what changes in your body. Okay, notice your body. Now, focus on the sound (or bring up the image/picture).
Tell me what changes. Now add the words, ‘I am in danger.’ Tell me what changes.” See Figure 3.7 for a graphical picture of the EMDR components in the Assessment Phase for Terry.

When you are going through the Assessment Phase procedural steps with the client, it is important to write down everything as it is done in Tables 3.9 to 3.12. Write down exactly what the client says, not what the clinician thinks the client says, and reflect the words back to him in his exact language when the need arises. If a clinician were to say to Terry, for example, “When you focus on the event and those words, ‘I am unsafe’ (what Terry did not say) instead of ‘I am in danger’ (what Terry did say), what emotions come up for you now;” the clinician has not allowed the client’s process to work for him. The clinician is using his words, not the client’s. This format also gives a broader perspective of the client’s responses to the questions in the protocol.

This was a straightforward setup. Even though this client had not reprocessed with EMDR before, he was able to understand and provide what was needed without too much effort. This is not always the case. It sometimes will become necessary for the clinician to tease out what is needed to smooth the way for adequate processing of the dysfunctionally stored
material around the targeted event. Table 3.9 is a reminder for the clinician to write down everything the client says during the Assessment Phase.

### Case Example 3C: Mariko

Mariko suffered severe neck, back, and shoulder injuries during a car accident with a drunk driver 2 years ago while proceeding north on a divided four-lane highway. Mariko told the police officer that she saw a vehicle heading toward her. While she tried to avoid the car, Mariko became hemmed in by other moving traffic and was struck by the vehicle driven by a young woman. Mariko’s car was hit on the passenger side and spun around before it came to rest backwards partially in the highway median. Mariko had collided with a 27-year-old woman who was driving in the wrong direction. At the time, the woman stated that she did not know she was driving the wrong way and was unsure how that happened.

Immediately following the accident, Mariko was rushed to a local hospital with significant injuries. She later had to have back surgery as a result. When Mariko came to therapy, she stated that she had not been able to drive since the accident. As a single parent, she was the sole provider of income for herself and her two children. Mariko realized the importance of getting back behind the wheel of her car as soon as possible. She was
mending physically and nearing the time when her long-term disability would expire.

Clinician: Mariko, what image (or picture) represents the worst part of the incident?

Because there was more than one possible image (or picture) the client could select that was linked to the event, the clinician asked the client to select the image (or picture) that held the most disturbance. It would be inappropriate and counterproductive for the clinician to target the entire narrative rather than the most disturbing aspect of the client’s experience.

If the client cannot name an image (or picture) that represents the worst part, the clinician may ask, “When you think of the accident, what do you get?”

Mariko: Seeing the car heading toward me and not being able to do anything to get out of the way. There were cars on both sides and behind me. There was just nowhere for me to turn. I had no choice but to get hit by this oncoming car.

Clinician: What words go best with that image (or picture) that express your negative belief about yourself now? I am _____ (the client fills in the blank).

Mariko: I was afraid.

This is not an appropriate negative cognition. Why? While it is self-referencing, is it a belief? No, it expresses the emotion of fear. The task then is to tease out the negative belief that is associated with this negative emotion.

Clinician: I understand that you were afraid. What is the belief about yourself now that goes with the fear? Or “What does the fear make you believe about yourself now?”

Mariko: That I am out of control. I feel so helpless.

Here the client has stated one belief, “I am out of control,” and is feeling a sense of helplessness that might be translated into, “I am helpless.”

The clinician teases this out further so that he can obtain the belief that goes with the negative emotion the client has already expressed.

Clinician: As you focus on the image (or picture), which belief resonates the most, lack of control or helplessness, now?

Mariko: Lack of control.

Clinician: So “I am out of control” is what you believe about yourself as you focus on the event now?
The negative cognition is restated to be certain that this is what the client believes about herself as she focuses on the past event. This cognition meets all the criteria for an appropriate negative cognition. It is self-referencing. It is stated in the present. It is generalizable, and it reflects the negative emotion that the client associates with her current difficulties.

Mariko: Yes.

Clinician: When you bring up that image (or picture), what would you like to believe about yourself now?

Mariko: I can take care of myself.

Clinician: What could be the flip side of “I can take care of myself” for you?

Mariko: I can’t take care of myself.

Clinician: Does this resonate with you as you focus on the incident or does, “I am out of control”?

Mariko: I am out of control.

Clinician: What is the reverse of “I am out of control” for you?

Mariko: I always have control.

The positive cognition cannot be an absolute statement. Therefore, avoid the use of words such as “always,” and “never.” When this happens, assist the client in reframing her cognition to something more reasonable or realistic.

Clinician: Is it possible to always have control?

Mariko: Probably not.

Clinician: What would be a more reasonable version of “I always have control”?

Mariko: I have control, I guess.

Clinician: When you bring up that image (or picture), is this what you would like to believe about yourself now?

Mariko: Yes.

Clinician: Mariko, when you focus on that image (or picture), how true do those words, “I have control” feel to you now on a scale from 1 to 7, where 1 feels completely false and 7 feels completely true?

Mariko: It’s a one. It’s not true at all.

When the client states that the positive belief feels like a 1, it is indicative that this might not actually be a realistic goal for the client. It may just be part of the client’s magical thinking that she can have control over all people, places, and things. So, we need to fine-tune it so that the positive cognition is more realistic and attainable.
Clinician: Is it realistic to state in this situation that you have control?
Mariko: No. Probably not.

Clinician: What might a more realistic preferred belief look like for you as you focus on the event?
Mariko: I have some control.

Clinician: And how true does, “I have some control” feel on a scale of 1 to 7 now?
Mariko: It’s not much higher. Let’s say a 2.

Clinician: When you bring up that image (or picture) and those words, “I am out of control,” what emotion(s) do you feel now?
Mariko: Fear. I still feel so afraid.

Notice that the negative cognition resonates with the associated affect stated by the client.

Clinician: From 0, which is neutral or no disturbance, to 10, which is the worst disturbance you can imagine, how disturbing does it feel to you now?
Mariko: Ten. I’m terrified.

Clinician: Where do you feel it in your body now?
Mariko: In my stomach and in my chest.

The clinician is cautioned to refrain from offering cognitive restructuring or psychoeducation during this phase.

Table 3.10 is a reminder for the clinician to write down everything the client says, especially during the Assessment Phase.

| TABLE 3.10 |
| Protocol Setup: Mariko |

- **Target**: Car accident 2 years ago
- **Image/worst part**: Seeing the car heading toward her and not being able to do anything to get out of the way
- **NC**: I am out of control
- **PC**: I have some control
- **VoC**: 2
- **Emotion**: Fear
- **SUD**: 10
- **Body**: Stomach and chest
Case Example 3D: Geraldo

Originally presenting with generalized anxiety, Geraldo had successfully reprocessed the death of his younger brother. Previously, he had worked through guilt over his brother’s death and his wish that he could have done something more to help his brother through his lingering illness. He worried incessantly about the stress of his brother’s death on his fragile mother’s health, but obsessed more about the day when she would pass and the pain he anticipated that he would feel.

Geraldo came from a family of one brother and three sisters. Now that his brother was dead, there was no one to carry out the family lineage. Tragically, he discovered at a very young age that he was sterile as a result of an earlier bout with meningitis. He did have three sons whom he and his wife adopted at birth. But he still felt that he had failed in his familial responsibility to carry on the family name. These were the issues that Geraldo had previously successfully reprocessed with EMDR. Yet, there was one final lingering splinter that still seemed to stick out as he focused on his brother’s death.

His younger brother’s new wife was still in the picture. Prior to his death, his brother apparently was unable to manage his financial matters on his own. He had set up a will in which he named his wife the chief beneficiary but did not name his wife as the executor of the will. He named Geraldo instead, which created two problems. Geraldo became overwhelmed by the intricacies of the legal matters with which he had to deal. His brother’s wife was not happy about the arrangement and caused difficulties within the family.

Most of Geraldo’s apprehension centered on his feelings of inadequacy involving legal matters of any kind. He was a teacher, not a lawyer. It was his insecurity regarding the meetings with the lawyer handling his brother’s will that bothered him the most.

Clinician: When you focus on the situation, what do you get?

Geraldo: The last meeting with my brother’s lawyer. I felt so inept at legal matters. I don’t want to disappoint my brother even in death.

Clinician: What image (or picture) represents the worst part as you think of it now?

Geraldo: I remember stuttering when the lawyer started asking me questions about what was in the will. I never stutter.

Clinician: What words go best with that image (or picture) that express your negative belief about yourself now?
Geraldo: I am incompetent.

Clinician: When you bring up that picture, what would you like to believe about yourself now?

Geraldo: I am competent.

Clinician: Geraldo, when you focus on that image (or picture), how true do those words, “I am competent” feel to you now on a scale from 1 to 7, where 1 feels completely false and 7 feels completely true?

Geraldo: It feels, well maybe, about a 3.

Clinician: As you bring up the image (or picture) and those words, “I am incompetent,” what emotion(s) come up for you now?

Geraldo: I am feeling really apprehensive about these meetings. I possess a lot of self-doubt, too.

Clinician: From 0, which is neutral or no disturbance, to 10, which is the worst disturbance you can imagine, how disturbing does it feel to you now?

Geraldo: It’s only about a five. I thought it would be higher.

Geraldo reported feeling apprehension and doubt. The SUD level measures total disturbance, rather than the level of disturbance on each separate emotion identified.

Clinician: Where do you feel it in your body?

Geraldo: I don’t know.

Some clients are unable to report body sensations, no matter how hard a clinician tries to coach them. When this is the case, the clinician only needs to have the client focus on the identified components of the target and concentrate on assisting in locating the emotions in his body as reprocessing progresses through the immediate or successive sessions. Another approach is to utilize the client’s calm (or safe) place to elicit body consciousness and then refocus the client on the target memory to assist him in noticing the change in his body.

Clinician: Do you remember your calm (safe) place represented by the word “mountain?”

Client: Yes.

Clinician: Please bring it up. (Pause) Notice how that feels to be there now. Head to toe…how safe, how relaxing? Let me know when you have it by nodding your head. (Pause) Good. Now, bring up the disturbing incident. What changes in your body?

Client: I feel jittery in my stomach.
Table 3.11 is a reminder for the clinician to write down everything the client says during the Assessment Phase.

<table>
<thead>
<tr>
<th>TABLE 3.11 Protocol Setup: Geraldo</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target:</strong> Last meeting with his brother’s lawyer</td>
</tr>
<tr>
<td><strong>Image/worst part:</strong> Stuttering in the meeting</td>
</tr>
<tr>
<td><strong>NC:</strong> I am incompetent</td>
</tr>
<tr>
<td><strong>PC:</strong> I am competent</td>
</tr>
<tr>
<td><strong>VoC:</strong> 3</td>
</tr>
<tr>
<td><strong>Emotion:</strong> Apprehension and self-doubt</td>
</tr>
<tr>
<td><strong>SUD:</strong> 5</td>
</tr>
<tr>
<td><strong>Body:</strong> Stomach</td>
</tr>
</tbody>
</table>

**Case Example 3E: Henri**

Henri and his clinician had been working for weeks identifying and clearing out old memories that were fueling his current symptoms. He was feeling better and better about how he was handling his relationship with his wife, 15 years his junior.

Despite his successes in therapy, Henri continued to be self-loathing. It was this negative deep-seated feeling about himself that he simply could not lose. “I hate myself,” he would say. “I simply do not like myself, and I do not know why.” When asked about historic events and memories that may have elicited this feeling, he could identify none. Consequently, the therapist first works with Henri to identify a specific memory before proceeding to the Assessment Phase.

**Clinician:** Focus on the words, “I hate myself.” Where do you feel that self-hatred in your body?

**Henri:** In my gut.

**Clinician:** What emotion is associated with that physical sensation in your gut?

**Henri:** Anxiousness.

**Clinician:** As you focus on those words, “I hate myself,” the physical sensation in your gut, and the anxiousness that you feel, what words go best that describe your negative belief about yourself right now?

**Henri:** I am worthless.
Having identified his negative self-belief, “I am worthless” and the negative emotion associated with this self-belief, the clinician led Henri into the floatback technique (see Chapter 4).

Note: The steps for setting up Phase 3 Assessment and the floatback technique are similar. The clinician asks the client to focus on the issue (e.g., Henri’s experience of thinking, “I hate myself”) and identify the emotion(s) and negative cognition associated with the issue.

Clinician: Henri, bring up that (negative) belief, “I am worthless” and the emotions you are feeling now and let your mind float back to the earliest time when you may have felt this way before and just notice what comes to mind (Shapiro, 2009–2014).

Henri floated back to when he was 5 years old. He was in the basement playing while his dad was busy cutting on a piece of plywood. The plywood had been placed between two sawhorses. He did not remember what his dad was working on. He just wanted to play and was busy doing so when his dad jerked him up and placed him firmly on the piece of plywood. And then his father continued cutting with his circular saw.

Henri was terrified. All he remembers seeing and hearing from that point on was the buzzing of the saw as it made its way toward him. His father used Henri as an anchor to keep the board from shifting out of place while he made his cuts. Henri said, “I shook. I cried. I was so scared.” Aggravated, his father jerked him off the board, threw him angrily on the floor, picked up his 3½-year-old sister, Martha, made her take Henri’s place on the plywood, and continued his project.

It was at this point that the clinician set up the EMDR protocol around this event, and Henri was able to process to a successful resolution.

Clinician: What image (or picture) represents the incident?

Henri: I can still see myself standing on the board.

Clinician: What words go best with that image (or picture) that express your negative belief about yourself now?

Henri: I am weak. Afraid. I can’t do it. I am incompetent.

Except for one, the client rattled off several statements which could possibly serve as the negative cognition around this event. “I am afraid” is not an appropriate negative cognition. It is a feeling. Because there were appropriate negative cognitions available, the clinician did not say, “Fear is what you feel. What does that make you believe about yourself as you focus on the event?” The clinician believed that it was more important to weed out the best cognition from the three that the client provided. Had the clinician not done this, it is possible that the results would have turned out
differently. This was a judgment call on his part. As you will see later, the client did bring this trauma to a successful resolution.

Clinician: Other than feeling afraid, which one of those statements resonate the most when you focus on the event?

Henri: I am incompetent.

If Henri was unable to recall his previous statements (i.e., “I am weak. Afraid. I can’t do it. I am incompetent”), the clinician may repeat them and ask the same question as earlier.

Clinician: When you bring up that image (or picture), what would you like to believe about yourself now?

Henri: I am competent.

Clinician: When you focus on that image (or picture), how true do those words, “I am competent,” feel to you now on a scale from 1 to 7, where 1 feels completely false and 7 feels completely true?


Clinician: When you bring up that image (or picture) and those words, “I am incompetent,” what emotion(s) do you feel now?

Henri: Anger and fear mostly.

Clinician: When you bring up the image (or picture) on a scale from 0 to 10, where 0 is no disturbance and 10 is the worst disturbance you can imagine, how disturbing does it feel to you now?

Henri: It’s pretty high. Let’s say an 8.

<table>
<thead>
<tr>
<th>TABLE 3.12</th>
<th>Protocol Setup: Henri</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target:</strong> When he was 5 years old, his experience of his father using him as an anchor to hold a board while cutting it with a saw</td>
<td></td>
</tr>
<tr>
<td><strong>Image/worst part:</strong> I can still feel myself standing on the board.</td>
<td></td>
</tr>
<tr>
<td><strong>NC:</strong> I am incompetent.</td>
<td></td>
</tr>
<tr>
<td><strong>PC:</strong> I am competent.</td>
<td></td>
</tr>
<tr>
<td><strong>VoC:</strong> 3</td>
<td></td>
</tr>
<tr>
<td><strong>Emotion:</strong> Anger and fear</td>
<td></td>
</tr>
<tr>
<td><strong>SUD:</strong> 8</td>
<td></td>
</tr>
<tr>
<td><strong>Body:</strong> Chest</td>
<td></td>
</tr>
</tbody>
</table>
Clinician: Where do you feel it in your body?

Henri: In my chest.

Table 3.12 is a reminder for the clinician to write everything down that the client says, especially during the Assessment Phase.

Reminder: Reprocessing includes the Desensitization, Installation, and Body Scan phases. Reprocessing is complete when SUD = 0, VoC = 7, and the body scan is clear.

**RECENT TRAUMATIC EVENTS AND SINGLE-INCIDENT TRAUMAS**

Most clinical problems are treated with the 11-step standard EMDR procedure (i.e., image, negative cognition, positive cognition, VoC, emotion, SUD, location of body sensation, desensitization, installation, body scan, and closure) and the standard three-pronged approach (i.e., targeting the past, present, and future). However, protocols are available for special populations (e.g., children, couples, sexual abuse victims, combat veterans, or clients with dissociative disorders) or special conditions or disorders (e.g., phobias, performance anxieties, substance abuse, and pain control). It is important not to overlook the importance and differences in processing these types of events utilizing EMDR. These cases may require special protocols or customized treatment regimens (Shapiro, 2001) and are beyond the scope of this Primer. Explanations and examples of many of these are available (Luber, 2009a, 2009b, 2015, 2016a and b) from other sources.

In Chapter 1, incidents described as recent and single-incident traumas were identified and discussed. Because references to each type of trauma are interspersed throughout the Primer, the specific protocols outlined by Dr. Shapiro (2001) are presented here as well.

**Recent Traumatic Events Protocol**

Dr. Shapiro developed the Recent Traumatic Events Protocol for incidents that still contain separate disturbing aspects or fragments of an event and have not had adequate time in which to fully consolidate into one primary memory. As a result, it becomes necessary to target each separate aspect of the traumatic event by separately targeting and assessing for each the image, negative cognition, positive cognition, VoC, emotions, SUD, and body sensations using the standard protocol. Case Example 3F is an example of the Recent Traumatic Events Protocol (Luber, 2015; Shapiro, 2001). Further information on the Recent Traumatic Events Protocol can be found in Appendix C.
Case Example 3F: Patrick

Approximately 3 months before coming to therapy, Patrick was directly involved in a chemical explosion and fire at the plant where he worked as a maintenance technician. Although many others were taken to the hospital as a result of this explosion, Patrick was the only seriously injured employee and the only one who was in the room where hazardous materials had spilled and caught fire. He had just checked a valve in the vicinity of the explosion and was walking away when the explosion occurred. His shocking comment about himself was, “Thirty more seconds, and I would have been toast.” After determining appropriateness for EMDR Therapy and orientation to present safety through calm (safe) place and grounding techniques, the Recent Traumatic Events Protocol would proceed as follows:

1. Obtain a narrative history

Clinician: Patrick, tell me what you remember from beginning to end. That might be when you knew it was over, or even until now.

Utilizing the recent events protocol, the clinician asks the client to relate the details of the event in narrative form.

Patrick: I had just finished checking a valve on my regular safety rounds and was walking away and, “BOOM!” I didn’t know what was happening. I just knew I had to get out of there quickly. I don’t even know where I was when the explosion occurred. I just know that I had to get out. I was disoriented. It was dark and smoky. I didn’t know which way to go. I was panicking because I couldn’t breathe. I kept thinking, “What happened? What happened?” And, I don’t know how, but I quickly reached the door to the outside. The second the light and air hit my eyes, they started burning. I threw myself down in the snow and started rolling around. It was so cold. I threw snow on my face and rubbed my eyes with it. I hadn’t been out long when Bill and Pete grabbed me and led me back into another entrance of the building. Bill said, “You know the drill,” and threw me into a cold shower, clothes and all. I still couldn’t see. I was freezing. It was so cold. Whenever I tried to get out of the shower, one of them would push me back in. Then they made me take all my clothes off and shoved me back in. (This was a documented safety procedure. It was important that Patrick got all the chemicals off his body to ensure that no further complications might arise.) God, it was cold! I was freezing. Next thing I remember is being loaded into the ambulance. I kept thinking, “What happened? Why me? Where’s my wife? I can’t see. I can’t see! Why can’t I see?” My wife arrived at the hospital about the same time that I did. The doctor told us both that the burns were pretty bad, and I’d have to stay in the hospital. I still couldn’t see. “Oh God. Why me?” When I was in the hospital, I kept retracing my steps. “Was it me? Did I do something wrong?”
Clinician: Anything else?

Patrick: I was in the hospital for a while. They kept treating my eyes and checking pressure and stuff like that. That was really hard on my wife and my kids. Then, my vision started to clear a little bit. It was really blurry, and the light hurt. Then it started getting better.

Clinician: And where do things stand now?

Patrick: Well, my vision is okay right now. I still have to go in and get the pressure checked regularly and will probably need a corneal transplant in the future. I went back to work last week, but I sure get anxious when I have to go in and check those valves. I’m not sure I can do it.

2. Target the most disturbing aspect of the memory

There are several experiences in Patrick’s narration that could be treated as separate events (e.g., the explosion, not being able to see or breathe inside the building after the explosion, the air and light hitting his face and eyes and the burning sensation that occurred, the shower experience, the ride to the hospital, and being told by the doctor that it looked pretty bad). As the client is providing a narrative, the clinician records these separate events.

Clinician: Patrick, is there a particular part of your story that is more distressing than another?

Patrick: Not being able to see.

Patrick was able to identify the most disturbing part of his memory. Although not shown here, the clinician would set up the EMDR standard procedure specified in the Assessment Phase by identifying the image, negative cognition, positive cognition, VoC, emotions, SUD, and physical sensations associated with what Patrick has identified as the worst aspect of his memory of the explosion. This memory fragment would then be reprocessed with the standard Desensitization and Installation Phases. The body scan would be skipped at this point. It is assumed that, given the other unprocessed parts of the entire sequence of events, it would be impossible to get a clear body scan. It would not be surprising if the positive cognition did not reach a 7. There are other targets relating to this same event that may need to be reprocessed first before this can occur, such as his hospitalization and/or aspects of his medical treatment, impact on his family and work.

Note: Because Patrick’s trauma involved potential injury to his eyes, the type of bilateral stimulation chosen by the clinician was tapping rather than eye movements.

3. Target the remainder of the narrative in chronological order

After the worst part of the memory has been reprocessed, the clinician needs to target the remaining events in the client’s narrative in chronological order.
If he were to have identified one of the events to be more disturbing than the rest, the clinician would target this one first and then the remainder as they occurred during the telling of his story. Each target is treated separately in terms of the standard EMDR protocol (i.e., Phases 3–5) up through the Installation Phase, being mindful to exclude the body scan for each. The body scan is initiated only after the last target of this traumatic event has been identified and addressed so that all the associated negative physical sensations can be eliminated.

4. **Visualize entire sequence of the event with eyes closed**

Once all the separate events in Patrick’s narrative have been identified and reprocessed, the client is asked to visualize the entire sequence of the event from start to finish.

**Clinician:** Patrick, close your eyes and visualize the entire sequence of events of the explosion.

**Patrick:** Okay.

**Clinician:** Any time a disturbance arises in any form (i.e., visual or auditory, emotional, cognitive, or somatic), stop and open your eyes. (Pause)

**Patrick:** Why? Why did it happen to me? The company had just replaced the valve. Didn’t anyone check it to see if it was connected correctly?

Something disturbing has arisen. Because it is still disturbing, the clinician would implement Assessment, Desensitization, and Installation Phases again with this newly identified disturbance. Once this has been processed, he would then ask the client to visualize the entire sequence of the event once again from the beginning to see if further disturbances arise. If so, he would reprocess each disturbance that surfaces using the standard protocol (i.e., Phases 3–5).

5. **Visualize entire sequence of events with eyes open**

When the client is able to run the experience through and no distressing material comes up, the clinician moves to the Installation Phase. An overall positive cognition is identified: “As you think of the entire experience, from beginning to end, what would you like to believe about yourself now?” The positive cognition might be something like “It’s over. I survived.” Once the overall positive cognition is identified, have him hold the positive cognition and visualize the entire event one more time from beginning to end with his eyes open. Add long set of bilateral stimulation. The client is asked to give the “stop” signal when his processing has been completed. This is continued until the VoC is 7. As an additional check, the client closes his eyes and reviews the entire event along with the positive cognition. This is to ensure that the VoC equals 7 for the entire event. If not, target that part of the memory until the VoC feels completely true (7) or to a degree that is ecologically valid.
6. **Conclude with body scan**

Once this open-eyed visualization has been completed, a normal body scan is done.

7. **Process present stimuli, if necessary**

Any current situations (triggers) that lead to distress are also processed using the standard protocol (i.e., Phases 3–6). With present triggers, you need not use the modifications outlined above. In Patrick’s case, this included having to check the valves and his concerns about a corneal transplant in the future. His positive cognition in both situations was “I’m strong. I can do it.”

8. **Develop a future template**

After reprocessing each present trigger, the client is instructed to run a movie of the desired response for coping with a similar situation or challenge in the future. The process for the future template is described in detail in the next chapter.

---

**Caveats When Using the Recent Traumatic Events Protocol**

There are several caveats (Shapiro, 2001) the clinician needs to keep in mind when administering the Recent Traumatic Events Protocol (see Table 3.13).

**How Do You Know When Its Use Is Appropriate?**

A common question regarding recent events is: “How recent is recent?” Or “How does a clinician know when a memory has consolidated or is consolidated enough to use the standard three-pronged approach?” There are two possibilities in answering this question. First, if a client is processing the worst part of

<p>| TABLE 3.13 |</p>
<table>
<thead>
<tr>
<th>Caveats Associated With Recent Traumatic Events Protocol</th>
</tr>
</thead>
<tbody>
<tr>
<td>The clinician must ensure that the timing for this intervention is adequate (i.e., within 2–3 months of recent event).</td>
</tr>
<tr>
<td>Client should be able to give a narrative account of the event and be oriented to the present before initiating this protocol.</td>
</tr>
<tr>
<td>The clinician may need to reprocess present distressing stimuli (e.g., startle response, reminders of the event, nightmares) that may emerge for a client after reprocessing the entire event.</td>
</tr>
<tr>
<td>Reprocessing of a recent event may take more than a few sessions. Be patient with the process if it does.</td>
</tr>
<tr>
<td>Distressing material from unresolved earlier events with the same thematic issues (e.g., safety) as the recent event may surface during or after the reprocessing.</td>
</tr>
</tbody>
</table>
a traumatic incident and other channels of association open up, the event may have been consolidated. Second, if the first memory reprocessed using the Recent Traumatic Events Protocol processes down to a 0 SUD and 7 VoC, it is likely that the memory has been consolidated. In either case, the past, present, and future prongs need to be processed. Refer to Figure 3.8 for the illustrative example related to Case Example 3F—Patrick.

**FIGURE 3.8** Recent Traumatic Events Protocol.
Single-Incident Traumas

A client may present with a single traumatic event. When this occurs, the clinician will want to consider using the standard EMDR procedure and apply it to the following targets identified by Dr. Shapiro (2001) if they are available: (a) the memory (or image) associated with a traumatic event; (b) a flashback scene the client has experienced; (c) a recurring dream or nightmare or the most disturbing or traumatic scene in the dream; (d) stimuli that trigger the client in the present; and (e) the incorporation of a future template.

With single-event traumas, there are some targeting possibilities the clinician may want to consider. For instance, are there historical linkages that need to be elicited? Or, are there additional related events associated to the traumatic event (Shapiro, 2009–2014)? If possible, thorough questioning during the intake interview may help to elicit this information.

Single Traumatic Event Protocol

**Case Example 3G: Rayshawn**

Rayshawn was involved in a bank robbery when he was working as a teller at a local bank. The bank robber stormed into the bank, brandishing a gun. The gunman jumped over the counter and held the gun to Rayshawn’s head, demanding he put money in a canvas bag that he shoved into Rayshawn’s hand. The robber fled the scene within a matter of minutes and was not seen again until 6 months later. The same unmasked bank robber entered the same bank, held a knife to a teller’s throat, demanded money, and fled. The gunman was apprehended 10 minutes after the robbery and was sent to jail. As Rayshawn was one of two who could identify the gunman, he eventually ended up testifying at the robber’s trial. As the gunman had been involved in other robberies where bank employees had been injured or killed, he was easily convicted and sentenced to death row.

1. **Identify the image (or picture) that represents the entire incident.**

   **Clinician:** Which event would you like to target today?
   
   **Rayshawn:** I would like to work on the first bank robbery.

2. **Clinician:** What image (or picture) represents the worst part of the incident (or traumatic event)?

   **Rayshawn:** The gun to my head. I can still feel the cold, hard barrel against my forehead.
If the client cannot identify an image (or picture), ask, “As you think of the memory, what is the worst part of it?”

**Clinician:** As you focus on the image (or picture), what words best express your negative belief about yourself now?

**Rayshawn:** I am going to die.

2. **Identify the client’s positive cognition.**

**Clinician:** When you bring up that image (or picture), what would you like to believe about yourself now?

**Rayshawn:** I am safe.

3. **Check for the Validity of Cognition.**

**Clinician:** When you focus on that image (or picture), how true do those words, “I am safe,” feel to you now on a scale from 1 to 7, where 1 feels completely false and 7 feels completely true?

**Rayshawn:** Two.

4. **Identify emotions associated with the image (or picture) and the NC.**

**Clinician:** When you bring up that image (or picture) and those words, “I am going to die,” what emotion(s) do you feel now?

**Rayshawn:** Fear.

5. **Check the Subjective Units of Disturbance**

**Clinician:** From 0, which is neutral or no disturbance, to 10, which is the worst disturbance you can imagine, how disturbing does it feel to you now?

**Rayshawn:** Eight.

**Clinician:** Where do you feel it in your body?

**Rayshawn:** My chest. I am having difficulty breathing.

6. **Process Phases 4 through 6 for each incident identified by the client.**

7. **Process Phases 4 through 6 for each flashback identified by the client.**

Use the same protocol above, substituting the “flashback scene” for “picture” in it.

8. **Process Phases 4 through 6 for each dream image of the most traumatic scene in a recurring nightmare identified by the client.**
Use the same protocol above, substituting the “dream image or recurring nightmare” for “picture” in it.

9. **Elicit from the client a list of the people, places, situations, and so on, that triggers the client’s trauma.**

Clinician: Rayshawn, can you identify any situations, events, or any other stimuli that trigger your memory of the gun being held to your head?

Rayshawn: The biggest one is when I see a flash—like the sun off someone’s ring or car keys. I get startled and then become extremely anxious.

Clinician: Anything else?

Rayshawn: I get edgy and irritated whenever someone comes at me fast or stands too close to me.

10. **Process Phases 4 through 6 for each trigger identified by the client.**

Use the same protocol mentioned earlier.

Clinician: What trigger would you like to work on today?

Rayshawn: The flash of metal.

11. **Immediately following the reprocessing of a present trigger, install a future template for that trigger (see Luber, 2009b, pp. 129–132, on the steps to incorporating a future template for each trigger identified in a single event trauma).**

12. **Closure.**

Whether the reprocessing is unfinished or complete, end EVERY reprocessing session with Phase 7—Closure to ensure that the client is well grounded.

**Treatment Planning Guide (TPG)**

Treatment planning and target selection are usually structured using Dr. Shapiro’s (2006a) Treatment Planning Guide (TPG). The guide may also be structured around recent trauma, single-incident trauma, and presenting problems defined by negative and positive cognitions, problem behavior, disturbing affect or body sensation, and external stimuli, such as odor, touch, experience, situation, perpetrator, or anniversary date. A more comprehensive plan may revolve around a complex presentation (e.g., complex PTSD or client with an Axis II diagnosis). A treatment plan may also be generated using chronological time lines and genograms during the History-Taking and Treatment Planning Phase. In any case, the incident/event selected for
targeting in the Assessment Phase comes from some version or variety of the TPG suggested by Dr. Shapiro.

It is during the initial intake interview that the clinician begins noting and recording the past, present, and future (i.e., anticipated) negative and positive incidents/events reported by the client. It is from this collection of recorded events that the clinician may develop a Treatment Planning Guide utilizing the three-pronged format. It is here that the clinician can uncover past experiences that resonate with the presenting problem, beginning with the touchstone event (if any), past events, present triggers, and future desired outcomes. See Appendix C for more information on Dr. Shapiro’s Treatment Planning Guide.

**SUMMARY STATEMENTS**

1. Try to not confuse the Assessment Phase with the assessment taken during the History-Taking and Treatment Planning Phase. History-taking and treatment planning are used to evaluate a client’s total “rail” system (light or complex) where the Assessment Phase loads the “train” in readiness to head down one specific “track.”

2. An assessment for past, present, and future is made with all types of client presentations. This assessment is completed for a target immediately preceding the Desensitization Phase.

3. Targets are more concrete versus abstract, more specific than general.

4. Negative and positive cognitions do not need to be perfectly parallel. However, they generally focus on the presenting issue and address the same thematic schema.

5. Write down as much as possible during the Assessment Phase. It is important to be able to accurately reflect what the client has said.
Chapter 4

Building Blocks of EMDR Therapy

*Although the world is full of suffering, it is full also of the overcoming of it.*

—Helen Keller (*Optimism*, 1900)

**EMDR THERAPY IS A THREE-PRONGED APPROACH**

In the client History-Taking and Treatment Planning Phase of Eye Movement Desensitization and Reprocessing (EMDR) Therapy, the clinician begins the process of identifying past disturbances or traumatic experiences, present triggers or difficult recent experiences, and anticipated future occurrences or situations related to the presenting issue chosen as the focus of treatment. These are the true building blocks of EMDR Therapy. A client’s success with EMDR Therapy relies on a balanced focus on all three prongs of the EMDR protocol and the order of processing in which they are accessed and reprocessed. It is on these blocks—past, present, and future—that the momentum and treatment effects can build and the healing process can be completed.

When new to EMDR Therapy, it is easy to overlook the second two prongs, especially the third. Clinicians may become accustomed to focusing on a client’s past for answers to what is happening in the present and possibly the present situations that continue to create difficulty but do not always get an opportunity to process the final prong. Some EMDR clients feel so good after having resolved some of their past issues and present triggers that they terminate therapy prematurely.

As the three prongs of EMDR Therapy are reviewed, return the focus to assessing appropriate targets and outcomes in relationship to past, present, and future. An understanding of this relationship is important to the construction of an EMDR Treatment Planning Guide suggested by Dr. Shapiro (2006a) to ensure the successful accomplishment of overall treatment goals.
Building Blocks of EMDR Therapy: Past, Present, and Future

A client who has experienced a single traumatic event can usually be treated by targeting the original traumatic memory and additional past incidents related to the primary event (e.g., car accident and related traumas: the car catching on fire while trapped in the car; being told she would never walk again; the long, difficult recovery) and any presenting situations that continue to trigger anxiety (driving on the same mountain road). Clients who present with multiple issues and/or symptom presentations or with complex presentations of traumatic life events or extreme stress over a prolonged period of time will require a more comprehensive treatment approach. When a client’s history is traumatically complex, it is important to identify and treat these three areas of concern: touchstone memories and other contributor memories, present triggers, and future alternative behaviors. Whether targeting single or multiple traumatic events, it may be necessary to sequentially target the traumatic event(s) and present triggers/recent experiences that have manifested as a result and work on skills a client needs to be more successful or comfortable in the future (see Figure 4.1).

In the first prong of EMDR treatment, the clinician and client work together to reprocess any past incidents associated with the presenting issue and, if present, the early and critical touchstone memories (i.e., crucial memories that set the foundation for a client’s current disturbance). The second prong is much like the first in that the clinician and client focus on reprocessing (i.e., Phases 3–6); present triggers (e.g., people, circumstances, places, or other forms of stimuli that activate disturbing reactions or responses); or difficult present experiences. The third prong focuses on alternative behaviors to aid the client in meeting his future therapeutic goals.

Although past incidents, present triggers and experiences, and future outcomes associated with the presenting issue are initially identified in the History-Taking and Treatment Planning Phase, they may also emerge anywhere throughout the eight phases (e.g., emergence of blocking beliefs or feeder memories, during reprocessing, between sessions). Figure 4.2
identifies the treatment planning guidelines suggested by Dr. Shapiro (2009–2014) and will serve as the targeting model for this Primer.

Note: In earlier EMDR trainings, clinicians were taught to identify and reprocess targets in order of past, present, and future. Although this remains largely true, the clinician is encouraged, when needed, to modify the three-pronged protocol to meet the clinical demands with which a client presents (Shapiro, 2009–2014). For learning purposes, the standard three-pronged protocol will be discussed. The conditions that may be present to fit the demands of altering the protocol will be covered later in the chapter.

**CLINICAL PRESENTATION POSSIBILITIES**

Clients initially present to therapy specific issues, problems, and disturbing events that are accompanied by a constellation of symptoms (i.e., cognitive, affective, somatic, and behavioral; Shapiro, 2009–2014). The presenting issue can be driven by associated negative cognitions (NC) such as “I am unsafe,” or “I am different (i.e., don’t belong).” It may be defined by a problem behavior or a self-destructive pattern, inappropriate or negative affect (e.g., overwhelming sadness), or physical sensation (e.g., unexplained chronic headaches). Or it may be activated by external stimuli such as touch (e.g., brushing up against something or someone), odors (e.g., the smell of after-shave), a particular experience (e.g., driving past an intersection where a bad accident occurred), or an anniversary date (e.g., the death of a loved one).
A pictorial conceptualization of the types of presenting issues for EMDR Therapy identified by Dr. Shapiro (2001, 2008) and how they fit the three-pronged targeting and reprocessing plan can be found in Figure 4.3. As the figure demonstrates, there are several types of traumas with which a client can present, but clients do not always present with a trauma. They
more often come in with symptomatology, such as depression, anxiety, or panic attacks.

Here are some types of traumas and other issues with which clients may initially present, listed in order of complexity

**Single Incident Presentations**

1. **Acute Stress Response (i.e., “Fight or Flight”).** An acute traumatic event that has happened within the past 48 hours and has caused a set of symptoms directly attributed to the event. After 48 hours, it becomes Acute Stress Disorder.

   **Example:** Kelly was working as a cashier at a fast-food restaurant when a man wearing a ski mask walked up to the counter, pulled out a revolver, pointed it at her, and shouted angrily, “Give me all the money in the drawers or I will shoot you.” Three days after the event, Kelly came to therapy complaining of fatigue, irritability, and sleeplessness. She had frequent nightmares of the event and found it increasingly difficult to concentrate.

2. **Recent Event Trauma.** A recent traumatic event is when “the memory has not had sufficient time to consolidate into an integrated whole” in terms of information processing (Shapiro, 2001). For recent events, the clinician will use the EMDR protocol for recent traumatic events. A recent event is one that has occurred within a 2- to 3-month period.

   **Example:** Within 3 months of his accident, Patrick came to therapy after being seriously injured in an explosion at the chemical plant storage facility where he worked. He continues to experience flashbacks, intrusive thoughts and nightmares, anxiety, sleeplessness, and fatigue. He remains in a constant state of hypervigilance and experiences frequent bouts of anxiety. A complete transcript of Patrick’s EMDR recent traumatic event session can be found in Chapter 3 under the heading Recent Traumatic Events Protocol.

**Single Dominant Issue/Symptom Presentations**

1. An event or series of events may be categorized as a single issue or symptom if there is a dominant theme or issue organized around a single symptom (e.g., client has a single negative irrational core belief about self, patterns of behavior, affects, body sensations, and other sensory input, people, places, and situations, and specific time periods). These types of presentations may be exacerbated by an adverse life experience (i.e., small “t”) experienced in early childhood.
Example: Jesse was on the swim team at his high school. He had a strong sense of competitiveness and had won major swim competitions in prior years. This year he was beginning to fall way below the mark in competitions. The clinician learned that Jesse’s swim coach was aggressive and often hurled verbal insults (e.g., “You’re stupid.” “You’re fat.” “You will never measure up.”). Jesse began to exhibit pervasive anxiety and issues of self-doubt. Other possible single presenting symptoms in this case could be a belief of “I am no good,” having frequent leg cramps, or perfectionist behavior in all areas of his life.

2. Posttraumatic Stress Disorder (PTSD): The client has experienced a life-threatening event or series of events that meet diagnostic criteria for PTSD outlined in the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013) and has experienced hyperarousal, intrusions, and/or avoidance of stimuli that trigger negative symptoms with possible origins in early childhood incidents of neglect and/or abuse. Cases of simple PTSD involve single-event traumas (e.g., war and violence, natural or man-made disasters, accidents, and sudden losses or serious illnesses) or a cluster (i.e., repeated) of similar events (e.g., physical or sexual abuse). The symptoms of simple PTSD stem from the occurrence of a critical event. The clinician needs to identify the incident, including earlier contributing events, if any, the triggers, including current manifestations (e.g., nightmares, flashbacks, recurring dreams), and future templates.

Example: A young woman witnessed a fatal car–pedestrian accident while driving on the interstate on her way to work. The victim was a pedestrian who was killed instantly, and the speeding car that hit her did not stop. Nine months later, the woman is still finding it more and more difficult to drive on the interstate. She becomes extremely tense and anxious while driving on more than two-lane highways, has experienced several full-blown panic attacks while driving in high-speed interstate traffic, and has had difficulty getting up on the mornings she has to go to work. With regard to a prior history, the client’s past is unremarkable. In the case of this tragic incident, the accident itself is the touchstone event and hence was the first to be targeted and reprocessed in the sessions that followed.

Multiple Issues/Symptoms Presentations

It is not uncommon for a client to seek therapy to overcome more than one presenting problem and/or symptom.

Example: A client presented with both work-related difficulties and grief issues citing ongoing symptoms of depression, anxiety, and frequent panic reactions. His wife had died three years earlier having suffered a brain
Vague or Diffuse Presentations

A client may present as one who appears to have a “perfect” life history, but feels joyless and unfulfilled and does not know why. The client may complain of many vague symptoms with unknown origins. When asked about past traumas or disturbing life events, she may answer, “I can’t think of anything.” This is what is called a vague or diffuse presentation. In this case, the clinician needs to strategically tease out potential targets. The clinician may want to consider a more extensive look into the client’s symptom origin and developmental history, including a history of disrupted attachment, neglect, and ubiquitous disturbing experiences that may not occur to the client as significant or worthy of mention. It should be noted that the apparent lack of significant history may be a red flag for a dissociative disorder, and a careful screening using the DES and diagnostic tools may be required. In these cases, history taking may need to be titrated—with an emphasis on stabilization using Phase 2 interventions and integrating other stabilization or skills building techniques.

If past contributory experiences continue to be illusive, it may be productive to identify recent experiences of the issue and use the floatback or affect scan to link to earlier, more defined experiences. The usual chronological ordering of targets may need to be altered. A current experience of the issue may be reprocessed first; and, if the processing becomes blocked or loops, the clinician can trace back through floatback or affect scan for the source of any blocking beliefs or emotions. Once identified, the earlier memories can be reprocessed using Phases 3–6. With vague or diffuse presentations, a thorough accounting of her medical history and a depression screen in addition to dissociation screening would also be in order.

Example. With this type of presentation, the client may report numerous experiences over her lifetime that could have produced her current pathology (i.e., severe depression; history of panic attacks; interpersonal, familial, and professional problems; or some dissociation). However, the client does not remember much of her childhood and/or may not meet the full diagnostic criteria for 309.81 (Posttraumatic Stress Disorder).
Complex Posttraumatic Stress Disorder (C-PTSD)

Complex PTSD is characterized by: (a) a complex presentation of traumatic life events over an extended period of time; (b) often including early abuse, neglect, or attachment disruptions; and (c) presenting with symptoms of a personality disorder and/or dissociation. Additionally, individuals with complex PTSD may experience difficulties with emotional regulation, self-perception, relationships with others, and one’s sense of meaning.

Example: Sandra’s mother died when she was 5 years old. Her abusive father was left to care for their four young children. He sexually abused and beat Sandra if she was not totally submissive and obedient from the time her mother died until she ran away from home at the age of 17 years. She was used as replacement for his deceased wife and told it was her job because she was the oldest female. She became highly dissociative. If the client is too unstable, additional interventions and options for the order of reprocessing have been discussed in literature addressing EMDR Therapy with clients with symptoms of complex PTSD and/or dissociation. In these cases, the inverted (Hoffman, 2009) or the reverse (Adler-Tapia, 2012) protocols may be used. These protocols reorganize the order of processing from past, present, and future to future, present, and past (i.e., future rehearsal, present triggers, and past events) so that the client may focus on developing hope, capacity, and skills for the future. Use these protocols to address present challenges and triggers before processing any foundational trauma. EMD may also be an option with reprocessing to start reprocessing a highly disturbing target as it can help reduce the SUDs fairly quickly and limit associations. See the section EMD versus EMDR in Chapter 1. For more information on these protocols and other options for dealing with clients with symptoms of complex posttraumatic stress disorder (C-PTSD), reference the Francine Shapiro Library (emdria.omeka.net).

The presenting problems in each type of case (single-incident trauma, vague or diffuse, and the comprehensive presentations—single and multiple) need to be processed in the order of past events (touchstone event and all additional past events), present triggers, and future templates.

The types of a client’s possible presenting issues have been limited in this Primer to those covered in the EMDR Therapy Weekend 1 and 2 trainings. Other possibilities for presentation types may be of a relational nature (e.g., divorce or sibling rivalry), ongoing stressful events, someone who is in imminent danger (e.g., being stalked), or other complex presentations.

**FIRST PRONG: EARLIER MEMORIES/TOUCHSTONE EVENTS**

**Touchstone Event**

A touchstone event is synonymous with the earliest memory the client can remember that created the foundation for the client’s present dysfunction or pathology. It is usually identified during the History-Taking and Treatment
Planning Phase. In some cases, touchstone events may not be apparent in Phase 1. They may emerge spontaneously during processing or may be revealed through the clinician’s use of strategies for blocked processing or other interventions, such as direct questioning, floatback technique, and affect scan. And, with some cases, the event that brings the client to treatment is the touchstone event.

The touchstone event brings home the fact that our presenting problems are often linked to traumatic or other disturbing events in the past (i.e., “the past is present”; Shapiro, 2009–2014). With the exception of clients who present with an intense recent trauma or those who may not be initially able to tolerate going back to a painful touchstone event (e.g., a police officer losing his partner in the line of duty), the client’s touchstone event is generally identified and reprocessed first.

Past events may be recent events, other adult events, or childhood experiences. Note that the symptoms presented by the client are not always precipitated by events in the past. There are cases where the presenting issue is the issue and the target, that is, there is no earlier touchstone event. This may be true in relational issues, ongoing stressful events, or recent traumatic events.

A simplified example of uncovering the touchstone event in an EMDR-directed session begins with the client presenting a problem (i.e., complaint, issue, or concern) on which she would like to work. Maybe the client is having a difficult time saying “no” or handling stress in the workplace. Perhaps she is experiencing relationship issues or has anxiety attacks in elevators. In an effort to uncover more information about the presenting issue, the clinician either asks the client explicitly if she can relate some specific and recent situations or events where she experienced her particular concern or remembers the first time she encountered the problem. If not forthcoming, the clinician may need to obtain the information implicitly through intensive history taking.

In the case of a client who has difficulty saying “no,” the clinician might ask, “Tell me about some recent situations where you have experienced that issue.” A summary of the client’s possible answers can be found as follows:

- Volunteering to take on extra work at the office even when she knows she already has more work than she can handle.
- Agreeing to take care of her sister’s three dogs for a week when she can’t find time to adequately care for her own two dogs.
- Being the only one of five siblings who visits her mother twice a week and does her grocery shopping before she does her own.

The client may have an entire laundry list of events that fits the criteria of the presenting issue. In this case, the clinician needs to sort out which incident is most disturbing and representative of the issue (i.e., “Which is the most disturbing recent incident that represents your issue?”). “My boss knew I would never say, ‘No,’ to his personal requests. He never once
stopped to think about my feelings and what I thought about what he was asking.” This experience exemplified her presenting issue and was used as the starting point for identifying past, present, and future targets.

**Strategies for Accessing the Touchstone Memory**

Direct questioning, the floatback technique, and the affect scan can be utilized to access the touchstone event. As an organizing technique, it is probably most useful for the beginning EMDR clinician to utilize these tools in the order presented here. During the history-taking process, the clinician attempts to identify a recent time the client remembers experiencing the current difficulty that represents the presenting issue (e.g., her boss asked her to pick up his laundry yesterday, and she was unable to say “No”). Once a recent incident is identified, the clinician attempts to elicit an image (or picture) and an associated negative cognition (e.g., “I am insignificant.”) as well as the emotions and body sensations associated with the recent incident.

**Direct Questioning (i.e., Go Back)**

Through direct questioning, the clinician assists the client in identifying past events where the client felt or believed something similar. The earlier the event, the better (e.g., somewhere in the formative years of the client’s life—from birth to 10 years). Remember, the clinician is probing for the touchstone memory, if there is one. The following are some questions clinicians might ask to elicit this information:

- When was the first time you remember feeling, thinking, or reacting that way?
- When was the first time you heard (or learned) “I am insignificant?”
- What incidents come to mind from childhood or adolescence?

In addition to the earliest event, other related past memories are identified.

**Floatback Technique (i.e., Think Back)**

If the client is unable to identify the touchstone through direct questioning, the clinician’s next option is to use the floatback technique (Browning, 1999; Young, Zangwill, & Behary, 2002) to elicit the past event that is foundational to the development of the current dysfunction. The floatback is an imagery exercise that acts as a bridge to earlier dysfunctional memories. Use the floatback technique:

- If the negative cognition is clear (i.e., “I am insignificant”) and is identified as a relevant and important part of the client’s presenting issue (i.e., inability to say “No”).
• When the present event is not fully accessible.
• If the negative cognition is unclear or difficult to access. The floatback technique can still be implemented to access the touchstone event responsible for the client's current dysfunction by using the client’s current emotions or physical sensations as a bridge to the past.

If the negative cognition is clear, the clinician instructs the client to focus on the earliest identified memory up to this point, the negative cognition, and emotions associated with the event by saying, “Float back to the earliest time when you experienced these.” Or, if the client cannot easily focus, consider saying, “Now, bring up that negative belief (i.e., ‘I am insignificant’) and the emotions you are feeling now and let your mind float back to the earliest time when you may have felt this way; and just notice what comes to mind.”

**Affect Scan (i.e., Feel Back)**

A hypnotherapeutic technique called an affect bridge was developed by Watkins (1971). This is similar to what we use in EMDR Therapy when we ask a client, “When was the first time you experienced this emotion?” In either case, the client is asked to focus on the most recent memory of an event as a starting point for scanning back into time through similar memories to find the original memory or the cause of the client’s presenting problem or issue. The affect scan (Shapiro, 1995; independently developed and without the hypnotic/reliving component contained in Watkins & Watkins, 1971) is probably the easiest and quickest way to get to the touchstone event and can be the most powerful. However, it may elicit higher levels of emotion and body sensation that the client may not be prepared to experience. Thus, the floatback technique may be preferred with clients who have a higher level of negative affect. Note that the affect scan can be extremely effective when: (a) the negative cognition is not clearly stated; (b) the earliest memory has not been able to be identified; and (c) the client becomes stuck during reprocessing, and the clinician checks for a feeder memory.

To initiate the affect scan, the clinician instructs the client to “Bring up that experience (i.e., the last memory identified in the floatback), the emotions, and the sensations that you are having now; and allow yourself to scan back for the earliest time you experienced something similar.”

If nothing emerges, the clinician may want to explore family of origin issues with the client by inquiring, “Do you remember feeling like this in your family when you were young?” Or, “As you were growing up in school or in the neighborhood, do you remember similar things happening?” It is important not to limit exploration of the touchstone event to her family of origin. The disturbing event may have happened outside the familial circle (e.g., molestation by a neighbor, bullying on the playground).

**Note:** The memory device “Go back, think back, and feel back” was developed to help the clinician to conceptualize the focus of direct questioning, floatback, and affect scan (B. Korzun, personal communication, April 15, 2015).
It is not unusual for a client to come to therapy to work specifically on an early pivotal experience that happens to be the touchstone event. There are cases in which a client cannot identify an earlier memory and weeks later it may (i.e., most likely, but not always) spontaneously emerge. Touchstone events are usually traumatic or other disturbing events that occur in a client’s formative years from birth to age 10. It is best to find the earliest possible memory for reprocessing because it is identified as the event that laid the foundation for the client’s current problem. Exceptions to this may be: (a) clients who present with intense recent trauma (e.g., the client may not be able to tolerate going back to the touchstone event [i.e., fireman losing a friend in a fire]); (b) returning military personnel involved in combat; or (c) survivors of an acute recent trauma, such as first responders and medical emergency personnel (Shapiro, 2009–2014).

These techniques are used when appropriate but not without caution as they may increase clients’ current levels of distress. In all instances, it is important to ensure that clients have sufficient affect tolerance to handle whatever comes up and feel safe within the therapeutic relationship. In the case that follows, the client’s presenting issue will be used to elicit the touchstone event through the use of the direct questioning, floatback, and affect scan techniques.

Finding a touchstone event is a strategic process in terms of when, how (as seen earlier), and if ever (i.e., there is no touchstone event). See Table 4.1 Strategies for Accessing Touchstone Memory for a more extensive view of the differences and sequencing of these strategies.

**Case Example 4A: Betty**

Betty, a 55-year-old retiree, had been suffering with depression and low self-esteem after a long-drawn-out divorce from her husband of 36 years. She had great success with EMDR in the past, and she was determined to use it again to help with current relationship issues.

Betty wanted to be in a loving relationship. She thought it was a possibility after she had undergone the empowering effects of EMDR. Six months before coming back to therapy, Betty had met Richard, a wonderful man who was warm, compassionate, smart, and independent. She was comfortable with herself in this relationship.

Betty came into the session upset over an incident involving Richard. Both maintained separate residences and spent time away from each other with their own children and other family members. So, Betty had looked forward to spending time with him over the entire Labor Day weekend. When her companion left on Sunday morning instead of that night, she was devastated and could not understand why. She cried the entire day and was upset with herself.
### TABLE 4.1
Strategies for Accessing Touchstone Memory

Before proceeding to direct questioning, floatback, and affect scan (in this order), ensure that:
1. A recent incident, which represents the current difficulty, is identified.
2. An image (or picture) and negative cognition are identified.

#### DIRECT QUESTIONING

“When was the first time you remember feeling (thinking, reacting) that way?”
“When was the first time you heard (or learned) _____?”
“What incidents come to mind from childhood or adolescence?”

#### FLOATBACK TECHNIQUE
(POSITIVE COGNITION + EMOTIONS)

Use floatback if:
- Client is unable to identify the touchstone memory through direct questioning.
- The negative cognition is clear and identified as a relevant and important part of the client’s presenting issue.
- The present event is not fully accessible.
- Client demonstrates a higher level of negative affect.

**If the negative cognition is clear, the client focuses on the earliest memory identified in direct questioning, the negative cognition, and emotions associated with the event.**

“**Float back to the earliest time when you experienced these.**”

**If the client has difficulty focusing, say:**

“Bring up that negative belief and the emotions you are feeling now and let your mind float back to the earliest time when you may have felt this way and notice what comes to mind.”

#### AFFECT SCAN
(MOST RECENT MEMORY + EMOTIONS + PHYSICAL SENSATIONS)

Use affect scan if:
- Client is unable to identify the touchstone memory through the use of the floatback technique.
- Negative cognition is unclear and difficult to access. In this case, use the client’s current emotions and physical sensations as a bridge to the past; or

**If a touchstone is not identified using floatback, say:**

“Bring up that experience (i.e., the most recent memory identified in the floatback), the emotions, and the physical sensations that you are having now, and allow yourself to scan back for the earliest time you experienced something similar.”
This case will be utilized to demonstrate the use of direct questioning, floatback, and affect scan in identifying Betty’s touchstone event.

**Target:** Richard left rather than spend the day with me.

**Image/Worst Part:** Being in my empty house after he drove away.

**Negative Cognition (NC):** I am unimportant.

**Positive Cognition (PC):** I am important.

**Emotions:** Loneliness, sadness

**Body:** Throat, stomach

**Identifying the Touchstone Through Direct Questioning**

Because of Betty’s previous history in therapy, the clinician knew that this was not an isolated event and that there was an inherent relationship pattern that had been with Betty for most of her life. The clinician wanted to identify the earliest event that established the foundation for her current symptoms.

Here is how the **direct questioning** went:

**Clinician:** Are there earlier times in your life when you thought that you were unimportant?

**Betty:** Yes, I remember in college my dorm mates often excluded me from social events.

**Clinician:** Can you think of any other times when you thought that you were unimportant?

**Betty:** Yes, my father was rather distant. He never had much to say or do with me. Once he just looked at me and grunted.

**Clinician:** As you focus on that experience and the negative thoughts, are there any childhood memories that come up?

**Betty:** I remember waking up from an afternoon nap. I had had a nightmare. I was terribly afraid, so I ran to find my mom. I said, “Mommy, mommy, hold me. I’m scared.” My mother just looked at me and said, “Not now. I don’t have time for you right now, little missy.”

If the aforementioned touchstone had not been identified using direct questioning, the clinician may consider using the floatback technique.

**Identifying the Touchstone Event Using Floatback.** When implementing the floatback technique, the client is asked to repeat the **last** identified memory that was accessed from the direct questioning technique. For the purposes of demonstration, the clinician assumes that the earliest memory identified up to this point was the memory of her distant father just looking at her and grunting.
Clinician: As you focus on that event (incident, experience) and the negative thoughts, are there any earlier childhood memories that come up?

Betty: No, I can’t think of anything.

Clinician: Okay, now bring up that negative belief (i.e., ‘I am unimportant’) and the emotions you are feeling now and let your mind float back to the earliest time when you may have felt this way and just notice what comes to mind.

Betty: I remember waking up from an afternoon nap. I had had a nightmare. I was terribly afraid, so I ran to find my mom. I said, “Mommy, mommy, hold me. I’m scared.” My mother just looked at me and said, “Not now. I don’t have time for you right now, little missy.”

If, again, Betty had been unable to access an earlier or touchstone memory, the clinician could also explore family of origin issues at this point by asking, “Any incidents from your family of origin where the negative thought ‘I am unimportant’ come to mind?”

If the aforementioned touchstone had not been identified using the floatback technique, the clinician may consider utilizing the affect scan.

*Identifying the Touchstone Event Using Affect Scan*

If the client is still unable to identify an earlier memory, utilize the affect scan by incorporating the earliest memory already identified from the floatback technique. The affect scan can be used to access the touchstone event based on her emotional and physical sensations. Be sure to start by using the client’s earliest memory identified in the floatback. Again, the clinician assumes that the earliest memory identified up to this point was the memory of her distant father just looking at her and grunting.

Clinician: Bring up that event (incident, experience) (i.e., the earliest memory identified in the floatback), the emotions, and the sensations that you are having now, and allow yourself to scan back for the earliest time you experienced something similar.

Betty: I remember waking up from an afternoon nap. I had had a nightmare. I was terribly afraid, so I ran to find my mom. I said, “Mommy, mommy, hold me. I’m scared.” My mother just looked at me and said, “Not now. I don’t have time for you right now, little missy.”

Note that direct questioning was employed first to see if Betty could recall an earlier time in her life when she experienced similar thoughts of “I am unimportant.” It was only after it was determined that she could not that the floatback technique was utilized. Remember, floatback and affect scan may occasionally cause the client to experience high levels of emotions.
and body sensations that they might not be able to tolerate at the time. Use these two techniques cautiously.

It is not always necessary to have a negative cognition to identify a touchstone memory. If it cannot be accessed, you can use the affect scan “to use the sensations as a bridge to the past” (Shapiro, 2006a).

If appropriate, identify and reprocess the touchstone memory before continuing on with the processing of later past memories, present triggers, and future situations when using either direct questioning, floatback, or the affect scan. (Note: There is not always a touchstone memory to reprocess.) Once the memory has been accessed and it is determined that the client is ready to begin the reprocessing phases of treatment, use the procedural steps to complete the assessment using this identified earliest memory for processing (see Figure 4.4).

When the touchstone event and all the past events have been identified using the methods described earlier, they need to be targeted and

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**FIGURE 4.4** Past event: strategies for identifying the touchstone event.
Building Blocks of EMDR Therapy

reprocessed before continuing to the next prong. Once completed, the clinician then progresses to targeting and reprocessing the client’s present triggers and future templates.

**Touchstone Revisited**

Current EMDR Therapy training places a greater emphasis on identifying and targeting a touchstone event before reprocessing other memories that arise. However, the training focus in no way negates the importance of dealing with present issues as they arise. Be cautious about being overzealous in looking for these touchstone events. There may not be one, or it may not be significant enough (i.e., does not have sufficient emotional resonance) to utilize effectively. Sometimes, an orange is an orange. The clinician needs to be aware of the clinical choices (or trauma presentations listed earlier) in order to determine whether a client’s current focus needs to be on the present or the past. The appropriateness of the clinician’s recommendations will be apparent in light of the client’s presenting issues, current functioning (including affect tolerance), and history.

**SECOND PRONG: PRESENT EVENTS AND TRIGGERS**

The second step of the three-pronged protocol is identifying and reprocessing the present events and situations that continue to resonate with the presenting problem. In other words, identify all current situations, conditions, or people that (a) may be continuing to trigger the client’s current symptomology (i.e., inappropriate or negative emotions, physical sensations, beliefs, or behaviors); (b) continue to evoke avoidant or maladaptive behaviors or emotional disturbance; or (c) elicit physical sensations and urges that are residual sources of the same. These current situations are initially obtained during the early clinical intake interviews with the client; they may be added to after the past memories are successfully processed. The client should reprocess conditional responses, events, and other stimuli associated with the presenting problem using the standard EMDR protocol (i.e., Phases 3–6) with each present trigger followed by a related future template before moving on to the next present trigger.

**What to Look Out For**

When processing present disturbances, the clinician also attends to the following:

1. *Ecological validity:* Is the level of disturbance appropriate for the client’s circumstances? For example, the client states that she cannot reach a 0
or 1 on the Subjective Units of Disturbance (SUD) scale by saying, “I don’t ever want to forget that this happened.” This refers to a client, for example, who had a serious motor vehicle accident where someone in the other car died. She was no longer traumatized by the event. Her driving and ability to be a passenger had returned. Even though the accident was not her fault, the fact that someone had died as a result of the accident made her say that a 1 was enough. For her, there could not be a 0 level of disturbance for something that had such an impact on a family. Consider another example where a client is recovering from colon cancer. Currently, he is in remission with a good chance of long-term survival. However, in processing the diagnosis and the treatment, he was unable to reach a 0 SUD level. The cancer had totally changed his life, and it was impossible for him to say that the impact was totally over.

2. **Blocking beliefs**: Is there an inappropriate belief actively involved in the current disturbance? In an example of a domestic violence case, the client might be unable to reach a 0 on the SUD scale because of the emerging belief “I can’t let this go since I am not worthy enough to feel safe.”

3. **Peelback memories**: Did an earlier associated memory emerge? Even when targeting an obvious critical incident in the present, such as a rape, associations to earlier experiences may surface.

4. **Feeder memories**: Is an earlier memory feeding the underlying disturbance identified in a non-childhood target? For instance, a client is processing his most recent disturbing incident of being stuck in an elevator when a memory of being trapped in a closet that was being held shut by his older brother emerges. This is a memory that was not accessed during the History-Taking and Treatment Planning Phase or the reprocessing of past memories.

Comprehensive history taking prior to EMDR processing is helpful in identifying these types of beliefs and memories and curtailing stalled processing later on. If they do arise, use of the floatback technique or the affect scan can help identify the earlier memories.

Many of the triggers present at the beginning of EMDR Therapy will no longer exist once the touchstone and other past events have been identified and reprocessed. Current events or situations that previously induced a high level of disturbance may no longer cause the symptoms reported by the client in the past. The negative behaviors, emotions, sensations, and thoughts associated with the earlier events may have been flushed out and no longer accessible. The client’s present distress may have been resolved; and the trauma can now be considered a learning experience, rather than something to be looked on with dread.

In this case, these triggers do not continue to cause any symptoms because the negative emotions, sensations, thoughts, and behaviors associated with the traumatic event are no longer stored in the memory network.
The current stress caused by the trauma has been transformed into a learning experience.

Some triggers may still be active due to second-order conditioning (see below). Two things may be happening: (a) The previously targeted distress may have sensitized numerous existing stimuli in the present that have become independently disturbing; and (b) another previously unaccessed memory network may be activated by the distress. The generalization effect did not resolve everything; and, hence, these triggers will need to be accessed and targeted separately in order to reach resolution (Shapiro, 2009–2014).

In this part of the process, the clinician has the client access a recent event so that the level of disturbance, if any, can be evaluated: “Bring up the last time you remember feeling/behaving _____ (fill in the blank).” If there is still disturbance, implement Phases 3 to 6.

**How Can Triggers Remain Active After So Much Processing?**

There are at least three reasons why some present triggers may be active after all past events have been reprocessed:

1. Second-order conditioning: Second-order conditioning refers to a conditioned stress response created as a result of past distress being repeated in the presence of certain situations. In the case of a process phobia called cyberphobia (i.e., fear of computers or working on a computer), for example, there could be additional stimuli that need to be processed separately because of unrelated circumstances or events that may trigger the fear. In this case, the client may become frightened on hearing that his young child is learning to use the computer in school, his wife has signed up for a computer class to learn word processing, or his older daughter is begging for a laptop of her own.

2. Fed by information left over from earlier events: This information was not processed because every channel of association has not been cleared.

3. Recent situations may have occurred where the emotions and perceptions are different than the earlier event: These triggers are freshly charged by recent events and have been stored in memory along with other emotions and perceptions that are different from those in previously processed events.

Each trigger will need to be assessed and reprocessed, and then a future template can be performed on a related future challenge prior to reprocessing the next present trigger. The clinician will need to direct the client in assessing recent events that were originally distressing and then determine whether the events are still disturbing. An instruction may be, “Bring up the last time you remember feeling/behaving _____ (fill in the blank).” “What do you get?” If a disturbance is still present, the clinician will reprocess each
event identified. The recent event or trigger will be reprocessed until SUD = 0, VoC = 7, and the body scan is clear. A future template is then installed for each trigger by imagining an encounter with the situation sometime in the future or reprocessing anticipatory anxieties about such an encounter.

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**Case Example 4B: Peter**

Peter, a proud military person who served his country voluntarily and honorably, was back from his second tour of duty in South Asia. His wife and he presented initially for couples counseling, but it quickly became clear that Peter needed individual work. All efforts at marital counseling were suspended, and Peter came to therapy for his individual issues. Peter worked for weeks on both early childhood and war experiences so that he could successfully navigate his civilian world. He was eating and sleeping better, his irritability had almost completely abated, and his marriage was beginning to flourish.

Certain things still triggered him, however, such as loud noises, gun shots, flashes of light of any kind, and construction zones. With these in mind, the clinician and Peter set out to process his startle responses to these external triggers. The following is Peter’s session.

**Assessment**

*Target:* Peter lives in hunting country and had been bird hunting many times before the war without much attention to the sounds of guns shooting around him. “Bird shot,” he said, “is so heavy that it does not travel far nor can it do much damage at large distances.” *While he was in therapy, he happened to go hunting with his friends.* During the hunt, someone fired in his general direction—not an uncommon event—and the shot exploded yards before him. “I hit the ground,” he said. “I thought I was going to die.”

*Image/Worst part:* The worst part was the sound of the bird shot coming toward him.

*NC:* I’m in danger.

*PC:* It’s over. I’m safe now.

*VoC:* 2

*Emotions:* Anger, fear, irritation

*SUD:* 8

*Body:* Chest
Desensitization

Clinician: Bring up the sound, those words, “I’m in danger,” and where you feel it in your body. Just let it go wherever it goes. Just let whatever happens, happen. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What comes up for you now?

Notice the change in the language in the discussion. The client reported a sound rather than an image (or picture) as the worst part.

Peter: Am I doing this right?

It is not unusual for clients to question before, during, and after EMDR processing whether or not they are “doing it right.” These are common questions: What if I don’t do it right? Am I doing it right?

Clinician: There is no right or wrong way to do EMDR processing. Everyone does it differently. Just trust the process and let happen whatever happens. Go with that. (Set of BLS) Good. You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Peter: Okay. I feel my chest tightening up.

It is important for the clinician to maintain neutrality throughout the client’s reprocessing.

Clinician: Go with that. (Set of BLS) Good. Good. Take a breath. (Pause) Let it go. What’s happening now?

Take a breath with the client to model how it is done. Otherwise, many clients may not fully inhale and exhale. Modeling complete inhalations and exhalations for the client facilitates his reprocessing of the trauma. Breathing is an important component of the reprocessing of traumatic memories as it inherently enables the client to let go of the negative sludge that has been laying stagnant in the client’s system. However, the clinician should not take this too far. Guiding the client in breathing exercises during reprocessing may interfere with sufficient access to the memory for successful reprocessing.

Peter: No change. I feel it in my chest.

Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Peter: It has moved to my stomach.

Clinician: Go with that. (Set of BLS) Good. You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What are you noticing now?
Peter: It feels like it is moving just above my legs.

Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What’s happening now?

Peter: I’m feeling pretty good.

Clinician: Go with that. (Set of BLS) Let it go. Take a breath. (Pause) Let it go. (Pause) What do you get now?

Peter: It’s about the same.

Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What are you getting now?

Notice that the clinician encourages the client throughout the process.

Peter: I’m safe now. It’s over.

Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Peter: It’s the same.

Clinician: When you go back to the original event (incident, experience), what are you getting now?

(Reminder: Original event [incident, experience]—the recent experience of hunting where someone fired in his general direction.)

Peter: I’m feeling real relaxed.

Clinician: Go with that. (Set of BLS) Good. Good. Take a breath. (Pause) Let it go. (Pause) What comes up for you now?

Peter: I’m not feeling anything.

Clinician: What does “I’m not feeling anything” mean?

The clinician is asking this question because she is unclear about what is happening. This could be a sign of dissociation, or it could represent completed reprocessing of this particular channel of association (i.e., nothing simply means nothing).

Peter: I feel kind of numb.

Clinician: What does numb mean?

Client: I don’t feel anything.

Again, the clinician attempts to discern whether the client is stuck, dissociating, or if processing of this channel of association is complete.
Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Peter: I am getting tingly all over.

Clinician: Notice that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Peter: There’s something in my head. I don’t know what it is. It’s not a headache. It’s numbness. I can’t describe it. I don’t hurt. I can just feel something going on.

Clinician: Go with that. (Set of BLS) You’re doing fine. Take a breath. (Pause) Let it go. What are you getting now?

Peter: Nothing.

Clinician: What does “nothing” mean?


Clinician: Go with that. (Set of BLS) Good. Good. Take a breath. (Pause) Let it go. (Pause) What are you getting now?

Peter: It’s the same. I feel good. Still relaxed. Still good.

Clinician: When you go back to the original event (incident, experience), what are you getting now?

Peter: It’s over. I am safe.

Clinician: Go with that. (Set of BLS) Good. Good. Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Peter: I feel safe.

Clinician: When you focus on the original event (incident, experience), on a scale from 0 to 10 where 0 is neutral or no disturbance and 10 is the worst disturbance you can imagine, how disturbing is the event (incident, experience) to you now?

Peter: One.

Clinician: What prevents (keeps) it from being a zero?

If a blocking belief emerges, and depending at which phase it appears, it is reprocessed with bilateral stimulation until SUD = 0, VoC = 7, or body scan is clear. The clinician also needs to consider any new skills needed by the client and ecological validity when dealing with blocking beliefs.

With clients who have issues with numbers and/or perfection, a clinician may say instead, “What makes it ____? (1 or 2)” or “Is it better or worse?” It is important to be flexible.

Peter: My knowing that I’m going to get mad if it happens again. My believing that my body will react.
Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What’s happening now?

Peter: I’m really relaxed.

Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Peter: I am still relaxed.

Remember that one criterion for returning to target is for the client to provide at least two neutral or positive responses.

Clinician: Focus on the original event (incident, experience) and tell me what comes up. What comes up for you now?

(Reminder: Original event [incident, experience]—the recent hunting experience when someone fired in his general direction.)

Peter: Nothing.

Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What’s happening now?

Peter: I am as relaxed as I have ever been.

Clinician: When you focus on the original event (incident, experience), on a scale from 0 to 10 where 0 is neutral or no disturbance and 10 is the worst disturbance you can imagine, how disturbing is the event (incident, experience) to you now?

Peter: Zero.

Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) How disturbing does it feel now?

Peter: Zero still.

Installation

Clinician: Focus on the original event (incident, experience). Do those words, “It’s over. I’m safe now” still fit, or is there another positive statement you feel would be more suitable?

Peter: Yeah. It’s over. I am safe now.

Clinician: When you focus on the original event (incident, experience), how true do those words, “It’s over. I’m safe now,” feel to you now on a scale from 1 to 7 where 1 feels completely false and 7 feels completely true?
Peter: Seven.

Clinician: Focus on the original event (incident, experience) and hold it together with the words, “It’s over. I’m safe now.” (Set of BLS) Take a breath. (Pause) Let it go. (Pause) On a scale of 1 to 7, how true do those words, “It’s over. I’m safe now,” feel to you when you focus on the original event (or experience)?

Peter: It’s still a 7. I feel relieved.

Body Scan

Clinician: Close your eyes and focus on the original event (incident, experience) and those words, “It’s over. I’m safe now.” Scan your body from head to toe for physical discomfort. If you feel anything, let me know.

(Reminder: Original event [incident, experience]—the recent experience of hunting where someone fired in his general direction.)

Peter: It’s a void. Relief. It’s like I kicked something out. There is space for something else now.

Clinician: Go with that. (Set of BLS) You’re doing fine. Take a breath. (Pause) Let it go. (Pause). What are you getting now?

Peter: Nothing.

Clinician: Peter, what does “nothing” mean?

Peter: I’m good. I feel great.

Clinician: Go with that. (Set of BLS) You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Peter: I’m good.

Closure

Clinician: The processing we have done today may continue after the session. You may or may not notice new insights, thoughts, memories, or dreams. If so, just notice what you are experiencing. Take a snapshot of what you are seeing, feeling, thinking, and any triggers, and keep a TICES log. Then do a Calm (Safe) Place exercise to rid yourself of the disturbance. We can work on this new material next time. If you feel it is necessary, you may call me.

Peter came back the next week impressed with his progress. He stated that his startle response was “back to normal.” He said, “I don’t seem to be as
jumpy as I was before. I’m home. I am happy, and I just want to get on with my life.” The clinician would then suggest using the Future Template to help Peter to do just that. They would likely use the next time he is going hunting or hears “bird shot” as the similar future situation.

**Present Triggers Subsumed by the Reprocessing of the Touchstone Event**

As a client reprocesses triggers, other reported triggers may dissipate. There are times when a client’s present triggers are cleared by simply reprocessing earlier or touchstone memories. So, when the clinician revisits the presenting problem, the triggers often no longer exist.

An example of this is Yolanda, a client who experienced extreme fear whenever her boss asked to see her. “Whenever I stood before him, I felt like a 7-year-old who was in trouble. I never could shake the fear of it. The minute I would get an e-mail or a telephone call requesting my presence, I could immediately feel myself shrinking. By the time I got to his office, I was a mess. I just knew I had done something wrong. I had screwed up.”

During the initial history-taking interview, the client shared with the clinician that, whenever she misbehaved at home, her mother always said, “Wait until your father gets home.” Her dad never really talked to or played with her; so, when he called for her, she knew she was in trouble. This was a ubiquitous (i.e., constantly encountered) touchstone event. She could not recall one particular incident, because there were so many. They were similar in that she would shrink inside the second her dad called for her. She knew the reason he was summoning her could not be good and that consequences for her ill behavior would be worse.

After the original event (incident, experience) had been fully processed, the clinician went back to the event that brought her to counseling in the first place so that she could process the present triggers. It turned out to be no longer relevant, as it had been fully resolved by processing the touchstone events. The processing of the earlier events had turned the current difficulty into an important learning experience.

**THIRD PRONG: FUTURE EVENTS AND FUTURE TEMPLATES**

A future (or positive) template is utilized as a means of addressing avoidance, adaptation, and actualization within the EMDR process (Shapiro, 2001). The third prong of the approach focuses on a client’s ability to identify and make choices and utilizes a protocol for developing a future, positive template that will help the client to incorporate appropriate future behaviors. The clinician will apply a future template for each trigger identified by the client. Some clinicians may reprocess all the present triggers before working with future templates, while others create a future/positive
template following the reprocessing of a present trigger, and then process
the next present trigger.

**Goals of the Future Template**

The goals of creating a future template are diverse: (a) to provide the client
time to practice or rehearse a behavior (i.e., imaginal/behavioral rehearsal)
or to develop a desired action plan or skill building for an actual event in
the future before going out into the world (i.e., *in vivo*) or that is adaptive
to the client’s current life context; (b) to identify and reprocess residual or
anticipatory anxiety; (c) to provide another opportunity to reveal the cli-
ent’s hidden negative beliefs, fears, and/or inappropriate responses; and
(d) to strengthen any adaptive skills, behaviors, and/or emotional or sensory
responses that have emerged or developed in the client’s memory system.

There are three types of future templates with distinct goals. The first
type is the third prong of reprocessing when the past trauma and pres-
ent triggers have all been cleared, and the goal is to take the new learning
into future situations. It is uncomplicated and straightforward, following
the future template procedure and using long and faster sets of BLS. The
second, future rehearsal, is a skills-building and imaginal rehearsal future
template that helps a client develop a repertoire of skills and strengthen
his confidence. This is often done before all targets have been reprocessed
and follows the resource development protocols more closely, using short
and slower BLS. The third addresses anticipatory anxiety and the explora-
tion of new and more adaptive patterns of behavior. Future anxieties are
considered to be “flash forwards” and are addressed using the standard
protocol for present triggers. The ultimate outcome of the third prong is
to assure that the client has assimilated new information, including real
or imaginal experiences of adaptive functioning, which may translate to
future successes.

**Skills Building and Imaginal Rehearsal**

For this type of future template, the clinician does not need to implement
a full assessment of the target. He can start with simply having the client
imagine the anticipated event in his mind. For example, if a client repro-
cessed memories involving a significant person or a significant situation in
the past, she would be asked to imagine a future meeting with the person
or future situation to see if further disturbances arise. If a disturbance does
arise, it could be dealt with by several interventions (e.g., education, model-
ing of appropriate behaviors, assertiveness training, exploration of bound-
aries, and reprocessing of the disturbing material). If a client’s disturbance
is inappropriate, clusters of events are evaluated for unresolved issues. See
Figure C.1 in the appendices for the steps to these important processes.
Steps Needed Prior to Creating a Positive Template

Before a future template can be installed, it is necessary that the earlier memories that set the groundwork for the client’s presenting problem/issue and present stimuli that elicit dysfunctional material be successfully reprocessed and education and/or skills training (e.g., assertiveness training or social customs and norms awareness) be initiated. In addition, a full exploration is undertaken to examine how a client wishes to perceive, feel, act, or believe in the present and in the future.

Here are the steps that are completed prior to creating a positive template:

1. Resolve earlier memories and present triggers, internal and external.
2. Explore how the client sees herself in the future in terms of thinking, feeling, perceiving, acting, and believing.
3. Identify and teach appropriate skills, such as assertiveness training, social skills, and mindful behavior.
4. Refer for nonpsychological skills (i.e., computer classes, public speaking).
5. Identify anticipated future stressors that emerge during the reprocessing of past and present events.
6. Use future template following the successful reprocessing of each present trigger.

Once the steps outlined in Figure C.1 have been completed, the clinician may say to the client, “We have worked on past experiences in relation to your presenting problems, as well as present situations that have triggered your distress. Today, I would like to suggest that we work on how you will respond in the future to similar situations.” This refers to the last trigger that the client processed. See Figure C.2 in the Appendices for the progression of the future template.

Procedural Steps for Installing Future Templates: Desired Outcomes and Problem-Solving Situations (Shapiro, 2009–2014)

Desired Outcomes

The clinician introduces the concept of a future template to the client:

We have worked on the past experiences relating to your issue, as well as the current situations that triggered your distress. Let’s now work on how you would like to be able to respond to similar situations in the future.

This has to be carefully worded in some situations (Shapiro, 2009–2014). For example, if the client is in treatment for grief following the
death of a child, the clinician might alter the wording to say “Now let’s work on how you’d be able to respond in the future when you might experience a loss.”

The clinician instructs the client to identify a future situation (i.e., recent experience or present trigger) in which he would like a more adaptive response:

Identify a future situation and a positive belief you would like to have about yourself in the future.

The clinician instructs the client to run the movie:

While holding the positive belief about yourself in mind, run the movie of the situation as you would like to be able to respond, from beginning to end. Let me know if there is any part or parts of the movie that are uncomfortable or challenging.

There is no bilateral stimulation implemented at this point. After a short pause, ask the client, “What are you noticing now?” Then proceed accordingly:

1. If his response is positive, instruct the client to run a movie of his adaptive responses and add bilateral stimulation as long as his response(s) continues to be positive.

2. If his response is neutral, ask the client for clarification (such as lack of familiarity or need for a plan) and generate with the client his desired response. Run a movie of his desired response. Once it has been obtained, add sets of BLS until he has a positive response.

3. If the response is negative, instruct the client to focus on body sensations and add additional BLS until his response is neutral. Elicit his desired response and instruct him to run a movie with sets of BLS until his response is positive. If negative associations arise, these may need to be reprocessed.

Once a positive response has been elicited from the client, the clinician couples the future situation with his positive cognition. “Hold those words _____ (repeat client’s positive cognition) with that situation. On a scale from 1 to 7, how true does it feel now?” The clinician continues to install additional sets of BLS until the VoC = 7.
Problem-Solving Situations

In this case, the clinician instructs the client to create a problem-solving situation based on a recently processed trigger:

I’d like you to think of some challenge you may experience in this situation.

There is no bilateral stimulation implemented at this point. After a short pause, ask the client,

What are you noticing now?

Then proceed accordingly:

1. If her response is positive, add BLS as long as additional positives are being reported by the client.
2. If her response is negative, instruct the client to focus on body sensations and add additional BLS until any reported physical sensations are eliminated.

Once positive responses have been elicited from the client, the clinician couples the situation with the client’s positive cognition:

Hold those words _____ (repeat client’s positive cognition) with that situation. On a scale from 1 to 7, how true does it feel now?

The clinician continues to install additional sets of BLS until the VoC = 7.

Third Prong: Misunderstood, Disregarded, and Forgotten

The third prong of the EMDR approach is probably the most misunderstood and, often, most disregarded for clinicians who are new to EMDR Therapy. One of the reasons may be that the client is often surprised to see what progress can be made so quickly in the first and second prongs of the approach that the response to future events gets lost. As a clinician, it is important to stay focused and to ensure that all three prongs of the approach are adequately and successfully processed before termination.

If there is hesitancy by the client in approaching the future template, it may be an indicator of incomplete processing of past issues, present triggers, or secondary gain issues. If a feeder or earlier memory arises, he may find it necessary to process the contributing event and stimuli before continuing. In either case, provide needed education and assist in reprocessing these memories before the installation of a future template. The future (or positive) template may be thought of as a continuation of the Installation Phase of the EMDR procedural steps. See Table 4.2 with some instructions and cautions when dealing with issues of anticipatory anxiety.
If a client’s presenting issues encompass memories of significant people, places, or situations, the client could be asked to imagine herself with that person, that place, or that situation. Unresolved materials may need to be accessed and resolved, clusters of events reevaluated, residual dysfunctional memories targeted and reprocessed, assertiveness or boundary setting explored and retargeted, or use of a positive template employed to assimilate the newly uncovered information and to help the client identify appropriate adaptive behaviors. The focus on the third prong assures the incorporation of new and appropriate future actions or behaviors and is vital to the client’s continued movement toward adaptive resolution.

Again, each trigger identified in the present prong needs a future template. This process may be part of one session, or it may span many sessions depending on time and number of present triggers. Even though some triggers are neutral after a client processes past events (i.e., VoC = 7) and the trigger does not have to be processed utilizing Phases 3 to 6, the use of a future template for those triggers may still be helpful.

To reiterate, there are three basic types of future templates. One simply takes the positive cognition or new learning into a future situation and strengthens it using the future template procedure. Another addresses anticipatory anxiety, which is reprocessed using the 11-step standard EMDR procedure (i.e., image or picture, NC, PC, VoC, emotion, SUD level, location of body sensation, desensitization, installation, body scan, and closure). The third uses skills building and imaginal rehearsal, which does not require a full Phase 3 Assessment.

**TABLE 4.2**

**Anticipatory Anxiety**

<table>
<thead>
<tr>
<th>KEY POINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Like traumatic and other adverse life events, anticipatory anxiety (i.e., a present anxiety about the future or a “flash forward”) may be addressed according to the standard EMDR protocol (i.e., Phases 3–6). To proceed with the reprocessing, the SUD level is likely to be no higher than 3–4. If the SUD is higher than 3–4, the clinician will need to retarget feeder memories or present triggers. In dealing with anticipatory anxiety, the Desensitization Phase should be brief. If it is not and the SUD level is above 4, then the three-pronged reprocessing approach (past, present, and future) will need to be reimplemented.</td>
</tr>
</tbody>
</table>

With skills building and imaginal rehearsal, the client imagines an adaptive response in the future to a previously disturbing person, place, or thing, uncomfortable situation or circumstance, and/or doing a particularly upsetting future action. It is like “running a movie” of a potentially disturbing or upsetting action or event and the optimal behavioral responses to it. Positive
beliefs and sensations are identified, and an enhancing positive cognition is incorporated. The clinician leads the client in successive sets of bilateral stimulation as a means of assimilating information and incorporating it into a positive template for future action. During this imaginal rehearsal, residual negative beliefs or sensations are identified and reprocessed as needed.

The clinician may also want to consider doing a brief future rehearsal each and every time the client has a reprocessing session, regardless of whether it is complete or not, especially if a client’s focus is on performance issues or anticipated events. For example, if a client hesitates during a reprocessing session on a different issue because he fears he is “doing it wrong,” a short future rehearsal at the end of the session may focus on the client “doing it right.” Or, with someone having immediate performance issues at school but is working on a past event that precipitated the anxiety, he may need a few moments at the end of the session to focus on further developing his repertoire of skills of enhancing his confidence by rehearsing future situations.

Future Template—Examples

**Case Example 4C: Michael**

When leaving work, Michael remembered that he needed to buy a gallon of milk before going home. As he turned a corner to make his way to the grocery store, a young boy ran in front of his car. Michael stomped on his brakes and swerved dramatically to the right, but he could not stop his car before grazing the child. The little boy suffered a broken leg and was taken by ambulance to the hospital. This was a single-event trauma. Nothing in Michael’s life compared to the look on the little boy’s face just before he was hit. It took several sessions of reprocessing to alleviate his suffering from the memory.

During previous therapy sessions, the clinician and Michael had successfully processed several current triggers, including his driving anxiety and driving around dusk, the time of day when the accident occurred. Michael also had a dread of encountering the little boy’s parents, such as at church or at the mall. The future template script developed by Dr. Shapiro (2009–2014) will be utilized to create a future template for Michael regarding his anxiety around driving at dusk and his dread of unexpectedly encountering the parents.

Michael needed to be self-empowered, so the clinician elected to help him develop a positive template around the potential events. Driving at dusk (i.e., desired outcome) and potentially encountering the boy’s parents
(i.e., problem-solving situation) were challenging future templates. These sessions proceeded as follows:

**Desired Outcome**

**Trigger:** Fear of driving at dusk.

**Positive Cognition:** I am safe.

**Future Template:** Driving at dusk.

**Clinician:** We have worked on the accident as well as present situations that have triggered your distress. Now let’s work on how you would like to be able to respond to similar situations in the future.

**Michael:** Okay.

**Clinician:** Identify a future situation and a positive belief (PC) you would like to have about yourself in that situation.

**Michael:** Driving at dusk still scares me. I guess I would have to say I want to believe, I am safely in control.

The client has identified a situation and a positive belief he would like to have a positive response to in the future.

**Clinician:** While holding the positive belief about yourself in mind, run the movie of the situation as you would like to be able to respond from beginning to end. Let me know if there are any parts of the movie that are uncomfortable or challenging.

**Michael:** I can feel myself getting anxious, and my chest feels tight as I imagine driving at dusk in particular.

Michael’s response is negative, so the clinician asks him to focus on his body sensations. Sets of bilateral stimulation are added until Michael reports a neutral response. (Note that, if the client’s response is neutral or positive, other strategies are available [see Appendix C].)

**Clinician:** Focus on your body sensations. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

If the client continues to report negative responses, the clinician may elicit a desired response from the client utilizing bilateral stimulation, introduction of new information, new skills or resources, and the use of direct questioning, floatback, or affect scan.
Michael: I can feel my chest tighten up, and I am having difficulty breathing.
Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What’s happening now?
Michael: It’s the same. I just can’t seem to breathe.

Even at this stage, a new level of association may emerge; and the client may need to return to reprocessing.

Clinician: Are there other times in your life when you remember feeling this way?

The clinician uses direct questioning as a means of eliciting a desired response from the client.

Michael: Now that I think about it, I have always had a difficult time driving at dusk, especially in heavy traffic or driving toward the sun. It’s like my eyes cannot adjust. It’s anxiety-provoking for me much of the time.
Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What’s happening now?
Michael: I feel calm, relaxed, and confident. Up to the point of the accident, nothing bad ever happened. I always managed to negotiate the traffic despite the adverse elements.
Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?
Michael: I am picturing myself driving down the road and dusk is just beginning to set in. I am feeling even more relaxed.

The clinician will add additional sets of bilateral stimulation as long as the client continues to report additional positives.

Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?
Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?
Michael: It’s the same. I feel good. I am picturing driving at dusk in heavy traffic and feeling relaxed, calm, and confident. My chest continues to feel relaxed.

Now that the client’s response continues to be positive, the clinician will pair the future template with the positive cognition the client formulated in
assessing the trigger of driving at dusk. Install using bilateral stimulation until VoC = 7.

Clinician: Hold your positive belief (i.e., “I am safely in control”) with that situation. On a scale from 1 to 7, how true does it feel now?

Michael: It’s six and three quarters.

Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) How true does it feel now?

Michael: It really high. I would say it’s a seven. I always have some control.

Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) How true does it feel now?

Michael: It is a seven.

Clinician: Hold your positive belief (i.e., “I am safely in control”) with that situation. On a scale from 1 to 7, how true does it feel now?

Michael: Still a seven.

Clinician: The processing we have done today may continue after the session. You may or may not notice new insights, thoughts, memories, or dreams. If so, just notice what you are experiencing. Take a snapshot of what you are seeing, feeling, thinking, and any triggers, and keep a TICES log. You can also use your Safe (Calm) Place exercise to rid yourself of the disturbance. We can work on this new material next time. If you feel it is necessary, you may call me.

Problem-Solving Situation

Trigger: Dread of encountering the little boy’s parents.

Positive Cognition: I have some control.

Future Template: Encountering the little boy’s parents.

Clinician: We have worked on the accident as well as present situations that have triggered your distress. Now let’s work on how you would like to be able to respond to possible situations connected to the incident in the future.

Michael: Okay.

Clinician: I’d like you to think of some challenge you may experience around this situation.

Michael: Okay.

Clinician: What are you noticing?
Michael: This has been a fear of mine since the accident. I just think it’s inevitable that I will run into them some day. It makes me sick to think about it.

The client’s response is negative, so the next step is for the clinician to ask the client to focus on any body sensations he may be having and to add bilateral stimulation until the sensations dissipate.

Clinician: What are you noticing in your body?

Michael: My stomach feels so queasy, and my chest aches.

Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Michael: The sensations in my stomach and chest have eased somewhat, but I feel more anxious.

Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Michael: I am starting to get some relief.

Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Michael: It has eased. I imagined passing them while driving in my car. They just looked at me. There was no expression good or bad in their faces.

Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Michael: It’s good. My chest stopped aching, and my stomach feels normal. I can imagine meeting them without feeling the anxiety I felt before.

The clinician may throw in a challenge.

Clinician: What if it doesn’t go as you imagined? Do you have a plan?

Michael: Oh my. That makes me a bit nervous.

Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Michael: If I see them, I will put all my nervous thoughts in a container; or I will take breaths and, maybe, turn up the volume on my radio.

Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Michael: That makes it better. If they don’t respond in a nice way, I can just turn away. I don’t want to make them uncomfortable either. And, besides, it
turned out alright. Their son is okay. His leg did heal. I heard he was playing soccer again on his team.

**Clinician:** Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

**Michael:** I feel at ease. It will be okay if I run into them. I can handle it.

The clinician will add additional sets of bilateral stimulation as long as the client continues to report additional positives.

**Clinician:** Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

**Michael:** Since it’s all over, I could even contact them to see how he’s doing. That would feel much better than avoiding them!

**Clinician:** Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

**Michael:** I feel really good about it.

Now that the client’s response continues to be positive, the clinician will pair the future template with the positive cognition the client formulated in assessing the trigger of driving at dusk. Install using bilateral stimulation until VoC=7.

**Clinician:** Hold your positive belief (“I have some control”) with that situation. On a scale from 1 to 7, how true does it feel now?

**Michael:** It’s totally true. Seven.

**Clinician:** Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) How true does it feel now?

**Michael:** Seven.

**Clinician:** Are there important things from today that you want to remember?

**Michael:** That for me the war is over. I am safe now and free to enjoy my life with my family.

Regardless of whether a session is complete or incomplete, the clinician may use intermediate gains, what the client has learned during the session, and strengthen it with a future resource.

**Clinician:** The processing we have done today may continue after the session. You may or may not notice new insights, thoughts, memories, or dreams. If so, just notice what you are experiencing. Take a snapshot of what you are seeing, feeling, thinking, and any triggers, and keep a TICES
log. Then perform a Safe/Calm Place exercise to rid yourself of the disturbance. We can work on this new material next time. If you feel it is necessary, you may call me.

**Modifications of the Three-Pronged Approach**

In most clinical presentations, the three-pronged approach will be applied (Shapiro, 2009–2014). However, in some cases, the clinician may begin EMDR treatment by processing a recent past memory (i.e., secondary trauma) rather than a more pervasive early childhood experience that was uncovered in the history-taking process. This situation occurs when a client presents with intrusive symptoms that have arisen as a result of an event in a client’s recent past (e.g., military combat, accident, injury, and illness) and appears to be unrelated to the early childhood experiences identified in the History-Taking and Treatment Planning Phase. For instance, despite a client’s violent history of early childhood sexual and physical abuse, the intrusive symptoms occurring in the present may need to be resolved before reprocessing the abuse memories if possible. In this case, the clinician may target the more recent experiences in order to stabilize the client for future processing of earlier events.

If the client lacks confidence in herself or EMDR Therapy, presents with a diffuse clinical picture (i.e., earlier experiences are global, difficult to identify, or ubiquitous), or appears unstable in terms of her current psychosocial functioning or affect tolerance, the clinician may also consider modifying the three-pronged approach to meet the client’s current clinical demands. The client may present with a desire for symptom reduction or changes that may require a more comprehensive treatment plan. The client may enter therapy with the intention of working on a specific issue or memory (e.g., fear of flying). The clinician should explain to the client that other memories may emerge during processing. The clinician and the client should determine in advance a strategy to be used in the event that this occurs, including continuing or putting disturbing material in a container.

Another example of when to sidestep the typical three-pronged processing sequence is when a client is constantly triggered by external events. In this case, the client may need to focus on present triggers to achieve some level of stabilization before past events may be targeted.

**SUMMARY STATEMENTS**

1. There are three prongs to the EMDR Therapy approach—past, present, and future.
2. Three primary strategies can be used to access the touchstone event—direct questioning, floatback technique, and affect scan.
3. A touchstone event from childhood does not always exist.
4. A future template should be installed for each trigger identified in the treatment planning process or in the course of treatment.
5. The three-pronged protocol may be modified to meet a client’s current clinical demands.
Chapter 5

Abreactions, Blocked Processing, and Cognitive Interweaves

Healing is a matter of time, but it is sometimes also a matter of opportunity.
—Hippocrates

WHEN THE ENGINE HAS STALLED

Stalled Processing

Many Eye Movement Desensitization and Reprocessing (EMDR) clients process in a straightforward manner with few, if any, direct therapeutic interventions on the part of the clinician. For others, however, processing to completion without any additional interventions is unlikely. The reasons for blocked processing are varied and multifaceted. The question then becomes: How can the clinician facilitate the client’s spontaneous movement toward an adaptive resolution?

This chapter explores guidelines for facilitating abreactions, strategies for blocked processing, and applying more proactive interventions for achieving full treatment effect. To the degree possible, these interventions are intended to mimic a natural progression toward resolution. Clinicians who are trained in EMDR Therapy are already familiar with many of the strategies included in this chapter, particularly the strategies for clients who present with affect regulation difficulties or with complex trauma. Clinical supervision and/or consultation in these cases are always recommended.

In this chapter, three types of client responses—normal, overaccessing, and underaccessing—and strategies the clinician can apply when the client displays either low or high levels of emotions and/or blocked processing are explored.
Later in the chapter, a new and improved categorization of cognitive interweaves is presented (Laliotis & Korn, 2015) which outlines for the clinician a more systematic approach on how and when to intervene during the processing. These categories identify specific actions the clinician may take using the eight types of interweaves to help facilitate effective processing, particularly for more traumatized clients.

**ABREACTION**

**What Is It?**

For ancient Greek dramatists, the term *abreaction* was used to describe the purging effect that the release of emotion provides. It is a flow of intense emotions with the overall effect of releasing high levels of affect (Jackson, 1999). The meaning of abreaction has not changed much in the ensuing millennia. In today’s world of clinical psychology, it continues to represent a verbal and often emotional and physical expression or discharge of affect. From a psychoanalytic perspective, abreaction involves releasing emotional tension achieved through recalling a repressed traumatic experience.

In EMDR Therapy, conscious and unconscious material is stimulated in the memory network, and the client reexperiences the emotions in the same or reminiscent fashion of how she experienced the original incident or experience (i.e., at a high level of disturbance). At other times, a client may experience her reactions to a particular event in a way she was unable to at the time it actually occurred. For example, a client who had been physically restrained, frozen in her response, can experience for the first time her reaction to the event by experiencing emotions such as anger and hurt as well as the fear and anxiety she felt at the time. Conversely, during traditional talk therapy, a clinician will offer a holding environment where he witnesses, reassures, and expresses empathy for the client as she experiences emotions in the present related to past events. In EMDR Therapy, while the clinician is also providing that holding environment, it is the client’s own brain that is reprocessing the past experience with all the current information that was unavailable at the time of the event, thereby transmuting the way the memory is actually stored in the brain. The client never has to reexperience the event in the same way because the arousal has been released, and the memory is now stored with all the information that is currently available.

Although abreaction is an integral part of the healing process for many clients, it can also be challenging as it requires the client to allow difficult emotions in the context of a disturbing experience or set of experiences. The clinician’s role is to help the client tolerate the emotional distress while maintaining dual awareness of the present moment in order to facilitate a full reprocessing effect and effective resolution of experience.
Preparing the Client for Abreactions

During the Preparation Phase, it is very important that the client be made aware that abreactions or high levels of emotional distress may occur during the session and that: (a) it is a normal phenomenon in EMDR processing; (b) the clinician will be there to help him through it; and (c) once the client is on the other side of an abreaction, and, assuming there are no undiscovered pockets of dissociation, the symptoms will abate or disappear altogether. Before any reprocessing is initiated, the client will be reminded that he is in control of his experience in the present (unlike the past). There are ways in which he can maintain some distance from the experience, including: (a) imagining being on a train and allowing the vivid images to be scenery that passes by; (b) imagining watching a DVD and using his mental remote control; or (c) placing a thick protective glass between himself and the perpetrator. At the beginning of a session, the client is reminded that he has a stop signal that he can use, should he need it.

What Happens When a Client Abreacts?

There are many ways in which a client can abreact. If a client’s original trauma consisted of a near drowning, she may find it difficult to breathe or catch her breath in the present. If she was being chased in the woods by a perpetrator, her breath may rise and fall rapidly and inconsistently. If a client had been grabbed roughly and slapped sharply during the targeted abuse, the actual marks made by the hands of the abuser may appear on his face or arm. If the client is a war veteran, he can mimic the self-protective maneuvers that he used to protect himself when he was attacked. Clients may gasp, scream, shake, sob, choke, or cringe. When this occurs, the clinician gently encourages the client to allow for the completion of the experience, supporting the client through his reaction while simultaneously helping him maintain dual awareness until it is over and completely in the past.

From an information processing perspective, when a client experiences strong emotional responses during reprocessing, it is information being released. So, if a client is crying during reprocessing, let him cry. Remember that emotional responses have a beginning, middle, and end and that information is being released and reprocessed as it is occurring. Strong emotions are part of reprocessing for many clients, particularly clients with a pervasive history of early trauma over a prolonged period of time. Successive sets of bilateral stimulation (BLS) are maintained until the intense reaction dissipates. If a client tends to close or cover her eyes when crying, the clinician may change the modality of stimulation in order to allow the processing to continue uninterrupted (i.e., changing from eye movements to auditory and/or tactile). Or the clinician could say, “It’s okay to cry. Just follow my fingers.” Or the clinician can simultaneously be verbally supportive by
saying, “It’s in the past,” “It’s old stuff,” “Just notice it,” or “It’s over, you’re safe now,” and/or “That’s it. Stay with it. You’re doing fine.” This encouragement and reassurance helps the client maintain dual awareness so the brain can reprocess the experience while moving toward a more adaptive resolution. The clinician can also use the tunnel or train metaphors suggested by Dr. Shapiro (2001): “You are in the tunnel, just keep your foot on the pedal and keep moving” and “It’s just old information. Watch it like scenery going by” are alternatives to help the client continue processing during an abreaction. All of these strategies may help a client move through her emotional responses. If a client asks to stop, it is imperative that the clinician honor the request.

The client, by stopping, has the opportunity to reorient to the present. Often, the clinician will then initiate contact with the client to help him reorient, offering reassurance and support. Sometimes the clinician will initiate a state change intervention, such as the calm (or safe) place or sacred space or other self-control strategies, until the client is ready to resume reprocessing. It is important for the clinician to negotiate a plan of action based on the client’s needs, as well as the client’s capacity to continue. Incorporating the client’s feedback into a plan of action is an important contrast to earlier experiences where he had no control or choice. Once the clinician understands what the client is experiencing or is concerned about, the clinician can offer the necessary support in order to help the client resume processing at the earliest opportunity.

**Abreaction Guidelines**

Table 5.1 lists guidelines provided by Dr. Shapiro (2001) to aid in dealing effectively with client abreaction during EMDR.

**STRATEGIES FOR MAINTAINING PROCESSING**

If changes are not occurring while a client is reprocessing, the first line of approach is to change the way the BLS is being administered. The clinician may change speed (e.g., faster, slower); direction (e.g., up down, diagonal, elliptical); and/or modality (e.g., taps, tones). In the Preparation Phase, the clinician has already introduced the client to the different modes and has identified the best fit. Before changing the modality during the processing, the clinician informs the client of the proposed change. If a change in BLS does not effectively facilitate movement, the clinician may ask the client to shift her focus to her body or return back to target. It is suggested that the clinician attempt these strategies outlined earlier at the first signs of blocked processing as these strategies are mechanical and do not address the emotional, psychological, or content of the client’s experience.
### TABLE 5.1
Abreaction Guidelines

<table>
<thead>
<tr>
<th>GUIDELINES</th>
<th>WHAT DOES IT MEAN?</th>
</tr>
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<tbody>
<tr>
<td>EMDR assists in allowing a client to release distress.</td>
<td>EMDR reprocessing is a catalyst for change. It does not cause high levels of emotional disturbance for the client; it allows the client to access it, reexperience it (if necessary), and eliminate it.</td>
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<tr>
<td>Abreactions have three parts—a beginning, middle, and end.</td>
<td>The abreactions that occur are generally short-lived in nature and can be considered to be nothing more than a “flash-in-the-pan” when compared to the emotional upset that occurred in the original experience.</td>
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<td>Information is usually being processed during EMDR treatment.</td>
<td>Although the client can become disturbed during the processing, the disturbing material is transformed; and the client is moved to a state of resolution.</td>
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<td>A clinical position of detached compassion is called for during an abreactive demonstration by a client.</td>
<td>The clinician must demonstrate balanced detachment during the client’s reprocessing of a traumatic event (i.e., the clinician should be very empathic without rushing in to “fix” the client).</td>
</tr>
<tr>
<td>What a clinician or others might need during an abreactive response is usually what the client needs as well.</td>
<td>The clinician provides a calm and stable presence that will ensure the client’s sense of safety, calm, and support.</td>
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<tr>
<td>A sense of safety in the present when processing events in the past is crucial to effective processing.</td>
<td>The clinician reassures the client that it is “old stuff” he is experiencing by providing a metaphor that helps him maintain a sense of control and informs him to keep his eyes open so that the processing can continue. Sometimes the client just needs to hear she is safe at that moment.</td>
</tr>
<tr>
<td>Monitor the client’s nonverbal responses for indications that a new level of processing has occurred or that the set can be terminated.</td>
<td>Observe minimal cues that often accompany abreaction, such as changes in eye movement, breathing, posture, skin color, or bodily tension.</td>
</tr>
<tr>
<td>Continue the BLS until the abreaction has ended.</td>
<td>Continue the BLS while the changes are occurring and for several passes after the client relaxes to help solidify conscious or cognitive connections.</td>
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Overresponders and Underresponders: Guidelines for Clients Who Display Too Little or Too Much Emotion

There are three types of client responses possible during reprocessing—normal, underaccessing, and overaccessing. Normal processing is when the client’s experience is shifting on its own with relative ease and with minimal assistance on the part of the clinician, and spontaneous processing is occurring. When the client has difficulty managing her experience, this is known as overaccessing; she may be upset at a level that is higher than she can maintain. A client who is overaccessing may or may not possess the needed resources or affect tolerance to comfortably deal with accessing the information as it is currently stored in the memory network. It is also possible that the client is accessing a particularly difficult aspect of her experience and needs additional support and encouragement to stay with it and get through it. The overall goal is to continue with the set(s) until the intensity subsides. When underaccessing occurs, the client has minimal access to one or more aspects of his experience and appears to be blocked. In order to allow the client to access the traumatic event more fully, the clinician may use strategies that access, deepen, and accelerate the processing (Shapiro, 2009–2014).

It is not unusual for the same client to overrespond or underrespond at times, just as it is typical that some clients will generally overrespond or underrespond to the demands of EMDR processing. It is important for the clinician to be aware of the client’s inclinations under stress so that the appropriate strategy will be applied to help the client meet the processing demands (Figure 5.1).

Remember, the goal is to facilitate processing when it is not occurring spontaneously. These strategies are designed to slow down or speed up the processing in order to help the client access and tolerate the material that is coming up. This allows the client to be able to continue processing with greater safety and containment.

![Overaccessing vs. underaccessing](image-url)

**FIGURE 5.1** Overaccessing vs. underaccessing.
Tables 5.2A and 5.2B outline Dr. Shapiro’s (2001) strategies to intervene in the processing for both underresponders and overresponders. As described earlier, TICES is an acronym for trigger = image, cognition, emotion, and sensation.

The TICES alternative procedural strategies listed in Tables 5.2A and 5.2B enable a client to relate to the memory in a way that provides her with

<table>
<thead>
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<th>TABLE 5.2A</th>
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<tr>
<td>Strategies for Maintaining Reprocessing (Overaccessing)</td>
</tr>
<tr>
<td><strong>DECELERATION (FOR OVERRESPONDERS)</strong></td>
</tr>
<tr>
<td><strong>Dual awareness (i.e., can maintain a present awareness while revisiting the disturbing material)</strong></td>
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<tr>
<td>Ask the client, “How are you doing?”</td>
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<tr>
<td>Remind the client about the stop signal.</td>
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<tr>
<td>Remind the client of the clinician's continued presence.</td>
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<tr>
<td>Offer compassion and support.</td>
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<tr>
<td>Say to the client, “It’s over. It’s in the past. You’re here now, looking back on the experience” or “You’re here in my office. I am with you.”</td>
</tr>
<tr>
<td><strong>Narrowing the focus of attention</strong></td>
</tr>
<tr>
<td>Increase or decrease speed or length of eye movements (or other forms of bilateral stimulation).</td>
</tr>
<tr>
<td>Concentrate only on body sensations: “Where do you feel it in your body?” or “Where do you feel it (i.e., emotion) in your body?”</td>
</tr>
<tr>
<td>Concentrate on thoughts about the event rather than emotions.</td>
</tr>
<tr>
<td><strong>Mechanics strategies</strong></td>
</tr>
<tr>
<td><em>Continue bilateral stimulation, but:</em></td>
</tr>
<tr>
<td>Consider changing to tapping or auditory processing.</td>
</tr>
<tr>
<td>Change the length of the sets (i.e., shorter or longer).</td>
</tr>
<tr>
<td>Change the direction or slow speed of the bilateral movements.</td>
</tr>
<tr>
<td>If closed, ask the client to open eyes.</td>
</tr>
<tr>
<td><strong>TICES strategies (in order):</strong></td>
</tr>
<tr>
<td>Change color of image to black and white.</td>
</tr>
<tr>
<td>Visualize a perpetrator without action (i.e., freeze-frame).</td>
</tr>
<tr>
<td>Instruct client to visualize the disturbing event further away, eventually seeing it coming closer.</td>
</tr>
<tr>
<td>Visualize barrier to obscure part of the memory, then remove.</td>
</tr>
<tr>
<td>Provide client with the reality check, “It’s in the past.”</td>
</tr>
<tr>
<td>Instruct client to focus on one sensation at a time.</td>
</tr>
<tr>
<td>Instruct client to focus on one thought at a time.</td>
</tr>
<tr>
<td>Instruct client to focus on one emotion at a time.</td>
</tr>
<tr>
<td>Reduce the number of passes and then gradually increase if a client does not seem to be responding.</td>
</tr>
<tr>
<td>Increase the number of passes if a client seems to be blocked.</td>
</tr>
</tbody>
</table>
a sense of empowerment (i.e., “I am larger than the disturbance”) and feeling of being in control. These strategies can also mimic spontaneous processing (i.e., the clinician asks the client to deliberately do what has not occurred spontaneously on its own).

Table 5.2A provides concrete examples a clinician can use for a client who displays a high level of uncomfortable emotions that have remained unchanged after two successive sets of eye movements.

These strategies utilize mechanics and TICES interventions to restart processing of a client who is blocked or to amplify processing of a client who reports feeling too little or maintains too much distance from the target memory. The TICES strategies also assist the client by mimicking spontaneous processing (Shapiro, 2009–2014).

| TABLE 5.2B |
| Strategies for Maintaining Reprocessing (Underaccessing) |

| ACCELERATION (FOR UNDERRESPONDERS) |

**Initial strategies**

- Increase speed, length, direction, and intensity of BLS, depending on stimulus used (i.e., eye movements, auditory, tactile).
- Concentrate only on body sensations. Where do you feel it in your body? Where do you feel it (i.e., emotion) in your body?
- Change mode of bilateral stimulation. Or try a combination of two.
- Increase the number of BLS sets.
- Check for feeder memories (i.e., any memory that may be emotionally feeding or impeding the reprocessing of the current target).

**TICES strategies (in order):**

*For blocked processing to increase access:*

- Instruct client to return to target and scan for new visual data.
- If there is tension in the jaw or throat, check to see if there are words that need expression.
- Check to see if client’s muscle tension indicates a need to move/act; instruct client to move/act during BLS.
- Instruct client to scan the original target for any sounds or smells.
- Instruct client to scan the original target for any disturbing conversations.

*To increase feeling and responsiveness:*

- Redirect to negative cognition to access more disturbance.
- Add color to black-and-white picture.
- Visualize an “actionless” perpetrator into action.
- Instruct client to imagine getting closer to the event.
- Offer client some other behavioral stimulus (e.g., change the client’s seating) so the original event can be experienced more actively.
- Instruct client to focus on several sensations at once.
- Instruct client to focus on several emotions at once.
Cautionary Note

When intervening during a client’s abreaction by using any of the suggestions available in Tables 5.2A and 5.2B, the clinician is encouraged to maintain a position of detached compassion with the client. This posture allows the clinician to be present with the client, offering containment of the client’s experience, as well as being an empathic witness. Newly trained EMDR practitioners who are not experienced at handling abreactive processes are encouraged to consult with a more experienced EMDR practitioner.

Returning to Target Too Soon?

A common error of novice EMDR practitioners is to have the client return to target too soon or too often. This can circumvent the client’s processing and possibly even prevent the client from completely clearing out the dysfunctional material stored in the channels of association that would otherwise be accessed and processed. However, there are also times when a clinician may determine that more frequent returning to target is helpful.

When is it appropriate to return to target? When associations (i.e., changing imagery, sounds, sensations, emotions, tastes, smells) appear to level off in a channel, the client is instructed to return back to the target memory. For example if, during the processing of a rape, the client is focusing on the smell of the rapist and she can no longer smell him, it may be time to return to target. A return to target may also be warranted when associations are not changing. Another reason that a return to target is appropriate is if the clinician is confused about whether the client is processing the material (e.g., random thoughts that are seemingly unrelated).

There are several reasons you might redirect a client back to the original target: (a) when a client’s feedback between each set of bilateral stimulation (BLS) is consistently positive or neutral; (b) to identify and activate another channel of association; (c) to check in on the client’s progress; (d) to determine whether or not the end of desensitization has been reached; (e) to refocus on the original target; (f) if you cannot identify changes at the end of processing after two sets of BLS; (g) if the client is lost or confused after questioning the client; and (h) if the presence of ecological soundness is present. Another reason for taking a client back to target is when a client appears to be distracted. If it feels like a client is running around in circles or losing focus, take her back to target so that she has a starting point from which to begin processing again (Shapiro, 2001, 2009–2014).
STRATEGIES FOR BLOCKED PROCESSING

Blocked Processing

Have you ever had a client who seemed to stop responding favorably to EMDR processing? What do you think happened? What was your response? Did you stop the BLS? Did you do anything to help restimulate the processing? What are the indications of blocked processing in an EMDR session?

Clinical intervention is needed when the spontaneous linkage between dysfunctional and adaptive becomes blocked during the processing of a client’s traumatic event. Strategies for blocked processing (i.e., a strategy utilized in EMDR to restimulate processing that appears to be “stuck”) may vary from: (a) changing the mechanics (i.e., speed, intensity, direction, or modality) of the BLS; (b) changing from eye movements to tactile or auditory stimulation; (c) changing the client’s focus (i.e., thought, feeling, physical sensation, sensory—taste or smell) by saying, “Where do you feel it in your body?” or, “Is there an emotion that goes with that body sensation?”; to (d) utilizing a strategy for blocked processing or cognitive interweave to help move the client’s traumatic memory to adaptive resolution (Shapiro, 2001). It is recommended that the clinician use the order specified earlier to assist the client with minimal interference.

Identifying Blocked Processing

Processing can be considered to be blocked during a reprocessing session if: (a) the client reports no change in two or more successive sets of reprocessing; (b) the same thoughts, emotions, and bodily sensations occur in successive sets of BLS; or (c) the Subjective Units of Disturbance (SUD) scale continues to be the same for two subsequent sets of BLS. If one of these three situations occurs, the clinician can attempt to remove the block by using one of the mechanical strategies listed in the previous section. When these strategies are unsuccessful, offering a cognitive interweave would be the next step to stimulate movement.

The strategies for blocked processing of the primary (i.e., original target) and ancillary targets (i.e., contributing factors) have been condensed in Tables 5.3 and 5.4. These strategies may be used to restimulate processing in the event it becomes “stuck.” If ancillary targets arise, the clinician should be open to the possibility that they may need to be reprocessed before returning to the primary event.

Primary Targets for Blocked Processing

If processing has remained unchanged after two successive sets of BLS, the clinician may assume that processing has stalled on the tracks. The
Abreactions, Blocked Processing, and Cognitive Interweaves

TABLE 5.3
Strategies for Blocked Processing

<table>
<thead>
<tr>
<th>PRIMARY TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Processing has stopped when a client’s response remains unchanged after two consecutive sets of bilateral stimulation. The clinician can restimulate processing of an immediate target in the following order by:</td>
</tr>
</tbody>
</table>

**Returning to the original target and changing the direction, length, speed, and height of horizontal movements (if using eye movements) or a combination of these changes or change to alternate stimulus (e.g., tapping and tones):**

The clinician should only change direction or alternate stimulus with the next set — not within a set.

**Focusing on physical sensation:**
- Focusing only on physical sensations of a client while altering the bilateral stimulation.
- Focusing only on the most pronounced sensation (if more than one is reported).
- Verbalizing or giving voice to certain types of body tension (e.g., throat, jaw) and the associated affect (e.g., anger, rage).
- Acting out movement (e.g., punching, kicking) associated with a particular emotion (e.g., anger).
- Pressing or focusing attention on a body sensation that will not shift and has no associated images or thoughts.

**Scanning for:**
- Something that is more disturbing than the original event being targeted.
- A sound effect that remains disturbing.
- A dialogue that occurred during the traumatic event.

**Alterations (i.e., in focus of attention or actual target):**
- Ask the client to alter the appearance of the image (e.g., smaller, dimmer, more faded, in black or white, rather than color).
- Have the client visualize the perpetrator only—not what he is doing or what he did do.
- Alter the target event in terms of time and distance (e.g., have the client imagine the perpetrator in the hallway rather than on top the bed).

When different events emerge during processing in a particular channel, one event may appear to have a higher disturbance level. If, in subsequent sets, the client concentrates on the thoughts and feelings of this specific event, allow the client to process this event until the thoughts and feelings begin to possess a milder level of disturbance. Then redirect the client back to the image of the last event with a significant level of disturbance.
strategies in Table 5.3 offer variations in procedure to jump-start processing by asking the client to deliberately do something. It is recommended that altering the direction, speed, or length of eye movements and focusing on body sensation(s) be tried first. If these strategies do not work to unblock the processing, the reprocessing session should be terminated and other avenues of treatment explored.

See Table 5.3 for strategies developed by Dr. Shapiro (2001) to be used in clearing debris from a client’s “track.”

**Ancillary Targets for Blocked Processing**

When processing does not resume after one or more of these strategies have been employed, the clinician should look for ancillary targets or other factors that may be causing the block. These factors include feeder memories, blocking beliefs, and fears (i.e., fear of going crazy, fear of the worst case scenario, fear of losing good memories, fear of change, fear of losing respect or losing contact with the clinician, and wellsprings of disturbance). Review Chapter 1 for definitions and examples of these variables. Dr. Shapiro (2001) stresses that the earliest memories that contribute to present dysfunction are generally targeted first in order to minimize the possibility of later memories that are out of the client’s awareness from blocking the processing. See Table 5.4 for more sophisticated strategies to address this issue.
TABLE 5.4
Strategies for Blocked Processing

ANCILLARY TARGETS

Strategies for working with blocks caused by undiscovered channels of association:

**Feeder memories**
Floatback: The client is asked to float back to an earlier time that incorporates the negative cognition or any emotions or sensations. This strategy is indicative of looking for an earlier disturbing memory related to a current experience.

Affect scan: The client is asked to think about the target experience with the emotions and sensations and scan her memory for something similar in the past.

**Blocking beliefs**
What prevents it (i.e., client’s SUD score) from being a 0? What prevents it (i.e., client’s VoC score) from being a 7? If a blocking belief does not emerge, ask the client to close his eyes, focus on the situation, and verbalize anything that comes to mind. The clinician would then scan the client’s dialogue for negative blocking beliefs.

Examples: “I don’t believe in extremes.”
“Nothing is perfect.”

**Fears**
The client’s fears and secondary gain issues must be addressed before targets can be reengaged and processing continued.

Examples
Going crazy: “What if I lose my mind during this process?” Response: “There have been no reports of anyone losing her mind before.” This is usually because the information during reprocessing comes quickly and, seemingly, out of nowhere. The clinician should reassure the client that her brain is just gathering similar experiences along the way.

Losing good memories: “If I lose this memory, I will lose my loved one.” Or “If I don’t have the memory, did it really happen?” Response: “Is there another way to hold this in memory that is not so ______ (fill in the bank) (e.g., painful, hurtful, negative)?” The clinician may let the client know that good memories may also strengthen with reprocessing. It is important to pay attention to the client’s pace so that he can adapt and incorporate changes along the way.

Not being able to handle the treatment process: “What if I don’t do it right?” Response: “There is no right or wrong way to do EMDR reprocessing.” It is important to pay attention to the client’s pace so that he can adapt and incorporate changes along the way.

(continued)
TABLE 5.4  (continued)
Strategies for Blocked Processing

<table>
<thead>
<tr>
<th>ANCILLARY TARGETS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategies for Blocked Processing</strong></td>
</tr>
<tr>
<td><strong>Change:</strong> “With change there is a loss.”  <strong>Response:</strong> Deal with the loss change can bring beforehand. The clinician should help the client address the potential change and/or loss before any changes take place.</td>
</tr>
<tr>
<td><strong>Worst case scenario:</strong> “I will start crying, and I will not be able to stop.”  <strong>Response:</strong> “Has that ever happened to you before?”</td>
</tr>
<tr>
<td><strong>Losing respect of the clinician:</strong> “If I tell you my deepest secrets, will you lose respect for me?”  <strong>Response:</strong> “Your memories will process whether you tell me or not.” The same holds true for clients with issues of guilt and shame.</td>
</tr>
<tr>
<td><strong>Losing contact with the clinician:</strong> If a client has been with a clinician for years, there may be a fear of losing her support system.  <strong>Response:</strong> “I will still be your therapist, but we can work on expanding your support system.”</td>
</tr>
<tr>
<td><strong>Wellsprings of disturbance</strong></td>
</tr>
<tr>
<td>The clinician targets the early memories associated with blocking beliefs that hinder a client’s ability to feel emotions.</td>
</tr>
<tr>
<td><strong>Note:</strong> Precise definitions and examples of these ancillary targets can be found in Chapter 1.</td>
</tr>
</tbody>
</table>

THE ART OF THE COGNITIVE INTERWEAVE

Cognitive interweaves introduce information or offer another perspective into the processing track when it gets stuck and the mechanical strategies of jump-starting the process have been unsuccessful. The cognitive interweave can be one of the most challenging EMDR strategies for newly trained as well as seasoned clinicians to understand and apply effectively. Although EMDR is a client-centered psychotherapy approach, the clinician is expected to guide the process to facilitate a successful resolution. Thus, the cognitive interweave is subject to underuse, overuse, misuse, and misunderstanding. However, if used sparingly and deliberately, it is an elegant and artful means of facilitating EMDR processing. As with any intervention, timing, accuracy, and appropriateness are paramount to positive treatment outcomes.

**What Is a Cognitive Interweave?**

The cognitive interweave is a statement or a question that is being offered to the client by the clinician in response to a blockage in the processing or to facilitate relevant connections, optimize generalization effects, help the
client with affect regulation, address defensive responses, and to maintain dual awareness. When the client is working on attachment-related trauma, it is also used to help the client feel supported and understood and to bring attention to the fact that he is not alone in his experience.

**Client-Generated Material + Clinician = Derived/Elicited Statements (Cognitive Interweave) = Access to Adaptive Information (hence, reprocessing continues)**

Or, see Figure 5.2 for a more graphic example.

**FIGURE 5.2 Understanding the cognitive interweave.**

**Using a Cognitive Interweave Effectively**

In order to utilize cognitive interweaves most effectively, it is necessary to begin collecting information from the earliest contact with the client. It is “a sensuous flowing together of presenting problems, client behavior and clinician skills” (Zangwill, 1997) and emphasizes the importance of recognizing, collecting, and utilizing a client’s vulnerabilities and schemas (i.e., broad organizing principles that help the client make sense of his life experience, such as a sense of “defectiveness;” Young, Klosko, & Weishaar, 2003). Dr. Shapiro (2001) states, “clinicians will be able to use the cognitive interweave most beneficially if they are aware of the relevant clinical issues” and “can introduce new adaptive perspectives in a progressive manner that parallels the typical client’s natural healing process.”

The most important question to ask in terms of effectively utilizing the cognitive interweave is: What are your client’s underlying schemas, and how has he coped with them (Zangwill, 1997)? This entails discovering the client’s clinical themes and underlying coping mechanisms and collecting the information to use later to construct strategically placed cognitive
interweaves during processing to aid the client in reaching adaptive resolution of his trauma.

When to Use a Cognitive Interweave

Table 5.5 shows the circumstances under which cognitive interweaves can be used (Shapiro, 2001).

<table>
<thead>
<tr>
<th>REASON</th>
<th>WHAT DOES THIS MEAN?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Looping</td>
<td>The clinician has used EMDR reprocessing variations to unblock processing; and, even after successive sets of eye movements, the client continues to remain at a high level of disturbance with the same negative thoughts, affect, and imagery reoccurring.</td>
</tr>
<tr>
<td>Insufficient information</td>
<td>The client is unable to progress cognitively or behaviorally because he did not have the appropriate data, or the client has the information and, for whatever reason, is not connecting with it.</td>
</tr>
<tr>
<td>Lack of generalization</td>
<td>Processing does not generalize to ancillary targets, despite the client’s achieved success in reaching a positive emotional plateau with respect to a targeted event.</td>
</tr>
<tr>
<td>Time dilemma</td>
<td>Time is running out, and the client erupts into an abreaction or fails to process an abreaction sufficiently. The target may be multifaceted (i.e., more than one negative cognition is associated with it). More time may be needed to reprocess.</td>
</tr>
<tr>
<td>Extreme emotional stress</td>
<td>If the client is abreacting to the point of exhaustion, the clinician needs to intercede.</td>
</tr>
</tbody>
</table>

Case Example 5A: Renee

Renee, now 25, was 10 years old when she was involved in a car accident in which her 34-year-old mother was seriously injured. Renee was strapped
in the front seat opposite her mother, who was driving, when a semi-truck hit them head on. Her vivid memories include her mother being unconscious and slumped over the steering wheel while Renee crawled out of the window of the car and rushed to the other side to help her mother. The impact of the semi-truck rendered it impossible to budge the bent and crumbled door. No matter how hard she tried, she could not open the door to rescue her mother. The smell of gasoline helped Renee to choke back her tears as she tried to tug the door open. She was near hysteria when the firemen pushed her aside and pulled her mother out of the car just before it exploded into a fiery inferno. She stood and watched as her unconscious and helpless mother was removed from the car with a crowd of strangers looking on in horror. In a matter of minutes, Renee’s world became empty and unsafe, and she went on to live a life of anxiousness and uncertainty.

Renee, 10 years old at the time of the crash, had experienced fear, terror, disbelief, and helplessness as she viewed her trapped mother, and she continued to experience deep sadness and guilt for her mother’s injuries. When Renee presented for therapy 15 years later, she was overweight, struggling with insomnia, and having frequent nightmares and flashbacks of the accident. She also suffered from depression and anxiety.

According to the Adaptive Information Processing model (Shapiro, 2001), Renee’s information processing system (i.e., her natural healing mechanism) “stalled on the tracks” the day of the accident. The elevated levels of stress that she experienced that tragic day persisted long after the accident had taken place until EMDR Therapy helped her to clear the emotional and sensory debris from the “track” so that processing could occur. The most disturbing parts of the event were left on the “track” (i.e., the image of her mother slumped helplessly over the steering wheel, the firemen pulling her away from the devastating scene, the fiery explosion, the range of emotions she felt throughout the event, the rise of her adrenaline as she climbed out of the car to rush to her mother’s aid) and instead were generating symptoms because they were stuck in her memory in the same state-specific form in which she had originally experienced it. This dysfunctional material stored in Renee’s nervous system subsequently was responsible for the symptoms described previously, and she was eventually diagnosed with posttraumatic stress disorder (PTSD).

As with many people who suffer from PTSD, years later, when she passed by an automobile accident or heard about an explosion on the news, Renee would experience the same fear, terror, disbelief, and helplessness, as if the accident were occurring all over again. The information (i.e., thoughts, images, cognitions, emotions, sensations) from the original accident had been isolated in its own memory network and frozen in time. Neither new learning, nor the passage of time, was able to impact the way she reacted to these triggers. It was only when the memory networks were
connected through EMDR processing that insight and integration could naturally occur. With the aid of EMDR Therapy, Renee was able to bring up the accident and assimilate the related negative information into its proper perspective (i.e., that it belonged to the past) and then was able to release the negative and the distorted cognitive content.

**Choices of Cognitive Interweaves**

Dr. Shapiro (2001) identifies and explains several choices of cognitive interweaves.

**Case Example 5a: Renee (continued)**

It was during a session where Renee ran into a huge timber lying on her “train track.” No matter what strategy was used to unblock processing, nothing seemed to work. When she accessed this particular part of the memory, Renee expressed inappropriate feelings of guilt for failing to be the one who got her mother out of the car. Nothing in Renee’s previous learning or education seemed to provide salvation from her guilt. What was needed was a piece of dynamite to obliterate the debris from the blocked “track.” During this session, a cognitive interweave was utilized to remove the timber from her “track.” It was used to strategically introduce new, but pertinent, information to Renee’s system to quick-start her stalled healing process.

*Renee:* If I only could have jerked the car door open. I could have helped her. I should have done something differently.

The issue of responsibility comes to the foreground.

*Clinician:* Renee, I’m confused. Are you saying that a 10-year-old should have been strong enough to open a jammed car door and drag an adult to safety?

*Renee:* Well, I suppose not.

*Clinician:* Go with that.

From the examples in Table 5.6, a number of different interweaves could have been utilized if continued processing did not cause a spontaneous change in her feelings.

In introducing the information in that manner, Renee was able to get in touch with her more adaptive adult perspective and assist in linking the information that was deliberately inserted to the appropriate memory
networks. Renee’s perspective, somatic responses and personal referents of the accident came from that of a 10-year-old, the age she was at the time of the accident. The cognitive interweave served to link dysfunctional information stored in an isolated memory network to Renee’s present-day adult and to activate the adaptive material stored in a healthier network. This provided her with a more realistic adult perspective of the accident.

After successfully processing the guilt she had felt for her mother’s car accident, Renee realized that she was just a child at the time of the accident. Since the accident, she had difficulty riding in a car for sustained periods

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**TABLE 5.6**

Choice of Cognitive Interweaves

<table>
<thead>
<tr>
<th>CHOICE</th>
<th>PURPOSE</th>
<th>EXAMPLES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New information or perspective</strong></td>
<td>Used when the client lacks the information needed to correct a maladaptive cognition.</td>
<td><em>Renee</em>: I should have been able to get the car door open. I did not try hard enough. <em>Clinician</em>: Most 10-year-old children do not have the strength to do what you are suggesting, even in the best of circumstances. Were you stronger than most children your age? <em>Renee</em>: No. <em>Clinician</em>: Go with that.</td>
</tr>
<tr>
<td><strong>“I’m confused ...”</strong></td>
<td>The clinician uses this when it is believed that the client already knows the answer to the question.</td>
<td><em>Clinician</em>: I’m confused. Who was bigger, you or the fireman? <em>Renee</em>: The fireman. <em>Clinician</em>: Just think of that.</td>
</tr>
<tr>
<td><strong>“What if it were your child?”</strong></td>
<td>As a variation of the above, this interweave uses the client’s children (if any) as a convenient intervention.</td>
<td><em>Clinician</em>: Do you mean that, if it was your daughter who was trying to get you out of the car, you would want her to stay and save you regardless of the outcome? <em>Renee</em>: No! I would want my daughter safe and out of harm’s way. <em>Clinician</em>: Go with that.</td>
</tr>
</tbody>
</table>
of time; and it was a struggle for her to drive. During a subsequent session, she began seeing images of the semi-truck hitting them head on and her mother’s injured body slumped over the steering wheel. Renee’s reprocessing had stalled for the last few sets of BLS. The following excerpt illustrates how the clinician attempted to unblock her processing and address her confusion around the issue of safety:

Renee: I just keep seeing the semi coming at us. It is as if it were yesterday. It came so fast and “bang,” it was over. The next thing I noticed was my mother’s limp body slumped over the steering wheel. I don’t know if she was breathing or not. I didn’t take time to think about myself. When I think of it now, I am fearful.

Clinician: Where do you feel the fear in your body?

The clinician used a TICES strategy for blocked processing to bring attention to Renee’s somatic experience so that she can “move the train further down the track.”

Renee: In my chest.

Clinician: Go with that.

Renee: I am so vigilant when I drive now. I can never take my eyes off the road. I never feel safe in the car. I’m always too tense in the car.

The issue of safety emerges. The clinician probed further by eliciting information with a pertinent question.

Clinician: Is that what your mother did? She took her eyes off the road?

Renee: Yes. No. For some odd reason, I am seeing my mother slumped over the steering wheel before the semi hit us.

Clinician: Just think of that.

Renee: She was... Oh, my God! My mother had a seizure!!! That’s why the semi hit us. I never made that connection before. My mother was an epileptic, and she had a seizure. She hit the truck and not the other way around. She couldn’t help it. That’s why the truck driver was not charged. I never could figure that one out. It was no one’s fault. My mother would have kept us safe if she could!

Renee never made this connection before this moment in the processing, even though her mother had told her at the time of the accident that she had a seizure.

Clinician: Go with that.
Renee: No wonder I am so tense when driving. I thought that, if I ever took my eyes off the road, I would crash just like my mom. She couldn’t help it. It wasn’t her fault. She didn’t mean to…

Clinician: Go with that.

After this session, Renee was able to drive with a higher comfort level. She started to relax more and, in her eyes, actually became a better driver. The resolution of her issue of safety also opened the door to a variety of choices in her life. Previously, Renee had never traveled too far from home. It was beyond her comfort level. Being more comfortable behind the wheel empowered her to drive to different places and try new activities. She actually accepted a teaching position one summer that required her to drive 50 miles roundtrip to another city.

After the issues of responsibility/defectiveness, safety/vulnerability, and power/control (or choice) were resolved, Renee was able to complete the session by reaccessing and fully processing the original target. Once the block dissipates, the client continues to process associated channels of dysfunctional material that may still exist.

Regardless of how a client moves through these important plateaus, the successful negotiation of one plateau facilitates the possibility of resolution in the next. The client may successfully negotiate these plateaus on her own, or she may be assisted by the use of questioning or educating by the clinician.

Comparison Between Strategies for Blocked Processing and Cognitive Interweaves

Strategies for blocked processing can be described as cognitive (e.g., “What negative thoughts go with that event?”); somatic (e.g., “Where do you feel that in your body?”); affective (e.g., “What are you feeling right now?”); or general (e.g., “What do you need right now?”). Changing the direction, speed, intensity, or location when using or changing alternatives for BLS can be effective strategies for blocked processing. These strategies tend to question, inform, and challenge the client’s obstacles (i.e., blocked beliefs, secondary gains or losses, feeder memories, ancillary targets, negative abreactions, performance anxiety, or lack of safety) during episodes of blocked processing until they are removed from the “track.” They are designed to help the client’s processing to move further down the existing “track” by removing the obstacle impeding progress.

See Table 5.7 for an encapsulated view of the differences between the two.
Responsibility/Defectiveness, Safety/Vulnerability, and Power/Control (or Choice)

The optimal outcome of reprocessing entails the client coming to an adaptive resolution. This occurs as appropriate memory networks spontaneously link to each other and move the targeted issue to adaptive resolution. In cases of early trauma, Dr. Shapiro (2001) believes a client’s perspective becomes distorted in terms of responsibility/defectiveness, safety/vulnerability, and power/control (or choice) (see Table 5.8).

Examples of effective cognitive interweaves addressing responsibility/defectiveness, safety/vulnerability, and power/control (or choice) follow:

Responsibility/Defectiveness Interweaves

- “Whose responsibility is it?”
- “Is that about you or them?”
- “Whose fault is it?”
- “I’m confused. Who was bigger, you or he?”

### TABLE 5.7
Comparison Between Strategies for Blocked Processing and Cognitive Interweaves

<table>
<thead>
<tr>
<th>STRATEGIES FOR BLOCKED PROCESSING</th>
<th>COGNITIVE INTERWEAVES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reactive</td>
<td>Proactive</td>
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<tr>
<td>Uses client’s spontaneous processing system.</td>
<td>Mimics client’s spontaneous processing.</td>
</tr>
<tr>
<td>Concentrates directly on client’s emerging material.</td>
<td>Introduces new information or a new perspective.</td>
</tr>
<tr>
<td>Helps remove obstacles from the client’s “track.”</td>
<td>Helps the client lay new “track.”</td>
</tr>
<tr>
<td>Useful when the “train” has stopped on the “tracks.”</td>
<td>Useful when the “train” is still moving, however slowing down. Accurate timing and sequencing are needed.</td>
</tr>
<tr>
<td>Questions, challenges, and informs.</td>
<td>Confronts three major issues: Responsibility/defectiveness, safety/vulnerability, and power/control (or choice). Fitted to the client.</td>
</tr>
<tr>
<td>Used usually before a cognitive interweave.</td>
<td>Usually used only as a last resort.</td>
</tr>
</tbody>
</table>
“Let’s pretend. If you could say something to him, what would it be?”
“Would you expect any 10 year old to know what to do in that type of situation?”

Safety/Vulnerability Interweaves

“Are you safe now?”
“Can he (i.e., the perpetrator) hurt you now?”
“If he (i.e., the perpetrator) tried something now, what would you do?”

Power/Control (or Choice) Interweaves

“What happens when you think of the words ‘As an adult, I know I have choices’ or ‘I can now choose’ or ‘I am now in control?’”
These issues are often processed in this order for processing to be the most effective (see Figure 5.3).

<table>
<thead>
<tr>
<th>Generally processed in this order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsibility/Defectiveness</td>
</tr>
<tr>
<td>Responsibility/Action</td>
</tr>
<tr>
<td>Safety/Vulnerability</td>
</tr>
<tr>
<td>Power/Control (or Choice)</td>
</tr>
</tbody>
</table>

Guilt, blame, shame                  Perceived lack of safety
Danger                               Helplessness
Powerlessness                         No choice

FIGURE 5.3 Cognitive and emotional plateaus.

Case Example 5B: Susie

When Susie was 10 years old, her uncle took her back behind his house to see the new shed he had built. This was her favorite uncle, so Susie was excited to share this with him. Once in the shed, her uncle grabbed her and pushed her down. Before she could do anything, he was on top of her, his hand clapsed over her mouth so that she could not scream.

The following transcript demonstrates an example of a client moving through these plateaus spontaneously and naturally.

Target: Being sexually abused by her uncle at age 10.

Image: The worst part of the experience for Susie was when her uncle turned around, grabbed her, and roughly pushed her down on the floor of the shed.

Negative Cognition (NC): I am powerless.

Positive Cognition (PC): I have power now in my life.

Validity of Cognition (VoC): 2

Emotions: Fear, shame, disgust, guilt

Subjective Units of Disturbance (SUD): 8

Body: Down there (the client points to her genital area).
Clinician: Susie, bring up that image, those words, “I am powerless” and where you feel it in your body. Just let it go wherever it goes. (Set of BLS) Take a breath. (Pause) What’s coming up now?

Susie: I see him on top of me, tearing at my clothes. I can hear children in the background playing and giggling. I can feel his weight on me. I tried to fight with him, but I was too weak.

Clinician: Notice that. (Set of BLS) Good. You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What are you getting now?

Susie: He kept pushing against me.

Clinician: Notice that. (Set of BLS) Good. Take a breath. (Pause) Let it go. What are you noticing now?

Susie: I am feeling a sharp pang in my chest.

Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. What are you noticing now?

Susie: He touched me. I let him... I allowed it... He told me he loved me. It was my fault. He asked me to come with him... and I did. I am such a bad person.

The client is expressing inappropriate feelings of guilt and is accepting the blame for going with her uncle to his shed.

Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. What are you noticing now?

Susie: He said what we were doing together was special and our own little secret. He told me that, if I told anyone, he would go to jail. He said if he went to jail it would be my fault. But it wouldn’t be. He was bad, not me. It was not my fault. I was so small. I did nothing wrong. I am not a bad person. He is.

The attribution of responsibility belongs solely to the perpetrator. The client making this emotional connection is tantamount to her resolving the first of three informational plateaus in her reprocessing.

Clinician: How does that make you feel toward yourself?

Susie: Better... that I am a good person.

The client has spontaneously shifted from “I am a bad person” to “I am a good person.” She no longer feels that she is to blame for what happened with her uncle in the shed.

Clinician: Go with that. (Set of BLS) Good. Good. Take a breath. (Pause) Let it go. What’s happening now?

Susie: It’s not my fault. No child asks to be treated in this way.
The cognitive and emotional shift continues to materialize in terms of the guilt and blame that she so readily attributed to herself only moments before.

*Clinician:* Just go with that. (Set of BLS) You’re doing fine. Take a breath. (Pause) Let it go. What are you noticing *now?*

*Susie:* I feel dirty. I feel so ashamed. I feel so vulnerable and helpless. I am so scared. I need to get away from him.

Client spontaneously opens another associated channel of her experience. This one involves the issue of *safety.* This cognitive and emotional plateau will need to be resolved as well before proceeding on to the next plateau.

*Clinician:* Where do you feel it in your body?

*Susie:* My stomach, chest, and legs.

*Clinician:* Go with that. (Set of BLS) Good. Good. Take a breath. (Pause) Let it go. What’s happening *now?*

*Susie:* Every time I saw my uncle after the incident, like at family functions, he would just smirk and wink at me. I was afraid he would try to do it again. I can still feel the fear.

*Clinician:* Where do you feel it in your body?

*Susie:* My heart is beating more rapidly, and I feel like there’s a weight on my chest.

*Clinician:* Just notice that. (Set of BLS) Good. Take a breath. (Pause) Let it go. What are you noticing *now?*

*Susie:* My uncle died several years ago. He had a heart attack while driving to work. He plowed into a tree. He died instantly. He can never hurt me again. I never have to see him at family events. I never have to feel the revulsion and hatred I felt for him every time I saw him.

The client continues to realize that she is safe from her perpetrator. As an adult, she does not need to fear for her safety.

*Clinician:* Just notice that. (Set of BLS) Good. Take a breath. (Pause) Let it go. What comes up for you *now?*

*Susie:* I am feeling calmer… and safer. I never have to see him again. It’s over. I have other family members who care for me and love me.

The client spontaneously separated the past from the present. She is safe now. He is dead, and he cannot hurt her anymore.
Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. What’s coming up now?

Susie: I don’t know if I can ever be free of him… the tainted feeling still lingers. What he did to me defined me for so many years. How do I get rid of that? How do I move on still knowing what he did to me and the years that he took from me?

Clinician: Just go with that. (Set of BLS) You’re doing fine. Take a breath. (Pause) Let it go. What are you noticing now?

Susie: Maybe I can be free of him. I no longer feel responsible. And I feel safe knowing he is dead. Maybe I can be free of him.

Clinician: Go with that. (Set of BLS) Good. Good. Take a breath. (Pause) Let it go. What are getting now?

Susie: It’s up to me. He’s dead and cannot hurt me now. I can choose to live free of him. He can’t hurt me anymore. I won’t let him. I can take my power back.

The third plateau begins to emerge. The client realizes her ability to choose to live free of the effect her uncle has had on her.

Clinician: Just go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. What are you noticing now?

Susie: I am feeling strong. I feel like he is gone, and there’s nothing he can do now. That’s just the way it is.

Dr. Shapiro (2001) contends that these themes should be processed in order of responsibility/defectiveness, safety/vulnerability, and power/control (or choice). Susie was able to spontaneously move through these cognitive and emotional plateaus successfully on her own. However, this does not happen with all trauma survivors. In some instances, the clinician may need to introduce or stimulate the issues of responsibility/defectiveness, safety/vulnerability, and power/control (or choice) for the client by strategically utilizing the cognitive interweave.

In an effort to demonstrate how this is done, Susie’s transcript will be altered, allowing the clinician to utilize cognitive interweaves to elicit the same information around these three important issues.

**Responsibility/Defectiveness**

Susie: He told me what we were doing together was special and our own little secret. He told me that, if I told anyone, he would go to jail. He said if he went to jail it would be my fault.
Clinician: Whose fault was it?

Client: It’s his, not mine. He’s bad, not me. It’s not my fault. I was so small. I did nothing wrong. I am not a bad person. He is.

Clinician: You are a good person.

Susie: I am a good person.

The clinician did for the client what she could not do for herself by weaving together the appropriate memory networks and associations. As a result, the client is able to transmute her belief, “I am a bad person” into “I am a good person.”

Clinician: Go with that. (Set of BLS) Good. Good. Take a breath. (Pause) Let it go. What’s happening now?

Safety/Vulnerability

Susie: Every time I saw my uncle after the incident, like at family functions, he would just smirk and wink at me. I was afraid he would try to do it again. I can still feel the fear.

Clinician: Where do you feel it in your body?

Susie: My throat. I could just scream. What if he tries to do it again?

Clinician: Where is your uncle now?

Susie: Oh my. My uncle died several years ago. I had forgotten. He had a heart attack while driving to work. He plowed into a tree. He died instantly. He can never hurt me again. I never have to see him at family events. I never have to feel the revulsion and hatred I felt for him every time I saw him.

Using a cognitive interweave to bring the client back into the present where her adult self lives, the clinician is able to demonstrate to the client that her uncle is no longer a danger to her.

Clinician: Just notice that. (Set of BLS) Good. Take a breath. (Pause) Let it go. What are you getting now?

Power/Control (or Choice)

Susie: I don’t know if I can ever be free of him. What he did to me defined me for so many years. How do I get rid of that? How do I move on still knowing what he did to me and the years that he took from me?

Clinician: What choices do you have today as an adult that you didn’t have then as a child?
Susie: I never thought of that. As a child I really didn’t have much choice, did I?

Clinician: Go with that. (Set of BLS) Good. Let it go and take a breath. (Pause) What is happening now?

Susie: Right! Right! I do have choices now that I did not have then…I am feeling calmer…and safer. I never have to see him again. I always felt tainted by what he did to me. I choose not to feel that way anymore.

With the assistance of the clinician, the client is able to proceed to the plateau of choice.

Use the Cognitive Interweave With Complex Trauma

While encouraging both clinician and client to “let whatever happens, happen” in EMDR reprocessing, it is often more complicated with complex trauma. A client who has been multitraumatized, especially in early childhood, often has difficulties with affect regulation and maintaining dual awareness and has dissociative processes that make it challenging for her to allow the processing to unfold naturally and with minimal assistance on the part of the clinician. In addition, her developmental deficits often result in a lack of important skills that are required to tolerate the demands of the processing.

Laliotis and Korn (2015) have categorized types of cognitive interweaves that bring attention to the purpose or action that is being taken on the part of the clinician as well as offering a more elaborate set of choices to more effectively navigate the moment to moment clinical demands of working with all clients, but most especially with complex trauma. A client with complex trauma has greater fragmentation in her memory networks, making it more difficult to access adaptive information and memory networks spontaneously. In addition to offering a client information she does not have, the use of cognitive interweave allows her to stay in her process, keeping her emotionally resourced in tracking the duality between present and past so she is less likely to get overwhelmed or shut down. Additionally, developmental repair is often required to fill in what was needed at the time in the client’s childhood but was not available. For example, the child of a chronically ill parent who learned not to speak up for himself may need permission to assert his needs. Furthermore, for clients with these attachment issues, it is important for the clinician to use the relational dimension of EMDR processing, bringing attention to the empathic attunement of the therapist as well as the recognition that he is not alone in the experience.

Table 5.9 shows the categories of interweaves that describe their purpose and the action being taken on the part of the clinician, along with examples of each. Table 5.9, “Clinical Interweave Categories (EMDDRIIA),” was adapted from Laliotis and Korn (2015). (EMDDRIIA is an acronym
**TABLE 5.9**
Clinical Interweave Categories (EMDDRIIA)

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>GOALS</th>
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<tbody>
<tr>
<td>Experiential</td>
<td>Bring attention to all components of memory and present experience. Help client upregulate arousal, track affective/somatic/cognitive experience, and expand field of consciousness. Help client access dissociated aspects of memory/experience, bringing them more fully into awareness.</td>
</tr>
<tr>
<td>Modulation</td>
<td>Help client downregulate arousal to stay within the window of tolerance. Maintain dual attention. Includes the use of soothing, containing, distancing, titrating, grounding, orienting, and unblending strategies.</td>
</tr>
<tr>
<td>Defense</td>
<td>Decrease blocks to processing by acknowledging and appreciating defenses from a place of compassion and empathy. Recognize efforts of “protective parts” and address internal conflicts to increase access to relevant memories and affective/somatic/cognitive material. Ultimately, help client approach inner experience as defenses are minimized or relinquished.</td>
</tr>
<tr>
<td>Developmental Repair</td>
<td>Create an opportunity for an intrapsychic “corrective emotional experience” to help with shame/guilt, profound despair, and aloneness. Facilitate developmental repair by connecting the adult self with the child selves/parts to address unmet and unrecognized longings and needs.</td>
</tr>
<tr>
<td>Relational</td>
<td>Provide an interpersonal “corrective emotional experience” and undo sense of aloneness through recognition and support. Activate the client’s social engagement system, increase sense of safety and security, and facilitate co-regulation, increasing capacity for exploration and processing.</td>
</tr>
<tr>
<td>Informational</td>
<td>Provide information, education, and adaptive adult perspectives in an attempt to facilitate processing. Information offered is in response to what is missing and, therefore, what is needed for adaptive resolution.</td>
</tr>
<tr>
<td>Integration</td>
<td>Facilitate generalization of learning, address present and future scenarios, and assist with integration of new experiences and perspectives into self-identity and personal narrative. Help client find meaning in experiences of the past and reevaluate sense of purpose for the present and future.</td>
</tr>
<tr>
<td>Action</td>
<td>Encourage the completion of thwarted fight/flight responses, helping the client move from a stance of immobilization/submission and powerlessness to mobilization/action and control. Facilitate verbalization of unspoken words and expression of adaptive actions to achieve a sense of empowerment and triumph.</td>
</tr>
<tr>
<td>CATEGORY</td>
<td>ACTIONS</td>
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<tr>
<td><strong>Experiential</strong></td>
<td><strong>Bring attention to the client’s moment-to-moment experience</strong></td>
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<td></td>
<td><strong>Facilitate mindfulness to all components of experience</strong></td>
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<td></td>
<td><strong>Help the client clarify, reflect on, and express what s/he is experiencing</strong></td>
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<td></td>
<td><strong>Broaden or narrow the focus of attention</strong></td>
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<td></td>
<td><strong>Help the client track the unfolding of experience through mirroring and shared observations</strong></td>
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<tr>
<td>CATEGORY</td>
<td>ACTIONS</td>
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</tr>
<tr>
<td><strong>Facilitate access to and experience of different aspects of self or “parts”</strong></td>
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<tr>
<td><strong>Modulation</strong></td>
<td>Enlist observing ego as a witness</td>
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<tr>
<td></td>
<td>Separate arousal from trauma-related emotions, thoughts, and images</td>
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<tr>
<td></td>
<td>Unblend adult self from traumatized child parts (to maintain dual attention and self-regulation)</td>
</tr>
<tr>
<td>Limit associations and work to contain affect, material, and/or memories</td>
<td>Would it be okay to set that (memory, association) aside for another time and finish with the memory we started with? If you could put this away until next session, where/what would you put it in? Imagine putting it into a container.</td>
</tr>
<tr>
<td>Titrate intensity of affective experience</td>
<td>What would it take to make it feel more tolerable right now?</td>
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<tr>
<td>Slow down the processing</td>
<td>Imagine a (protective bubble, emotion dial, TV with picture in a picture, faucet with a slow leak). Imagine letting only one drop or one percent of the feeling in.</td>
</tr>
<tr>
<td>Establish boundaries/distance</td>
<td>I’m wondering if you can give yourself permission to feel into your experience just a little at a time...notice that you can actually control your experience now. What [resource] do you need in order to continue? Imagine having/feeling that resource. Notice that you can choose what you want to do right now.</td>
</tr>
<tr>
<td>Help client recognize that s/he is in control of what is happening in the moment</td>
<td>As you notice the lightness in your chest, notice also where in your body you’re feeling ok...perhaps in your feet or legs or... Notice that you can see yourself now in the present at the same time that you’re seeing yourself as a child. Notice that you can feel into the experience of safety in this moment while you touch into the fear. Notice that you, as an adult, have a different idea about what is going on than the child.</td>
</tr>
<tr>
<td>Match the resource with the client’s process in the moment: – Somatic resource with body sensations that are uncomfortable or disturbing – Visual resource with a disturbing image of other aspects of self or “parts” – Affective resource with a disturbing affect – Cognitive resource with a disturbing thought</td>
<td>(continued)</td>
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</table>
**TABLE 5.9  (continued)**
Clinical Interweave Categories (EMDDRIIA)

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>ACTIONS</th>
<th>EXAMPLES</th>
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</thead>
<tbody>
<tr>
<td>Ground and orient</td>
<td>Feel your feet on the floor/your back against the chair. Look around the room and notice the familiarity of THIS space. Notice the sound of my voice. Stand up. Lengthen your spine. Push against the wall. Stretch your arms out.</td>
<td></td>
</tr>
<tr>
<td>When in a state of hypoarousal, help client gain access to components of experience</td>
<td>Notice the numbness; notice where you feel it in your body. Let yourself be curious about what you might be feeling beneath the numbness. See if you can sense into what is going on through your body. Let your body speak to you in its own language and be receptive to what comes up.</td>
<td></td>
</tr>
<tr>
<td>Defense</td>
<td>Name the defense</td>
<td>Notice the shutdown that occurs every time I ask you what is happening.</td>
</tr>
<tr>
<td>Defense</td>
<td>Find the resistance/block in the body</td>
<td>Where do you feel that (hesitation/fear/shutdown/protective wall) in the body? Stay with that.</td>
</tr>
<tr>
<td>Defense</td>
<td>Validate the defense</td>
<td>I know that this is how you protected yourself for a long time; maybe it’s finally safe enough to let yourself feel the (grief, anger, longing). Can you allow yourself to feel into the emotion now?</td>
</tr>
<tr>
<td>Defense</td>
<td>Guide client back to affect/body</td>
<td></td>
</tr>
<tr>
<td>Defense</td>
<td>Unblend the “protective part” from the “traumatized part”</td>
<td>I understand that this part of you is concerned and wants to protect you. See if this protective part would be willing to relax back just a bit to allow us to work with the traumatized part for a few moments.</td>
</tr>
</tbody>
</table>
| Validate the emotional need and renegotiate the strategy (defense) | If the protective part is unable/unwilling to relax back:  
**Ask this protective part what he or she is afraid will happen if s/he were to relax back?**  
**Would that protective part be willing to explore other ways of** (keeping him/her safe, managing the feelings/pain, making sure s/he can handle it?) |
|---|---|
| Explore for relevant earlier experiences connected to blocked processing, fears, and/or beliefs  
Float back to explore for relevant associations | When have you experienced this before?  
Where did you learn to respond that way?  
Whose voice is that?  
**Notice the feelings, thoughts, and sensations coming up here. Let your mind float back to an earlier time when you responded this way. What do you get?** |
| Remove the pressure | **No rush. It’s important to be kind to yourself...just take your time with what’s coming up.** |
| Coach | **You can stay with this. You can do this! I’m totally with you. You’re not alone this time. I’m right here. Let’s stretch a little.** |
| Make the conflict/resistance explicit | So, notice that one part of you really wants to let go of the anger, while another part isn’t so sure.  
**Notice both at the same time and be curious about what happens next.** |
| Developmental Repair | **Acknowledge and validate unmet developmental needs**  
**Connect the adult with the child part to repair unmet needs**  
**What does that child need now (that you wished someone could have done for you back then and didn’t)? Imagine offering this to him or her. Notice that you can go to this child now and s/he doesn’t have to be alone in this experience.** |

(continued)
<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>ACTIONS</th>
<th>EXAMPLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check receptivity of child</td>
<td>How is this child responding to you? Is this child feeling accepted and understood by you right now? What’s it like for this child to know that you’re with him/her? If the child is not receptive: Can you understand why s/he might be hesitant to let you in? Can you let him/her know that you understand why s/he is (scared, mistrustful, angry, and unable to respond)? Take it slow and allow for his or her experience.</td>
<td></td>
</tr>
<tr>
<td>Give back responsibilities/ burdens</td>
<td>Can you “give back” to your parents the responsibility of keeping the family safe? Can you consider it was wrong for them to ask you to take care of them when you were so little?</td>
<td></td>
</tr>
<tr>
<td>Fully acknowledge the emotional impact of having unmet needs/ longings from childhood</td>
<td>Can you accept that your mother will never be the parent you needed as a child? Can you allow yourself to feel the grief connected to this realization?</td>
<td></td>
</tr>
<tr>
<td>Relational</td>
<td>Use relationship with the therapist as a counterpoint to the past</td>
<td>Notice that you’re not by yourself right now...not at this time.</td>
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<tr>
<td>Undo aloneness</td>
<td>Stay with it and stay with me. You’re not alone. Do you feel me with you? I’m not going to let you drown. I’m right here. Whatever comes up, we’ll deal with it together.</td>
<td></td>
</tr>
<tr>
<td>Reassure and address unspoken fears</td>
<td>What do you see when you look at my face? Notice that (unlike your parent) I’m not scared or overwhelmed or sitting in judgment.</td>
<td></td>
</tr>
<tr>
<td>Use agreed-upon touch</td>
<td>Would it be helpful if I put a hand on your back so you can feel my support? If you’d like, you can rest your hand in my hand.</td>
<td></td>
</tr>
<tr>
<td>Ask client to stretch with you</td>
<td>Are you willing to work this edge with me for a minute or two? I’ll help you.</td>
<td></td>
</tr>
<tr>
<td>Undo shame with compassion and empathy</td>
<td>My heart is breaking for you right now. Notice what it’s like to feel my compassion for you right now.</td>
<td></td>
</tr>
<tr>
<td>Provide permission and encouragement to take in support</td>
<td>Go ahead and express what you’re feeling. Notice that it’s okay with me...that your feelings, your needs are not too much. In fact, I welcome them.</td>
<td></td>
</tr>
<tr>
<td>Meta-process</td>
<td>What’s it like for you to tell me this? Notice what it’s like for you to be seen/understood by me in this moment.</td>
<td></td>
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<tr>
<td>Make the experience dyadic</td>
<td>I’m wondering what it’s like for you to see me so incredibly touched by your experience?</td>
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<tr>
<td>CATEGORY</td>
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<td>EXAMPLES</td>
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<tr>
<td>Check client’s receptivity</td>
<td>What is it like for you to share this experience with me? ...to have us share this experience together? I am feeling _____ right now. Does that make sense to you? Is it okay with you that I’m feeling _____?</td>
<td></td>
</tr>
<tr>
<td>Informational</td>
<td>Provide psychoeducation:</td>
<td>Tears are welcome and healthy. They allow you to transform grief and move on.</td>
</tr>
<tr>
<td></td>
<td>Examples:</td>
<td>Children are never responsible for abuse.</td>
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<tr>
<td></td>
<td>– Function of emotions</td>
<td>Attachment is biologically driven. Of course you were looking for attention. This part may seem like the enemy but s/he is actually trying to help and protect you.</td>
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<td></td>
<td>– Appropriate responsibility</td>
<td>You probably wanted to fight back or flee but you couldn’t. The terror was too great and your body froze. That’s just what happens when you are facing an overwhelming threat. You can help your body know that it’s safe now and it can begin to relax.</td>
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<tr>
<td></td>
<td>– Nature of attachment</td>
<td></td>
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<td></td>
<td>– Role of “parts”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>– Fight/flight/freeze</td>
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</tr>
<tr>
<td>Normalize reactions, needs, and experiences, when appropriate</td>
<td>This is a normal, understandable reaction. Other people probably would have done the same thing in that kind of situation. Just like when you touch a hot stove and react, arousal is an involuntary reflex. It’s just what your body does. Of course, you were lonely and needed attention. You were a little girl and no one was taking care of you.</td>
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<tr>
<td>Question/challenge distorted perceptions and rigidly held beliefs</td>
<td>What if this happened to your daughter/best friend? What would you say to her? Who would you hold responsible? What do you imagine a good parent might say in this situation? If we could invite ______ into the scene, what would s/he say? I’m confused…you mean a child can cause a parent to drink?</td>
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<tr>
<td>Invite client to consider other points of view</td>
<td>Offer metaphors, analogies, and stories to offer perspective Reference common fairy tales, bible stories, popular culture, images from nature, etc. Just like running a marathon, it takes time and practice; and you’re in it for the long run. While there’s no way to undo what happened, perhaps there is a way to balance the scales going forward. It’s like a jigsaw puzzle, where you can’t see the whole picture until you have all the pieces. You’re like the boy in The Emperor’s New Clothes. You knew the truth, tried to get others to see it, but couldn’t.</td>
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<tr>
<td>Orient to current context; age and height, time and place, current sense of safety</td>
<td>Notice that you’re here and you are safe now. Look at your hands. How old do they appear to you? Where do you live now? How old are you? How tall are you? Send this information out to all parts of you.</td>
<td></td>
</tr>
<tr>
<td>Integration</td>
<td>Facilitate generalization of learning, linking new beliefs and sense of self to present and future goals Float forward to explore anticipatory anxiety Utilize future templates What would you like to be able to do now and in the future that you couldn’t do before? Imagine it… When you think of speaking to your (mother/father/boss) what comes up? What happens inside? Imagine speaking up to ______. Notice what it’s like to use your voice now. So, from this place of (mastery, triumph, readiness), imagine yourself taking center stage.</td>
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<th>CATEGORY</th>
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<tr>
<td>Integrate new experiences, perspectives,</td>
<td>What is it like to finally have an adult understanding of the child’s</td>
<td>What is it like to finally have an adult understanding of the child’s experience?</td>
</tr>
<tr>
<td>and learning into sense of self and evolving</td>
<td>positive belief do you have about yourself now, after successfully</td>
<td>What positive belief do you have about yourself now, after successfully (expressing your true feelings, recognizing that it wasn’t your fault, etc.)?</td>
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<td>life narrative</td>
<td>(expressing your true feelings, recognizing that it wasn’t your fault, etc.)?</td>
<td>Yes, and imagine how it can be different now and in the future. How does this [set of] experience(s) inform how you see yourself?</td>
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<td></td>
<td>Yes, and imagine how it can be different now and in the future. How</td>
<td>Yes, and imagine how it can be different now and in the future. How does this [set of] experience(s) inform how you see yourself?</td>
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<td></td>
<td>does this [set of] experience(s) inform how you see yourself? What</td>
<td>Yes, and imagine how it can be different now and in the future. How does this [set of] experience(s) inform how you see yourself?</td>
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<td></td>
<td>feels like the most important thing you learned about yourself or</td>
<td>Yes, and imagine how it can be different now and in the future. How does this [set of] experience(s) inform how you see yourself?</td>
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<td></td>
<td>for yourself today?</td>
<td>Yes, and imagine how it can be different now and in the future. How does this [set of] experience(s) inform how you see yourself?</td>
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<tr>
<td>Help client make meaning out of his/her</td>
<td>As you look back on this experience now, how do you make sense of it?</td>
<td>As you look back on this experience now, how do you make sense of it? How has changed in how you think about your life’s purpose?</td>
</tr>
<tr>
<td>life experiences</td>
<td>What has changed in how you think about your life’s purpose?</td>
<td>What has changed in how you think about your life’s purpose?</td>
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<tr>
<td>Highlight appropriate responsibility</td>
<td>What’s it like for you to realize that you were holding yourself</td>
<td>What’s it like for you to realize that you were holding yourself responsible for your parents’ failures?</td>
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<td>responsible for your parents’ failures?</td>
<td>What’s it like for you to realize that you were holding yourself responsible for your parents’ failures?</td>
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<td>What’s it like to have helped your child self unload that burden of</td>
<td>What’s it like to have helped your child self unload that burden of responsibility?</td>
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<td>responsibility?</td>
<td>What’s it like to have helped your child self unload that burden of responsibility?</td>
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<tr>
<td>Highlight present safety</td>
<td>What’s it like to know that it is truly over and that you are truly</td>
<td>What’s it like to know that it is truly over and that you are truly safe now?</td>
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<tr>
<td></td>
<td>safe now?</td>
<td>What’s it like to know that it is truly over and that you are truly safe now?</td>
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<td></td>
<td>What’s it like for your younger self to know that you are able to keep</td>
<td>What’s it like for your younger self to know that you are able to keep him/her safe now?</td>
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<tr>
<td></td>
<td>him/her safe now?</td>
<td>What’s it like for your younger self to know that you are able to keep him/her safe now?</td>
</tr>
<tr>
<td>Highlight power and choices in the present</td>
<td>What’s it like for you to recognize that you have a choice today?</td>
<td>What’s it like for you to recognize that you have a choice today? What’s it like to realize that you are not being held back by anything or anyone at this point in your life?</td>
</tr>
<tr>
<td></td>
<td>What’s it like to realize that you are not being held back by anything</td>
<td>What’s it like to realize that you are not being held back by anything or anyone at this point in your life?</td>
</tr>
<tr>
<td></td>
<td>or anyone at this point in your life?</td>
<td>What’s it like to realize that you are not being held back by anything or anyone at this point in your life?</td>
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<td>Notice what it’s like for you to be able to give your child self exactly</td>
<td>Notice what it’s like for you to be able to give your child self exactly what s/he needs [rather than having her/him waiting or looking for someone else to give it].</td>
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<td>what s/he needs [rather than having her/him waiting or looking for</td>
<td>Notice what it’s like for you to be able to give your child self exactly what s/he needs [rather than having her/him waiting or looking for someone else to give it].</td>
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<tr>
<td></td>
<td>someone else to give it].</td>
<td>Notice what it’s like for you to be able to give your child self exactly what s/he needs [rather than having her/him waiting or looking for someone else to give it].</td>
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</table>
| Action | Facilitate the completion of a thwarted fight/flight response in imagination  
Facilitate the completion of a thwarted fight/flight response by helping the client track and feel into the body’s action impulse  
Facilitate release of excessive arousal by allowing for somatic discharge of thwarted fight/flight response | How do you experience that (anger, hurt, resentment) inside of you? What does it want to do? Is there any impulse or urge that wants to come out? What does your (hand, foot, jaw, etc.) want to do? Imagine doing it now. Just FEEL into the impulse in your body to do now what it was unable to do at the time... just sense into it... notice it... trusting your body to do [finish] now what it was unable to do [finish] at the time. Notice the (shaking, trembling, temperature changes, vocal sounds, etc.) and allow it to move through you. It’s how your body is releasing all that stored up energy. |
| Tell the child that it’s okay/safe to reach out now. Imagine reaching out to that little boy/girl and holding her close. Imagine asking your wife/husband (in present day life) for help and letting her/him comfort you. Imagine yourself feeling relaxed, secure, and able to enjoy your partner’s safe touch. | Facilitate the expression of specific attachment-related actions/gestures in imagination | It was your parents’ responsibility to keep your sister safe, not yours. Are you ready to “give back” to your parents what is theirs? Okay, imagine doing that right now. Imagine handing that responsibility back to them. Imagine giving that shame back to them. It’s theirs, not yours. Or, do it right now. Take this (object) and notice what it feels like to let it go. |
| Facilitate the action of “giving back” responsibility to others and “letting go” of emotional burdens (in imagination or real time) |  |

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<tr>
<td>Give permission to verbalize unspoken words and/or complete thwarted actions (in imagination or real time) Encourage client to move from a passive (powerless) to an active (choices) stance</td>
<td>What would you like to say to him/her (perpetrator) now that you couldn’t say back then? Imagine it. What would you like to do now that you couldn’t do then? Imagine it... Go ahead and say/do it now... Show me what it would look like. Imagine fighting back. What would you say or do right now if s/he were here? Imagine that there are no limits. Stay with it until it feels satisfying enough or complete.</td>
<td>I’m wondering if you want to say or do something. Does that feel possible? How would it be for you to give yourself permission to...? Could you say, “I’m mad at you for betraying me?” Can you imagine slamming the door in his face?</td>
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<tr>
<td>Help the client with permission, words, or actions when s/he is frozen, scared or stuck</td>
<td></td>
<td>Push against the wall with your hands. Feel your strength. Feel the energy in your body. Throw this pillow with me. Notice what it’s like to throw it lightly/to throw it hard. Hold your hands up and say “STOP” as I approach you. Pay attention to your own personal boundary. Notice what it’s like to take action on your own behalf. Walk around the room and feel the freedom of movement. Find your stride. Have fun with it.</td>
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Abreactions, Blocked Processing, and Cognitive Interweaves

Cognitive interweaves allow a clinician to help a client remove obstacles to stalled processing. Please consider reasons that may cause a train to leave its tracks in terms of a clinician’s use of the cognitive interweave as outlined in Table 5.10, “Derailment Possibilities—Cognitive Interweave.”

**TABLE 5.10**
Derailment Possibilities—Cognitive Interweave

<table>
<thead>
<tr>
<th>Using a cognitive interweave before a clinician has been properly trained and supervised in its use. The cognitive interweave is a powerful strategy to help a client jump-start processing. A newly trained clinician should use it only after he has had adequate practice and supervision. A clinician should be proficient with the basic EMDR protocol and methodology prior to facilitating a cognitive interweave.</th>
</tr>
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<tbody>
<tr>
<td>Using a cognitive interweave when spontaneous processing appears to be occurring. The cognitive interweave was designed to be used only when spontaneous processing appears to be insufficient to achieve a client’s therapeutic goals. Cognitive interweaves are to be used when a client is looping, lacks sufficient information, processing does not generalize to ancillary targets, or if a client is abreacting and there is not enough time in a session to appropriately process information. If these reasons are not present, refrain from using this more proactive version of EMDR reprocessing.</td>
</tr>
<tr>
<td>Failing to determine if blocked processing is due to other reasons. The clinician should first determine whether blocked processing is due to other aspects of the treatment process (e.g., adequate preparation, existence of secondary gains or blocking beliefs, safety issues).</td>
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<tr>
<td>Using a cognitive interweave(s) as a means of analyzing, summarizing, reflecting, etc. (i.e., an excuse for talking). Cognitive interweaves should be used sparingly by the clinician so that a client possesses and retains the ability to process the material internally. This will greatly enhance a client’s self-esteem, self-efficacy, and self-empowerment.</td>
</tr>
<tr>
<td>After a cognitive interweave has been used, not allowing a client to return to spontaneous processing with successive sets of BLS. Once a blockage has been removed, the clinician should allow the client to return to spontaneous processing. Any time that the therapist has intervened to facilitate processing, it is important to return to the target and reprocess without intervention by the therapist to ensure that a client has successfully integrated new information.</td>
</tr>
<tr>
<td>Failing to use the cognitive interweave selectively. If at all possible, allow a client to utilize his own processing system to fully integrate any information that may arise during the reprocessing phase.</td>
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for Experiential, Modulation, Defense, Developmental Repair, Relational, Informational, Integration, and Action interweaves.)

If the strategies outlined previously (i.e., strategies for blocked processing, cognitive interweave) do not work to unblock the processing, the reprocessing session should be terminated and other avenues of treatment explored.

**SUMMARY STATEMENTS**

1. Blocked processing is first addressed by changing eye movements (i.e., speed, length, direction) or changing the client’s focus of attention.

2. A client should be informed beforehand of any changes in BLS, including a brief explanation of the clinician’s rationale and used only with the client’s expressed consent.

3. When using a strategy to reactivate stalled processing and a shift occurs, allow the reprocessing to resume on its own to the extent possible. It is important to go back to the original target in order to ensure that the client is reprocessing the memory unaided by the clinician’s interventions.

4. The cognitive interweaves described in this chapter are designed to mimic spontaneous processing and to facilitate change. It is important to remember that it is the client’s brain doing the work.

5. The cognitive interweave is a powerful intervention.

6. Spontaneous processing is the most desirable processing as it is determined totally by the client’s own brain and Adaptive Information Processing mechanism.

7. “All targets must be reaccessed and processed in undistorted form” (Shapiro, 2009–2014).
In this chapter, the clinician will be reintroduced to the basic components of Eye Movement Desensitization and Reprocessing (EMDR) Therapy through transcripts of therapy sessions. The EMDR reprocessing sessions are introduced in order of past (Airi, Karen), present (Delores, Breanna), and future (Jimmy), as well as with the use of the cognitive interweave and informational plateaus (Kevin) and EMD (Harlan). These are simple, uncomplicated sessions. These cases are presented in this way to demonstrate to the reader what a successful session looks like when the client reprocesses disturbing material without any interventions by the clinician. As a newly trained EMDR Therapy clinician, it is inadvisable to implement EMDR Therapy starting with your most difficult client. Begin using this approach with clients you believe success is possible for them and you. And practice, practice, practice. It is wise for any novice EMDR Therapy–trained clinician to seek consultation as a strategic course of action with an EMDRIA Approved Consultant.

The following questions cover some of the basic information needed to complete a successful EMDR reprocessing session.

**QUESTIONS**

After a set of bilateral stimulation (BLS), what does the clinician say? Does EMDR reprocessing have the ability to change something that is real or factual?
Has adaptive resolution been achieved when the clinician returns the client back to the original target?

How does the clinician know that the client is at the end of a channel of association?

How does the clinician close down the EMDR Therapy process?

How fast should the BLS be?

How is setting up a future template different from setting up the standard EMDR protocol for a past event or present trigger?

How many times should the clinician reinforce positive treatment effects identified by the client?

How often should the clinician reinforce and encourage the client throughout the EMDR process?

Is a positive cognition (PC) reflective of what the client believes or would like to believe about himself as he focuses on a particular trauma?

Is EMDR Therapy focusing on then or now?

Is it ever okay to initiate reprocessing without first establishing a negative cognition (NC) associated with the traumatic event being processed by the client?

Is the issue with which the client presents necessarily the same as the image she eventually reprocesses?

Is there any way for the clinician to utilize a negative physical sensation expressed by the client to further his process?

What are the characteristics of negative and positive cognitions?

What does the clinician do if the client begins to cry or visibly emote in any way?

What does the clinician do if the client only reports physical sensations between sets?

What does the clinician do if the client reports newly emerging memories or changes in what the client originally reported at the beginning of the EMDR reprocessing?

What does the clinician do if the client states more than one negative or positive cognition related to a specific traumatic memory or event?

What does the clinician do when the client cannot come up with an appropriate NC?

What does the clinician say to the client between sets? What is appropriate? What is not appropriate?

What does the clinician say after each set of BLS?

What does the Validity of Cognition (VoC) measure?

What is an option if the client reports an emotion during the feedback process?
What words does the clinician use to initiate processing with the client?
When is it appropriate for the clinician to return the client back to the original target?
When is it appropriate to ask the client what his Subjective Units of Disturbance (SUD) level is?
When is it appropriate to initiate the actual reprocessing of the client’s traumatic event?
When should the client proceed with the Installation Phase?
Why does the clinician redirect the client back to an original target?
Why is it imperative that the clinician does not intrude upon the client’s process?
Why is it important for the clinician to stay out of the client’s way?
Why is it important for the clinician to reinforce any positive shifts by the client?
Why is it important for the clinician to provide encouragement to the client during and between sets of BLS?
Should SUD = 0 be reinforced with a set of BLS? VoC = 7? Body scan = clear?
Why does the clinician check in with the client between sets of BLS? How does the clinician initiate it?
At the beginning of the Installation Phase, why does the clinician ask the client whether the original positive cognition is appropriate or not?
Can EMDR reprocessing work successfully with a general target?
What can the clinician do if the client continues to give a narrative report of what happened the day of the trauma?
What does the clinician do if she keeps witnessing movement in the client’s process?
What does the clinician do if there is no movement of any kind in the client’s reprocessing efforts for two or more sets of BLS?
When is it appropriate for the clinician to check the client’s current SUD level?
When is it appropriate for the clinician to redirect the client back to the original target?
Why does the clinician check in so frequently with the client?
What is the hallmark of EMDR Therapy?

In the following transcripts, it is assumed that the clinician has completed Phases 1 and 2 (i.e., History-Taking and Treatment Planning and Preparation). The client’s history has been outlined to provide the reader with a clearer understanding of the client’s chosen targets. Read the following cases and, when finished, come back and answer the aforementioned
questions again. Be prepared to write down the components of the target (i.e., NCs and PCs, emotions, and body sensations) and baseline responses (i.e., VoC and SUD) identified by the client.

In each case, when the clinician asks the client to focus on the original event (incident, experience), the client’s original target has been placed in brackets with a reminder (e.g., Reminder: Original incident—when Tom was bitten by a snake when he was in the second grade) to help the user remember the original target’s wording. If the reprocessing takes the client far afield, the clinician may need to remind the client of the target memory. However, do not repeat the target image back to the client. The words are placed there only as a reminder to the clinician of the client’s original target. In order to reinforce learning, some of the salient elements of EMDR Therapy have been repeated more than once.

Because of the simplistic nature of a Primer, the following cases mirror more what happens in EMDR Therapy much of the time—with no or very few interventions. It is important for the clinician to be able to master the basics of EMDR Therapy before utilizing it with more complicated cases. The reader is directed to the many EMDR Therapy books and articles (see the Francine Shapiro Library at http://emdria.omeka.net for more sophisticated examples of EMDR processing sessions).

**PAST**

**Case Example 6a: Airi**

**Situation:** At age 20, the client was jammed up against a blackboard by several students’ desks in the midst of a tornado that occurred during one of her college classes.

**Type of presentation:** Single incident.

**Symptoms:** Depression, lethargy, poor appetite, joylessness.

**Issues:** Unable to attend classes (eventually flunked out), reacts to extreme weather conditions, unable to hold a job, and has had multiple failed relationships.

Airi was looking out of a window daydreaming in one of her classes at a small college in the Midwest. With little warning, the previously clear sky became immersed with large, rapidly growing clouds until it resembled a grayish black wall. She remembers the clamor of constant thunder in the background and then the torrents of rain that began to descend almost instantly. The day had become night, and the tornado sirens began to roar and signal everyone to head for cover. But it was too late for her to seek cover. Her classmates scrambled for safety in the darkened corridors. The
force of the wind popped the windows out of their panes. Desks, papers, and other debris whipped around erratically and dangerously. Within minutes, hail as big as golf balls began to pummel the ground, some flying through the now glassless windows. Airi found herself jammed up against the blackboard by two or three of the students’ desks. She was quite shaken but appeared to be okay.

This was Airi’s first and only encounter with disaster. Having been brought up in a loving home in what she called a “normal” childhood, she had not experienced any kind of trauma, certainly not one of this magnitude. In her case, this was a one-time event. Even so, she did not fare so well. She found herself isolating in her room, unable to attend classes, especially if the weather was not sunny and clear. She became more and more lethargic and depressed. She had lost her appetite and her joy for living.

By the time Airi reached the clinician’s office, she was 25 years old. She appeared haggard and pale. A year after the tornado, she had flunked out of school, had been involved in multiple failed relationships, and could not hold down a job.

**Target**: The tornado.

**Image**: Sitting quietly in my chair and being flattened against the blackboard.

**NC**: I cannot protect myself.

**PC**: I can protect myself.

**VoC**: 2.

**Emotion(s)**: Terror, helplessness.

**SUD**: 10.

**Body**: Below belly button.

Although not repeated for each transcript that follows, before the Assessment Phase begins the clinician says to the client, “Often we will be doing a simple check on what you are experiencing. I need to know from you exactly what is going on with as clear feedback as possible. Sometimes things will change, and sometimes they won’t. There are no supposed to’s in this process. So just give as accurate feedback as you can as to what is happening without judging whether it should be happening or not. Just let whatever happens, happen.” Remember to tell the client about the STOP hand signal.

The clinician usually needs to repeat the complete instructions once to a client, unless the client has difficulty remembering what is expected of her from session to session. The clinician instructs just before desensitization and reprocessing begins, “Focus on the event (incident, experience), those words (NC), and where you feel it in your body. Just let whatever happens, happen. Let it go wherever it goes.”

Alternatively, the clinician may also say: “Remember, it is your own brain that is doing the healing, and you are the one in control. I will ask you to mentally
focus on the target and to follow my fingers with your eyes. Just let whatever hap-
pens, happen; and we will talk at the end of the set. Just tell me what comes up, and
don’t discard anything as unimportant. New information that comes to mind is con-
nected in some way. If you want to stop, just raise your hand” (Shapiro, 2001).

The following is a transcript of Airi’s first reprocessing session.

Assessment

Clinician: Last time we met, you indicated to me that you wanted to work on the memory of being in a tornado. What image (or picture) represents the most disturbing (or most traumatic) part of the incident?

As a part of an overall treatment plan, this memory was agreed upon by the client and the clinician in the History-Taking and Treatment Planning Phase as the touchstone memory related to the presenting issue. The target memory had been identified, but the image that represents it had not. The clinician invited her to select a single image with which to begin. She has many potential images, so the clinician asked her for the most disturbing part of the memory. By asking this question, the information about the incident becomes stimulated and accessible.

Airi: It all happened so fast. Within seconds, everything changed. One min-
ute I am daydreaming out the window. The next minute, I find myself flat-
tened like a pancake up against a blackboard with desks piled on top of me. I don’t remember anything in between. That’s the most disturbing part for me, the time in between sitting quietly in my chair and being flattened against the blackboard, not knowing exactly how I got there.

Clinician: What words go best with the image (or picture) that express your negative belief about yourself now?

This question can be difficult for some. Airi could have become confused between a feeling and a belief and blurted out something like “I was scared.” Or, perhaps, she might have provided a description of circumstances, such as “I was not in control.” In Airi’s case, this is a true statement. She was not in control. EMDR does not have the power to change something that is true or factual. And it does not have the power to change a past thought. If the client does not come up with a belief, try to elicit an appropriate one by asking, “What does that make you believe about yourself now?”

Airi: I cannot protect myself.

Airi’s negative cognition is appropriately stated in the present and is a belief about herself. It is not an emotion or a statement of circumstance. It is also self-limiting. In this case, Airi had quickly decided on an appropriate negative belief. What if she had initially responded with two or more
negative cognitions, such as “I am helpless,” “I am powerless,” or “I cannot pro-
tect myself”? These are three separate beliefs. The clinician may help the cli-
ent elicit the negative cognition that best fits as she thinks about herself with
respect to this event. In this case, the clinician might say, “As you focus on the
incident, which belief resonates the best?” Remember, the clinician is looking for
a belief the client has that continues now as a result of this experience.

The clinician should be cautious about feeding cognitions to the client
despite the temptation to do so. Make every effort to solicit these cognitions
from the client. And then, only if the client continues to have difficulty, pull
out a list of negative and matching positive cognitions (see Table 3.5) or the
placard developed by Trauma Recovery/EMDR Humanitarian Assistance
Program (HAP). If the client continues to have difficulty, it becomes appro-
priate for the clinician to offer potential cognitions. When cognitions are
offered, two or more should be suggested to avoid the client only agreeing
to a negative cognition to please the clinician.

Clinician: When you bring up that image (or picture), what would you like
to believe about yourself now?

Airi: I can protect myself.

Does Airi’s belief as stated meet all the criteria for an appropriate posi-
tive cognition? The “I” in the statement is indicative that it is self-referential
and it is stated in the present. Safety is her desired direction of change; it
is future oriented. It is a positive assessment that is generalizable in that
it could influence her perception of past events, current assessment, and
future expectations.

Clinician: When you focus on that image (or picture)), how true do those
words, “I can protect myself,” feel to you now on a scale from 1 to 7, where
1 feels completely false and 7 feels completely true?

Airi: I am not sure what you mean.

Clinician: Remember, sometimes we know something with our head, but
it feels differently in our gut. In this case, what is the gut-level feeling of the
truth of “I can protect myself,” on a scale of 1 to 7, where 1 is completely
false and 7 is completely true?

Does this belief reflect wishful thinking, or is it an actual possibility for
Airi? The VoC measures the possibility of the positive cognition. If the posi-
tive cognition is not possible, the VoC is not valid either.

Airi: It’s about a two. Maybe a little less than that.

Often 1 or totally false indicates that the client may have difficulty
believing the positive cognition though it is what she would like to believe.
The clinician could assist her to come up with wording that would make the statement more believable (e.g., “I can protect myself” might become “I can learn to protect myself.”). Even with her answer of 2, there is a need to assess Airi’s ability to assimilate this positive cognition successfully. The clinician believed she could.

**Clinician:** When you bring up that image (or picture) and those words, “I cannot protect myself,” what emotions do you feel now?

**Airi:** Terror. And I feel helpless.

**Clinician:** From 0, which is neutral or no disturbance, to 10, which is the worst disturbance you can imagine, how disturbing does it feel to you now?

**Airi:** Oh, that’s easy. It’s a ten!

**Clinician:** Where do you feel it in your body?

**Airi:** I feel it below my belly button.

**Desensitization**

**Clinician:** I would like you to bring up that image (or picture), those negative words “I cannot protect myself,” and notice where you feel it in your body. Just let whatever happens, happen. (Set of BLS)

Remember to maintain an air of neutrality and encourage the client throughout the process. The clinician is still watching, guiding, nurturing, and accepting while remaining compassionate but detached from the client’s responses to the processing.

If the clinician is using something other than fingers to facilitate eye movements or some other form of BLS, activate it to start and stop the stimulation.

After this initial set of BLS, the image and the negative cognition are not referred to again.

**Airi:** (Takes a breath)

Sometimes, the client will spontaneously take a breath. It is up to the clinician whether or not to ask the client to take another one. In either case, the clinician asks the client, “What are you getting now?” or “What’s coming up now?”

**Clinician:** That’s it. Take a breath. (Pause) Let it go. (Pause) What are you getting now?

**Airi:** I am resistant to going there.

“What are you getting now?” refers to the thoughts, emotional and physical sensations, and images that may have emerged during reprocessing.
During the course of EMDR reprocessing, the clinician checks in frequently to ascertain the client’s current condition and to see if new information has emerged. The client reports dominant image, emotional, and/or physical sensations. Based on what the client reports, the clinician will direct the client to “Go with that,” “Notice that,” or return to the original target if the clinician feels a new plateau of processing has been reached.

If using eye movements, the clinician initially uses horizontal movements to ensure effectiveness.

One of the basic strategies for encouraging a client to maintain a dual focus of awareness is for the clinician to utilize periodic supportive statements. Dr. Shapiro (2001) suggests the following statements: “That’s it, Stay with it. You’re doing fine.” “It’s old stuff.” “That was then. This is now.” “Just notice it.” “It’s in the past.” “It’s over. You’re safe now.”

The clinician is encouraged to maintain a receptive response.

**Clinician:** Use your stop signal if you need it.

It is important for the clinician to monitor the client’s verbal and non-verbal signals (i.e., breathing, posture, facial expression, energy level) at all times and to check in with the client as needed. In this instance, the client may or may not have wanted to stop processing as indicated by her words, “I am resistant to going there.”

**Airi:** No, I’m fine. I need to do this.

**Clinician:** Okay. Just notice that. (Set of BLS) Go with it. You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What’s coming up for you now?

Remember to be undemanding when asking the client to report on new information, images, emotions, or when dominant sensations have arisen between sets. The clinician needs only to determine if the actual reprocessing has taken place. Allow the client to report what is most salient to her at the time of the processing. Do not elicit this information by asking the client specifically “What are you feeling?” or “What is it that you see?”

When pausing between sets of eye movements, it is inappropriate to say “relax” or “close your eyes.”

**Airi:** I remember how excited I was when I first saw the clouds forming and saying to myself, “I wonder if this is a tornado.” I was so excited. I can feel the excitement now. I had never seen one up close before.

**Clinician:** Go with that. (Set of BLS) You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

**Airi:** The excitement turned to panic when I saw my classmates running toward the door. Before I could react, I could feel myself being lifted from my chair. I was terrified.
It is evident that information is being processed when the client describes a shift in one of the distinct aspects of the memory (i.e., image, sound, cognition, emotion, physical sensation). Another indicator is when a new event arises that is linked associatively (i.e., by an inherent belief, major participant or perpetrator, pronounced stimuli, specific event, dominant emotions, or physical sensations) with the original event (incident, experience).

Clinician: Notice that. (Set of BLS) You’re doing fine. Take a breath. That’s it. (Pause) Let it go. (Pause) What comes up for you now?

The clinician is encouraged to make comments like “Good” or “You’re doing fine” to reinforce the client’s efforts and to reassure her that she is reprocessing correctly. The clinician may want to be mindful to listen supportively and compassionately. This is a team-driven approach (i.e., clinician and client). As such, the clinician is encouraged to inhale and exhale along with the client. It helps to establish and solidify the bonding that is important to the process (Shapiro, 2001). Some clients may be uncomfortable with the word “good.” In these cases, use the phrase “That’s it.”

Airi: I can still feel the terror.

Clinician: Where do you feel it in your body?

Airi: All over. I feel electrified.

When a client identifies an emotion during the processing, ask her where (not what) she feels in her body.

Clinician: Notice that. (Set of BLS) You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Airi: It’s the same. It doesn’t seem to be going away.

Clinician: How are you doing? Do you want to continue? Do you want to take a minute?

Client: No. I think I can continue.

At this point, the clinician may offer a distancing strategy (e.g., change direction or speed of BLS) to further facilitate reprocessing.

After each set of BLS, the clinician asks for feedback. And the clinician may ask for it in several different ways, such as “What’s coming up now?” “What are you getting now?” “What’s happening now?” “What are you noticing now?” It is important to include the word now so that the client is reminded to respond with whatever she is dealing with at that particular moment. It is not necessary for her to recount everything that happened to her between sets—only what she ends up with.

Airi: I’m remembering the tornado siren and how frightening that feels right now.

The new image the client described now becomes the focus of concentration for the next set of BLS.

It is also suggested that, if Airi’s shifts in information were primarily cognitive, the clinician may want to increase the number of movements back and forth to 36 or 48 (or, for some clients, a set of less than 24) to see if the client responds better. It is unnecessary to count the exact number of movements. The clinician’s attention remains on the client’s facial expressions and other body cues, rather than on counting the exact number of movements.

Clinician: Where do you feel it in your body?
Airi: In my chest.

Clinician: Notice that. (Set of BLS) You’re doing fine. Good. Good. Let the memory peel off. Take a breath. (Pause) Let it go. (Pause) What are you noticing now?
Airi: I feel calmer.

Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What comes up for you now?
Airi: It’s the same. I just feel calm and relaxed.

Clinician: When you focus on the original event (incident, experience), what do you get now?

(Reminder: Original incident—At age 20, the client was jammed up against a blackboard by several students’ desks in the midst of a tornado that occurred during one of her college classes.)

Notice that the clinician asks the client to focus on the original incident, not specifying “the time in between sitting quietly in my chair and being flattened against the wall.” When the clinician asks the client to focus on the original incident, he may also use words like memory or experience where appropriate.

Airi: I see that the glass has been blown from the windows. My classmates are frantic. There is chaos everywhere.
Just notice as successive channels of association are revealed.

Clinician: Go with that. (Set of BLS) That’s it. Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Airi: I am looking around, and now I’m seeing that the other students appear disheveled. They are dazed and bruised, but they are okay. I am okay. It feels good.

Clinician: Go with that.

Airi: Everything happened so fast. One moment there’s a classroom and everything is normal. A few minutes later, everything is chaotic and debris is everywhere. I am vulnerable. I was then and I feel so now.

Clinician: Notice that. (Set of BLS) It’s just old information. Watch it like it is scenery going by. Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Again, continue to reinforce the client by saying “You’re doing fine” or some other words of encouragement during or at the end of a set. It helps keep the client grounded and in the present to hear the clinician’s voice. The clinician also needs to remain grounded in the present with his client.

Dr. Shapiro (2001) strongly suggests reassuring the client during processing by gently or unobtrusively saying “Good.” It is a neutral response and is preferred over “excellent” or “great.” Those words imply judgment on the client’s process and could impede or cloud the client’s progress.

Airi: There’s a commercial where the punch line is, “When life comes at you fast.” I think it is about insurance or something. I don’t remember. That’s how I felt, that my life was coming at me fast and that it might be ending fast. In the blink of an eye, everything had changed.

Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What are you getting now?

Do not try to interpret all the details the client provides between sets of BLS. By asking questions similar to “What are you getting now?” the clinician tries to determine how the information surrounding the original event (incident, experience) is stored now while the client is reprocessing.

Airi: I am feeling calmer. I survived with only a few scratches. I am going to be okay. I am okay.

Clinician: Go with that. (Set of BLS) Good. It’s over. It’s in the past. Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Airi: I am feeling great!
Clinician: When you focus on the original event (incident, experience), what do you get now?

Airi: I can’t seem to retrieve it. It feels far away. It’s distant somehow.

Clinician: Go with that. (Set of BLS) Just notice it. Take a breath. (Pause) Let it go. (Pause) What comes up for you now?

Airi: It’s time to move on with my life.

Clinician: When you focus on the original event (incident, experience), on a scale from 0 to 10, where 0 is neutral or no disturbance and 10 is the worst disturbance you can imagine, how disturbing is the event (incident, experience) to you now?

Airi: It is a zero. I just can’t connect with it.

She has reported a 0 level of emotional disturbance. The clinician reinforces it by doing another set of BLS.

Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What are you getting now?

Airi: It’s still a zero.

Once the SUD level is a 0, we can consider the original target to be desensitized…then, and only then, the clinician proceeds to the Installation Phase. At this point, all channels of revealed dysfunctional information appear to have been processed.

**Installation**

Clinician: Do the words, “I can protect myself,” still fit, or is there another positive statement you feel would be more suitable?

Airi: I can learn to protect myself fits better.

Clinician: Focus on the original event (incident, experience) and those words, “I can learn to protect myself.” From 1, which is completely false, to 7, which is completely true, how true do they feel now?

Airi: Six point five.

As long as the VoC keeps getting stronger or becomes more adaptive, the clinician continues reprocessing the positive cognition. If the client reports a 6, 7, or, in this case, a 6.5, the clinician will continue with additional sets of BLS to strengthen and continue until it can be strengthened no further. Then the clinician can implement the body scan.

If the client reports a VoC of 6 or less, the clinician will need to check the appropriateness and decide whether to address with additional reprocessing of existing blocking beliefs.
Clinician: Focus on the event (incident, experience) and hold it together with the words “I can learn to protect myself.” (Set of BLS) On a scale of 1 to 7, how true do those words, “I can learn to protect myself” feel to you now when you focus on the original event (incident, experience)?

Airi: It’s a seven.

Reinforce the positive cognition as well.

Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) How true do they feel now?

Airi: It still feels totally true.

**Body Scan**

Clinician: Close your eyes and keep in mind the original event (incident, experience) and those words, “I can learn to protect myself.” Then bring your attention to different parts of your body, starting with your head and working downward. Any place you feel tension, tightness, or unfamiliar or unusual sensations, tell me.

Airi: I feel some tightness in my throat.

The body scan is the last phase of the procedural reprocessing steps, and processing is not considered complete until all residual dysfunctional material associated with the original experience has dissipated.

If there is insufficient time in a session to complete a body scan, a clinician may resume this phase at the next session.

If the client reports either a negative/uncomfortable or positive/comfortable sensation during the body scan, it will be followed by BLS. For a positive or comfortable sensation, it will serve to strengthen it. If a negative or uncomfortable sensation is reported, the reprocessing will continue until it has dissipated.

It is possible that new associations may emerge during the Body Scan Phase and, if they do, they should be completely reprocessed.

With a body scan, the BLS remains at the same length and speed as before. Negative physical sensations will be processed and positive physical sensations may be reinforced.

Remember that reprocessing is considered incomplete until the body scan is clear of any residual, inappropriately associated body sensations and that the associated body responses are congruent with the neutralized memory and the positive cognition.

Clinician: Notice that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What are you getting now?

Airi: The tightness has dissipated, and I’m feeling really calm.
The clinician at this point initiates another set of BLS to reinforce the positive or comfortable physical sensations the client is experiencing.

Clinician: Notice that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What is happening now?
Airi: I am relaxed and calm.

Clinician: Hold the event (incident, experience) in mind again and rescan your body. (Pause) What do you get?
Airi: The same. I am very calm and very relaxed.

Before ending, the clinician instructs the client to hold the memory in mind along with the positive cognition and scan the body again. Before moving on from the body scan, the clinician ensures there is no residual tension, tightness, or physical discomfort of any kind. When clear, the clinician moves onto the next phase of the process.

**Future Resourcing**

Clinician: As you review your experience in our session today, what positive statement can you make to express what you have learned or gained?
Airi: That not only can I protect myself but that I did protect myself.

As an additional enhancement of the positive, the clinician may ask the client what she has learned or gained during the session regardless if it is a completed or unfinished session.

Clinician: Anything else?
Airi: That life can happen fast and that I need to appreciate and savor what I have day by day.

As will be seen later, some clinicians advocate using future resourcing as a part of closure to solidify any intermediary gains or a positive treatment outcome. The full procedure for *future resourcing* uses the Resource Development Protocol. When used as a part of closure, the procedure is abbreviated and focuses on any identified intermediary gains. Essentially, the clinician asks the client to identify and hold the new learning, pair it with an upcoming situation or challenge, then add BLS. Since all targets have not yet been completely reprocessed, future resourcing uses short, slow BLS.

Clinician: Is there a situation coming up in the next few days in which you would like to have a sense that “I can protect myself?”
Airi: It’s tornado season again. I am anticipating the high winds and possible hail.

Clinician: I’d like you to imagine yourself effectively being in that situation with a sense of knowing you can protect yourself and savoring what you have day to day. (Pause) What are you noticing?”

Airi: I feel a rush of energy. And then I see myself looking for cover. I can take care of myself. I need to enjoy and appreciate each day as it occurs. I need not sit in anticipation of another tornado. If it occurs, it occurs. I can and will handle it at the time if and when it happens.

Clinician: Just notice it. (Set of slow BLS) Good. Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Airi: I just feel confident in my ability to keep myself safe.

Clinician: Go with that. (Set of slow BLS) Good. Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Airi: Just energized, but calm.

Clinician: On a scale of 1 to 7, how true do those words, “I can learn to protect myself.” feel to you now when you focus on the original event (incident, experience)?

Airi: Seven.

Clinician: Go with that. (Set of slow BLS) Good. Take a breath. (Pause) Let it go. How true do they feel now?

Airi: It’s still seven.

Closure

Clinician: The processing we have done today may continue after the session. You may or may not notice new insights, thoughts, memories, or dreams. If so, just notice what you are experiencing. Take a snapshot of what you are seeing, feeling, thinking, and any triggers and keep a log or TICES grid. Then do the Calm (Safe) Place exercise to rid yourself of the disturbance. We can work on this new material next time. If you feel it is necessary, you may call me.

At the end of a completed session, a client is asked to practice established self-control techniques and to use a TICES grid to keep track of any associations that emerged between sessions.

Note: Airi only had one issue that she wanted to focus on in therapy and only one past memory associated with her presenting issue. No other memories emerged during history-taking or reprocessing. Before termination can occur, the clinician will target any remaining present triggers having a SUD = 0 using the reprocessing phase (i.e., Phases 3–6) and install
appropriate future templates of the present issue for each present trigger. If she did present with other issues, the clinician will complete the processing of the triggers and installation of future templates of this first issue before addressing other presenting issues. In other words, each presenting issue will have its own treatment plan.

**Case Example 6b: Karen**

*Situation:* When Karen was 13 years old, she dropped her pet cat off a second-story balcony.

*Type of presentation:* Single-event trauma.

*Symptoms:* Guilt, shame.

*Issues:* Dealing with injustice in her life.

Karen was 35 years old and had been seeing the clinician for 3 months. One day she came in and said “EMDR is good. I can see the effect in all areas of my life.” What she had discovered as one of the many insights since beginning EMDR Therapy was that a theme of injustice appeared to permeate her life—injustices done to her and others and injustices she had perpetrated onto others. She wanted to start with what she had done to others.

*Target:* She dropped her pet cat off a second-story balcony.

*Image:* Sound of cat shrieking before it hit the grass.

*NC:* I am bad.

*PC:* I am good.

*VoC:* 3.

*Emotion(s):* Guilt, shame.

*SUD:* 10.

*Body:* Chest.

**Assessment**

*Clinician:* Last time we met, you indicated to me that you wanted to work on the memory of dropping your pet cat off a second-story balcony. *What image represents the most traumatic (or most disturbing) part of the incident?*

*Karen:* I can still hear my cat shrieking before hitting the grass.

Sometimes memory is stored as a sound or a smell, rather than as an image. The clinician should adjust the language appropriately.
An EMDR Therapy Primer

Clinician: What words go best with the sound that express your negative belief about yourself now?
Karen: I am bad.

Clinician: When you bring up that sound, what would you like to believe about yourself now?
Karen: I am good.

If the client were to state her negative cognition as “I am not good,” or her positive cognition as “I am not bad,” the clinician may help the client to reframe the cognitions more appropriately by asking the client “Can you state it in a more positive way?” If it is the positive cognition, “Do you mean, ‘I am good’?” The reframing question is preferable because it allows the client a choice of what she would like to believe.

Clinician: When you focus on that sound, how true do those words, “I am good,” feel to you now on a scale from 1 to 7, where 1 feels completely false and 7 feels completely true?
Karen: Three.

Clinician: When you bring up that sound and those words, “I am bad,” what emotions do you feel now?

Clinician: From 0, which is neutral or no disturbance, to 10, which is the worst disturbance you can imagine, how disturbing does it feel to you now?
Karen: Definitely a ten!

Clinician: Where do you feel it in your body?
Karen: In my chest.

Desensitization

Clinician: Karen, I would like you to bring up that sound, those words, “I am bad,” and where you feel it in your body. Just let whatever happens, happen. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What’s coming up now?

Notice that, when setting up the client to perform the actual processing, the clinician does not recount how the client described her initial target or draw the client’s attention back to her reported negative emotions.

Incorrect: “Focus on the image of something ‘bad’ you did to your cat, those words, ‘I am bad,’ those feelings of guilt and shame, and where you feel it in your chest.” The focus begins to change as the protocol setup emerges. Image (or sound), emotions, and physical sensations may begin to shift, even as they are being reported. The clinician does not repeat back to the client her
description of the event, her emotions, or the exact place she feels it in her body because the image (or sound) and where she felt it may already be changing. The clinician does not want to hinder the client’s process by asking her to start all over again. Without repeating it, simply have the client focus on the image (or sound), the exact words she has chosen as her negative cognition, and where she feels it in her body. After this initial set of BLS, the image and the negative cognition (or, in this case, the sound) are usually not referred to again.

Correct: “Focus on the image (or picture) (or, if no picture, the event [incident, experience]), those words, ‘I am bad’ and where you feel it in your body.” The clinician, however, repeats the negative cognition just as the client said it. It is a belief that has shaped a lifetime and is deeply engrained in the client’s psyche.

Metaphorically, instructing a client to focus on the image/event (incident, experience), negative cognition, and where she feels it in her body is the equivalent of directing three laser beams at the dysfunctionally stored material.

Karen: It makes me want to cry. I feel prickly and sweaty all over.

Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What comes up for you now?

After each set of BLS, the clinician asks for feedback. And the clinician may ask for it in several different ways, such as “What’s coming up now?” “What are you getting now?” “What’s happening now?” “What are you noticing now?” It is important to include the word now so that the client is reminded to respond with whatever she is dealing with at that particular moment. It is not necessary for her to recount everything that happened to her between sets.

Karen: I am feeling less sweaty and less anxious.

Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What are you getting now?

Consistently say words like “Notice that” or “Go with that.” Thoughts, emotions, and physical sensations are meant to flow.

One of the aims of EMDR reprocessing is to get whatever is stuck into a flowing mode. Thoughts, emotions, or physical sensations are not static for very long without changing even slightly from one level to another (e.g., feeling extreme pain in your stomach to feeling less pain) or changing one kind to another (e.g., sadness turning into anger).

Karen: I’m feeling better.

Clinician: Notice that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What are you getting now?

Karen: I feel much better than when we started.
Clinician: Notice that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What are you getting now?

Karen: I’m still feeling better.

Clinician: Karen, when you focus on the original event (incident, experience), what do you get now?

(Reminder: Original target—She dropped her pet cat off a second-story balcony.)

Note again that, when the clinician took Karen back to the target, she asked her to go back to the original event (incident, experience)—she did not ask her to focus on dropping her pet cat off a second-story balcony or the shrieking sound the cat made before it hit the grass. This is an important point. As the clinician, you do not describe the event to the client for several reasons. From the time a client describes her target, the entire memory may begin to change or transform. It begins to lose some of its power over the client. We do not want to interfere with the client getting her power back. And, we may run the risk of tampering with the memory by not describing it fully or accurately.

Karen: I feel some remorse, but I do not feel as guilty as I did.

Clinician: Where do you feel it in your body?

Karen: My heart area.

Clinician: Notice that. (Set of BLS) Good. Good. Take a breath. (Pause) Let it go. (Pause) What’s coming up now?

Try to take a breath with the client. It serves to keep you grounded in the present with the client. During sets, it is easy for the clinician to drift off and think about other things. It also helps you to sidestep the negativity being dispelled by the client. This is not directly addressed in Dr. Shapiro’s works but is something that some clinicians are finding as they experience the process with their clients.

Karen: I was with her when she was put to sleep years later.

Clinician: Notice that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Karen: (Spontaneously blurted out…) I just had the strangest thought. I remember where I found her. (Pause) It’s gone… the guilt and remorse are gone.

Clinician: Notice that. (Set of BLS) You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What are you getting now?

It is important to give the client lots of encouragement throughout the EMDR process, especially during a client’s first EMDR reprocessing session. It is not uncommon for the client to think that she is not doing it correctly.
Karen: Nothing.

When processing gets stuck: When a client says “Not much,” “I’m just not getting (feeling) anything right now,” or “Nothing,” the clinician says, “What does that mean?” What are you noticing in your body right now?” or “What is the last image/thought you remember?” “Where did your mind go as you noticed nothing?”

Clinician: What does “nothing” mean?
Karen: The guilt and remorse are gone.
Clinician: Notice that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What comes up for you now?
Karen: I just feel light. It feels so good.
Clinician: Karen, when you focus on the original event (incident, experience), what do you get now?

The client appears to have reached the end of a channel, so the clinician redirected her back to the target to see if Karen had other accessible channels in need of processing. She did. Since there was enough time in the session to deal with new material that might have emerged, the clinician asked the client to go back to the original memory (i.e., memory that was addressed during the initial setup—dropping her pet cat off a second-story balcony). If there is not enough time to clean out another channel of association, close down and follow the procedure for an incomplete session.

When directing a client back to the target, it is unnecessary for the clinician to describe the experience. It may be stored differently now.

Karen: I still have a little sadness but not the guilt.
Clinician: Where do you feel it in your body?
Karen: In my chest as well.
Clinician: Notice that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?
Karen: It’s weird. I went to my safe place, and somebody was there. It was really weird but nice.

Typically, it is important for the client to tell the clinician when she wants to go to her calm (safe) place rather than going there spontaneously on her own. However, since this is what occurred naturally during the reprocessing, the clinician just says “Go with that” or “Notice that.”

Clinician: Notice that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What’s happening now?
Karen: I feel all right. I don’t feel the sadness anymore.

Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What comes up for you now?

Karen: Great. I feel wonderful.

Clinician: When you focus on the original event (incident, experience), what do you get now?

Again, the client appeared to be at the end of another channel, so the clinician redirected her back to the original target.

Karen: I can’t seem to retrieve the image…it’s blurred or something.

At this point, the client appears to have exhausted all open channels, so the clinician asked her to again rate her disturbance on a scale of 0 to 10. It is only when you determine or find evidence that a client has cleared out all negative cognitive, emotional, and physical residue from the targeted material that you ask for a new SUD level.

Clinician: When you focus on the original event (incident, experience), on a scale from 0 to 10, where 0 is neutral or no disturbance and 10 is the worst disturbance you can imagine, how disturbing is the event (incident, experience) to you now?

Karen: It’s a zero.

Remember that the goal is to process the client’s negative experiences toward an adaptive resolution. What this means in terms of the SUD level is that a 0 must be achieved in order for the process to be completed. There are exceptions, such as the ecological soundness.

**Installation**

Clinician: Focus on the original incident. Do those words, “I am good” still fit, or is there another positive statement you feel would be more suitable?

Karen: Yes. I learned from it.

Clinician: Focus on the original event (incident, experience) and those words, “I learned from it.” From 1, which is completely false, to 7, which is completely true, how true do they feel now?

Karen: I feel totally relaxed. It’s a seven.

Clinician: Focus on the event (incident, experience), and hold it together with the words, “I learned from it.” (Set of BLS) Take a breath. (Pause) Let it go. (Pause) How true do the words, “I learned from it,” feel to you now on a scale of 1 to 7?
Karen: Still a seven.

Clinician: Notice that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) How true do they feel now?

The clinician adds reinforcement to the validity of the cognition to ensure that it remains a seven.

Karen: Seven. I never thought I could feel this way about the incident.

**Body Scan**

Clinician: Close your eyes and focus on the original event (incident, experience) and those words, “I learned from it.” Now bring your attention to the different parts of your body, starting with your head and working downward. Any place you find tension, tightness, or unfamiliar or unusual sensations, let me know.

Karen: I feel totally relaxed.

The body scan is implemented at this stage of the process to ensure that there are no residual aspects of the target that need reprocessing. If the body sensations change in either direction, the clinician will continue to do additional sets until the change is complete. If discomfort is reported, BLS is implemented until it subsides. Then repeat the body scan procedure. After a neutral body scan, the clinician implements an additional set of BLS to help set in the neutral or positive change.

Clinician: Just notice that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What are you getting now?

Karen: Still relaxed.

Clinician: Hold the event (incident, experience) in mind again and rescan your body. (Pause) What do you get?

Karen: I continue to feel relaxed.

Even though this is a completed session, present triggers have not been addressed. As with Airi, the clinician may choose to help Karen strengthen positive intermediate gains by including a future resource.

**Closure**

Clinician: The processing we have done today may continue after the session. You may or may not notice new insights, thoughts, memories, or dreams. If so, just notice what you are experiencing. Take a snapshot of what you are seeing, feeling, thinking, and any triggers and keep a log or
TICES grid. Then do a Calm (Safe) Place exercise to rid yourself of the disturbance. We can work on this new material next time. If you feel it is necessary, you may call me.

Direct the client to keep a log of newly emerging after-session insights, dreams, memories, and thoughts. At the next session, ask the client “What has changed since you did the EMDR reprocessing? What is different?” Many may say “Not much” or “Nothing significant.” However, as the conversation progresses, the clinician often is able to point out something the client said to her that indicates something has changed.

How about the ambiguity of the target? Was it a problem? What did the client do “bad” to her pet? Originally, the client started to launch into a long dialogue about the pet without actually telling the clinician what she had done. She became emotionally agitated, and the clinician stopped her. The clinician told the client that she did not need to talk about it but could process it instead. It was not revealed what happened to the cat until after the session was completed. Reportedly, Karen was pressured by her friends and dropped her cat off a second-story balcony and into her yard. The cat was not injured.

When Karen said “I know where I found her,” why did the clinician not ask “Where did you find her?” Did the cat run away and die somewhere, and she found it later? What happened to the cat? The clinician resisted satisfying her curiosity to ensure the integrity of Karen’s process. She did learn later that Karen originally had rescued her cat—Cassie—from the side of the road where someone had dumped her. Cassie, a beautiful yellow tabby, lived to be 17. The clinician may have completely derailed or upset her “train” from going down the “track” had she gone along with her assumption that Karen did something to make the cat die.

When Karen stated that someone was in her calm (safe) place, one might also be tempted to interrupt her process by asking “Who was in your calm (safe) place?” The clinician did ask after the reprocessing was complete and discovered that the person who showed up was Tim, her brother-in-law. Tim had died 2 years previously. He had a massive heart attack while he was cutting his grass. He came to tell her “Everything is okay.”

Once a target has been fully processed, the clinician needs to reevaluate the treatment plan (or treatment planning guide) to determine the next memory that may need to be targeted and revisit the reprocessing phases to resolve it as well.

PRESENT

Case Example 6c: Delores

Situation: The client had been working in therapy on past issues and was slowly regaining a personal sense of power. She was triggered by an incident involving her husband.
Type of presentation: Present trigger.
Symptoms: Sense of lacking control of her life.
Issues: Husband’s job was in jeopardy; his exhibited alcoholic behavior; marital difficulties.

The clinician had been working with Delores on issues of self-esteem and self-control over a few months. Delores was gradually reclaiming her power as she discovered that she could express herself more confidently with the people around her. She had identified and reprocessed the childhood events that had surfaced, which initially ignited the present dysfunction in her life. However, there was a situation in her current life that triggered her.

Delores did not feel like an equal in her marriage. “Don is a good father,” she would say. “He comes home every night and does anything we need him to do. He brings dinner home sometimes or once in a while he may even cook. He goes to all the girls’ games and is very active in their activities.” But, once the girls were put to bed, Don would drive down to the local pub and sit for hours with some old high school buddies and drink beer while they related stories about the “old days.” He would come home around 11 or 11:30 p.m.

Don worked as an executive for a retail sales company. Because he did a lot of traveling, he drove a company car. Around the first of the year, Don hit another patron with his company car while trying to leave the parking lot of a bar. He got out of the car to see if the person was okay and then promptly left before the police arrived. Don was eventually apprehended and charged with a hit-and-skip accident, which he did not report to his employer. In June of the same year, the company informed Don that they were in the process of changing insurance companies. As part of the transition, they would be checking current driving records of all employees with company cars. Don feared that his job was now in jeopardy, and Delores’s emotional charge surrounding the event escalated. Delores felt that she was now ready to process the event in therapy.

Target: Hearing from Don that his job was in jeopardy because the company would learn about his hit-and-skip accident charges.
Image: The blank look on her husband’s face when he told her about his company checking employee driving records. “It didn’t seem to bother him.”
NC: I am not in control.

Check your training manuals. You will find a list of examples of negative and positive cognitions. If a client is unable to come up with an appropriate cognition, either negative or positive, there is nothing wrong with handing her this list saying, “Here is a list of possible beliefs. Focus on the event (incident, experience) and tell me if one of them resonates or if it helps you to come up with one of your own.”
A laminated version of the cognitions list may be purchased from Trauma Recovery/EMDR HAP.

Remember that present triggers can be identified during history taking, reprocessing, reevaluation, and/or ongoing feedback from a client’s TICES log.

PC: I have some control.

The positive cognition is also a self-referencing belief aimed at the client’s desired direction of change (i.e., from someone who has no control to someone who has control).

VoC: 3.

The VoC scale is measuring on a gut level how true or false the positive cognition feels.

Emotions: Desperation, anger, and fear.

Again, these are emotions the client feels in the present about something that happened in her past.

SUD: 8.

The VoC and SUD scales provide a quantitative basis and act as a reprocessing report card. The SUD is a report of the level of disturbance for the entire incident, not just the emotions felt by the client in the now.

Body: A little in my shoulder. Nothing else.

No matter how slight, the physical sensations reported by the client are targeted. A client’s hands or feet may tingle. Respiration or heart beat may accelerate. Anything identified by the client is not to be discounted.

Desensitization

Clinician: Bring up the image (or picture), those words, “I am not in control” and where you feel it in your body. Just let whatever happens, happen. (Set of BLS) That’s it. Good. That’s it. Take a breath. (Pause) Let it go. (Pause) What are you getting now?

After each complete set of BLS (eye movement or otherwise), the clinician instructs the client to “Take a breath. Let it go. What are you getting (or noticing) now?” The original meaning intended was for the client to “draw a curtain over the material” (Shapiro, 2001). This gave the client permission to take a break from the intensity of the material being reprocessed, thereby creating space for the client to reorient and to verbalize any new information that has arisen. The generally accepted usage now is to say “Take a
breath. (Pause) Let it go.” Regardless of which way the instructions lean, the client will tell the clinician what she is noticing. Once she is finished, the clinician will say “Go with that.”

When first facilitating the BLS, begin slowly and increase the speed as fast or tolerably comfortable for the client. The speed of the BLS is adjusted to the client’s need.

Delores: I feel like it has extended. It has not left my shoulders. I can feel the tension at the top of my head. It has just extended. It has not moved off me.

Clinician: Go with that. (Set of BLS) You’re doing fine. Good. Take a breath. (Pause) Let it go. (Pause) What’s happening now?

The clinician checks in with the client between sets to determine where the client is in the process and what has changed, if anything. The clinician then assesses the information received to determine if the client is moving toward adaptive resolution. Has new information emerged? Sometimes the information will change; sometimes it will not. Sometimes new information will emerge, and sometimes it will not. Regardless, it is important for the clinician to elicit clear feedback from the client. Neither the client nor the clinician is encouraged to judge the efficacy of the newly emerging and changing information. Just let whatever happens, happen and trust the process (Shapiro, 2001, 2009–2014). Whether the client reports something entirely related or unrelated to the original target, the clinician will say “Go with that” and continues the BLS. Reprocessing is in process, and as a result associated channels may open up.

A client with negative cognitions in the area of power/control (or choice) may not like the BLS activated by the clinician. In these cases, consider allowing the client to do it for herself. The clinician-activated stimulation may cause the client to link into her abuse history, so empower her further by giving her control of it.

Delores: I don’t know if it moved down. I am feeling it in my arms, and there is less tension in my head.

Clinician: Go with that. (Set of BLS) Good. That’s it. Take a breath. (Pause) Let it go. (Pause) What’s coming up now?

Other than “Good,” “Uh-huh,” or “You’re doing fine,” the clinician says little more than “Let it go.”

The clinician’s best strategy is asking the client to focus only on the new material that emerged during the last set by saying “Go with that” or “Just notice that.”


Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Delores: I feel it in my face…frustration, concern, worry.
The client reports the most dominant thought, emotion, sensation, or image. On the basis of what the clinician learns, she will direct the client to the new information or to the original target. In this case, the client reports some new emotions, and the clinician directs the client to focus on the new information.

**Clinician:** Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What’s happening now?

**Delores:** There is not much change. I feel it may be less in my face, but I feel more tension or the same here (she points to her forehead).

**Clinician:** Dolores I am going to switch to the faster speed that we talked about last week. Is that okay?

**Delores:** Sure.

**Clinician:** Notice that. (Speed of the BLS is increased) (Set of BLS) That’s it. Good. Take a breath. (Pause) Let it go. (Pause) What comes up for you now?

When asking a client what she is experiencing, the clinician uses general statements that allow her to report whatever is dominant in the moment (i.e., a change in thought, feeling, image, physical sensation, new event). The rule of thumb is that, as a significant change occurs with the set, use the same BLS (i.e., speed, length, intensity, and direction) as in the previous set. If no change occurs, vary the speed, length, intensity, or direction of the BLS. If a change fails to occur after subsequent sets, a more proactive approach may be needed (see Chapter 5).

**Delores:** As I focus on the event then, I feel less stressed. When I focus on the event as it affects me now, it gets worse. I feel it less in my forehead but feeling it more in my neck. I am having a difficult time splitting the two.

**Clinician:** Go with that. (Set of BLS) That’s it. You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What’s happening now?

Encouraging the client is important. During each set of BLS or at least when a shift is obvious, comment positively to the client by saying at least once “That’s it. Good. That’s it.”

**Delores:** I am not sure where I should be. I keep things to myself. How can I take control?

**Clinician:** Notice that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

**Delores:** I believe that I can take control. I can choose to sit back and let the circumstance take control over me, but I can make the decision if I need and
want to. I just don’t want the circumstance to rule me. When I think about it this way, I don’t feel so worried or feel the tension in my head and neck and face.

Movement continues to occur in the client’s reprocessing of the event, so the clinician keeps tracking the client’s process and progress as it occurs. The biggest responsibility the EMDR clinician has during processing is to track the client’s process but stay out of the client’s way. As long as movement of any kind is evident, the clinician needs only to say “Go with that.”

**Clinician:** Go with that. (Set of BLS) Good. That’s it. Take a breath. (Pause) Let it go. (Pause) What comes up for you now?

If the client reports newly emerging memories or changes in the client’s original image, thoughts, feelings, or sensations, the clinician supports the movement by saying “Go with that” or “Notice that.” What if no movement is reported by the client? Unless it is the end of a channel, the clinician is instructed to change the direction or speed of the BLS and add another set. Or the clinician could increase the length of the set.

**Delores:** I am feeling a bit more relaxed. Still less tension.

**Clinician:** Notice that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What comes up for you now?

**Delores:** I am still feeling relaxed.

Delores has not reported anything new or distressing for two consecutive sets of BLS. She appears to be at the end of a channel and is unable to make more linkages at this point to the original event (incident, experience). When a client reaches the end of a channel, the clinician needs to bring the client back to target in order that she may access additional channels, if they exist.

**Clinician:** When you focus on the original event (incident, experience), what do you get now?

(Reminder: Original incident—hearing from Don that his job was in jeopardy because the company would learn about his hit-and-skip accident charges.)

**Delores:** I am not so much focusing on the event. I find that I am calmer and less stressed in focusing on finding strength within myself. In this situation, where I was stressed because of the jeopardy he put his family in, I feel I can make the decision to stay or go to support my family rather than him supporting the family. It is more calming and more empowering. And, again, there is less tension.
Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What’s happening now?

Delores: It is an event that had nothing to do with me and, as it impacts our family, I can make a decision as to whether I will let this impact our family or not.

Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What comes up for you now?

Delores: My body feels relaxed. I feel more confident. I can handle this.

Clinician: When you focus on the original event (incident, experience), on a scale from 0 to 10, where 0 is neutral or no disturbance and 10 is the worst disturbance you can imagine, how disturbing is the event (incident, experience) to you now?

Delores: It’s a 4. Maybe a 3. It makes me less angry. I still feel some disappointment but less angry.

Did you catch the clinician’s omission? She needed to take Delores back to the original event (incident, experience) by saying “Focus on the original event (incident, experience) and tell me what comes up? What are you getting now?” before asking about the SUD level. The clinician made the assumption that the client was down to a 0 and jumped on it. She inadvertently forgot to have her focus on the original event (incident, experience) to check for other levels of disturbance that may have existed around this event. Fortunately, the next channel of association, the disappointment, became apparent.

Furthermore, the process would have probably been more effective if the clinician had just let her process to see if other insights would emerge.

Clinician: Go with that. (Set of BLS) That’s it. Good.

Delores: (The client begins to talk out loud) I’m not sure if I’m skirting it. If I focus on the disappointment, the tension comes back. If I focus on the strength in me, I feel more relaxed and confident. I don’t know if it’s right or wrong. It just causes tension.

Clinician: The mind moves faster than spoken word. If you process silently to yourself it will help speed the train faster down the track. Just go with that silently to yourself. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What comes up now?

When a positive track and a negative track come up simultaneously, focus on the negative track. After the negative is cleared, only the positive will remain.

The client may repeatedly begin speaking before being instructed to do so. When she has finished talking, the clinician may gently remind her to process silently to herself and say “It will speed the ‘train’ faster down the
‘track.’ And then “Go with that.” Instruct the same way at the next set by saying “Just go with that silently to yourself” to make sure that she understands.

Delores: I am a little less tense. I still feel it in the same spots, but it is less prevalent…which tells me the disappointment is still there.

Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Delores: It’s a lot less, but it’s still there.

Clinician: Go with that. (Set of BLS) That’s it. Good. Take a breath. (Pause) Let it go. (Pause) What are you getting now?

Delores: I tell myself that it happened, but it does not have to affect me. I am my own person, and I control what I do and how I react.

Clinician: Go with that. (Set of BLS) That’s it. Good. Take a breath. (Pause) Let it go. (Pause) What is happening now?

Delores: My body is relaxed again. The confidence is back. It feels permanent. I can handle this in my own way.

Clinician: When you focus on the original event (incident, experience) what do you get now?

The material the client reports has a neutral feeling, which flags that the client has reached the end of a channel. When this happens, the correct response for the clinician is to bring the client back to target.

Delores: I feel pretty calm. It’s difficult to feel much as I focus on it.

No matter what the client reports, the clinician will add a set of BLS.

Clinician: Go with that. (Set of BLS) Good. That’s it. Take a breath. (Pause) Let it go. (Pause) What is happening now?

It is only after retargeting the original event (incident, experience) and completing a set of BLS without the emergence of new associations or new images, emotions, or physical sensations that the clinician goes back and checks the client’s current SUD level.

Delores: I feel relaxed and calm.

Clinician: When you focus on the original event (incident, experience) on a scale from 0 to 10, where 0 is neutral or no disturbance and 10 is the worst disturbance you can imagine, how disturbing is the event (incident, experience) to you now?

No change occurred, so the clinician checked the SUD level.

Delores: It’s a two.
Closure

Clinician: We have run out of time, and we need to stop. We can take a further look at this next time. Are you okay with stopping right now?

Delores: Sure.

The goal at the end of a session is to direct the client’s attention away from the disturbing information and into the present. The clinician should not take a SUD measurement at the end of a session unless the client has reached the end of what appears to be the final channel of association and the clinician is ready to proceed to the Installation and Body Scan Phases. In this particular case, the clinician was nearing the end of the therapeutic session and did not have time to implement these two phases.

Even though they came so far in this session and the client is at a 2 in terms of SUD level, it is still considered an incomplete session. Since there is obviously more material to be processed, the installation of the client’s positive cognition and the body scan are shelved for the next session.

Clinician: You have done some very good work, and I appreciate the effort you have made. How are you feeling?

Even though the session is incomplete, it is important that the clinician provide sincere encouragement and support for the effort the client did make.

Delores: I feel better.

Clinician: You did a good job. As you review your experience in our session today, what positive statement can you make to express what you have learned or gained today?

While debriefing a client, it is optimal to leave them with a positive statement so that they will not leave dwelling on the negative with the possibility of opening up other negative channels of association.

Delores: I am too dependent on others, especially my husband; and I let them lead my life. I don’t like it. I don’t need it. I can and will be independent is what I learned today.

Clinician: Good. What I would like to suggest we do now is a relaxation exercise. How would you feel about doing the Lightstream Technique?

This is an exercise the clinician had previously done with the client. She could have suggested other forms of relaxation, such as imagery or calm (safe) place. The clinician might ask “What would you like to do?” Clients often
like some forms of relaxation better than others. Other possible alternatives are breathing, calm (or safe) place, or container exercises.

**Delores:** Sure. That would be good.

Clinician leads the client in the Lightstream Technique.

When a session ends in incomplete reprocessing, the clinician needs to use judgment in terms of the client’s ability to manage any emotions that may arise after she leaves the session. The clinician may request that she practice some form of self-control technique between sessions and to keep a log of what emerges during the intervening week.

**Clinician:** The processing we have done today may continue after the session. You may or may not notice new insights, thoughts, memories, or dreams. If so, just notice what you are experiencing. Take a snapshot of what you are seeing, feeling, thinking, and any triggers and keep a log or TICES grid. Then do the Calm (Safe) Place exercise to rid yourself of the disturbance. We can work on this new material next time. If you feel it is necessary, you may call me.

In closing down an incomplete session, the clinician (a) informs the client it is time to stop; (b) gives encouragement for what she did today; (c) debriefs by asking the client specifically what she has learned or gained today; (d) assures her of your availability throughout the interim week; and (e) encourages the use of calm (safe) place, relaxation, and/or container exercises.

Delores arrived at her session a week later feeling more prepared to handle whatever comes in terms of her husband’s work and driving record. She and her husband had talked about how it could affect them financially. She had lost trust in her husband and believed that she needed to begin taking steps toward making herself and her children more independent of him. “I find myself distancing from him,” she stated, “but also see how dependent I actually am on him. It’s scary.” Because Delores’s SUD level ended up at a 2 at the last session, the clinician takes her back to the original event (incident, experience) to see what other layers have emerged during the intervening week.

**Target:** Hearing from Don that his job was in jeopardy because the company would learn about his hit-and-skip accident charges.

**Image:** Husband without a job.

**Emotion(s):** Frustration, disappointment.

**SUD:** 1.

**Body:** Stomach, chest.

Notice that the emotions, location of body sensations, and the SUD have changed from last session. These changes provide a clear indication
that processing continued after the session ended in the previous session. To ensure nothing has changed in the interim, it is important that the clinician reevaluate the prior target even if the SUD = 0, VoC = 7, and a clear body scan was reported by the client at the end of the previous session.

**Desensitization**

*Clinician:* Bring up the image (or picture) and where you feel it in your body. Just let whatever happens, happen. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What is happening now?

When reprocessing an event from an incomplete session, the focus is on the worst part of the event (incident, experience) now—not the original event (incident, experience)—and the location of body sensations. The client may have also identified current emotions associated with the event prior to when reprocessing begins.

*Delores:* I really feel it in my shoulders, eyes, and chest.

*Clinician:* Go with that. (Set of BLS) That’s it. Good. Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

*Delores:* I’m trying to think what being in control looks like. If I had not been so dependent, would I have reacted earlier to what had been happening all along in our marriage?

*Clinician:* Go with that. (Set of BLS) You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

*Delores:* I’m feeling a lot less tension in my shoulders and neck, but I still feel it in my eyes. There’s the feeling there that I can be in control.

*Clinician:* Go with that. (Set of BLS) You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

*Delores:* Again, I’m a lot less tense.

*Clinician:* Go with that. (Set of BLS) You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What are you getting now?

*Delores:* I can be in control. I have been—long before I met him. I can be again.

*Clinician:* Go with that. (Set of BLS) You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What is coming up now?

*Delores:* I will be in control again.

*Clinician:* Delores, when you focus on the original event (incident, experience), what do you get now?

(reminder: Original incident—hearing from Don that his job was in jeopardy because the company would learn about his hit-and-skip accident charges.)
Delores: It’s his problem not mine.

Clinician: Go with that. (Set of BLS) You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Delores: I can feel my body letting it go.

Clinician: Go with that. (Set of BLS) That’s it. Good. Take a breath. Let it go. (Pause) What are you noticing now?

Delores: Good. It’s gone.

Clinician: When you focus on the original event (incident, experience), what do you get now?

Delores: He’s the one who is losing, and I can feel more separated from that event.

Clinician: Go with that. (Set of BLS) That’s it. Good. Take a breath. (Pause) Let it go. (Pause) What is coming up now?

Delores: Before, I was saying, “I can handle this.” Now I believe, “I will handle this.”

Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Delores: Yes, I will handle this.

Clinician: When you bring up the original event (incident, experience) on a scale from 0 to 10, where 0 is no disturbance and 10 is the worst disturbance you can imagine, how disturbing does it feel to you now?

Delores: It’s between a 2 and a 3. There’s the reality that I have to make sure I remember that it is his problem. I do not want to be pulled back into it. I want to remain separate from him. I want to decide what to do for me despite the situation. I will have to remind myself of it. I’m afraid prior concerns will come back.

The clinician erroneously believed that the client had opened and challenged all channels of association related to the current trigger. Obviously, she had not. Because EMDR reprocessing is such a fluid, dynamic process, no harm is done to the client. Simply continue with the reprocessing.

Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What’s happening now?

Delores: I am just thinking to myself that I don’t want it to come back and interrupt what I believe I need to do. I don’t want it to bother me anymore. When I continue to do that, it does not have the same impact. I can call it a two. I feel like I have to keep reminding myself to let it out. Let it go. It’s not about me. It’s not my problem.
Clinician: Go with that. (Set of BLS) That’s it. Take a breath. (Pause) Let it go. (Pause) What’s happening now?

Delores: As long as we continue to have to deal with it and it even involves him, I am connected in some way. It can never be a zero. I can continue to tell myself that it’s not my problem. It’s not my fault. Anything ahead will affect the family. Today, that’s where we are.

Clinician: Go with that. (Set of BLS) You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Delores: The same. I just have to go day by day and regain my control a day at a time. But, I can and will handle it.

Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What are you getting now?

Delores: I can have some control, and I can have it now.

Clinician: Delores, when you bring up the original event (incident, experience) on a scale from 0 to 10, where 0 is no disturbance and 10 is the worst disturbance you can imagine, how disturbing does it feel to you now?

Delores: It’s a zero!

Clinician: Go with that. (Set of BLS) You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What are you getting now?

Delores: I know I can regain control. I know I will.

**Installation**

Clinician: Focus on the original event (incident, experience). Do those words, “I have some control” still fit or is there another positive statement you feel would be more suitable?

Delores: No. I think “I am now in control” fits even better.

Clinician: Focus on the original event (incident, experience) and those words, “I am now in control.” From 1, which is completely false, to 7, which is completely true, how true do they feel now?

Delores: Six point five.

Clinician: Focus on the event (incident, experience) and hold it together with the words, “I am now in control.” (Set of BLS) Take a breath. (Pause) Let it go. (Pause) On a scale of 1 to 7, how true do those words, “I am now in control,” feel to you now when you focus on the original incident?
BLS in the Installation Phase is performed at the same speed and approximate duration as in the Desensitization Phase.

Note: The clinician has been instructed to check the VoC after each set. Some clinicians believe the VoC should be checked frequently until the positive cognition is totally true (VoC = 7). They feel checking after each set puts too much performance demand on the client, so they suggest checking it every second or third set. Clinicians are still being taught to check the VoC after each set.

Delores: I am really beginning to believe it.

Clinician: Go with that. (Set of BLS) That’s it. Take a breath. (Pause) Let it go. (Pause) How true do those words, “I am now in control” feel to you now when you focus on the original incident?

Delores: Still totally true. Seven.

Clinician: (Set of BLS) Take a breath. (Pause) Let it go. (Pause) How true do they feel now?

Delores: It’s still a seven.

**Body Scan**

Clinician: Close your eyes and focus on the original event (incident, experience) and those words, “I am now in control” and scan your body from head to toe for physical discomfort. Any place you feel tension, tightness, or unfamiliar or unusual sensations, please tell me.

Delores: The pain in my neck is gone.

Clinician: Just notice that. (Set of BLS) (Pause) What comes up for you now? Scan your body again for discomfort. (Pause) What are you getting now?

Delores: I feel good.

Clinician: Hold the event (incident, experience) in mind again and rescan your body. (Pause) What do you get?

Delores: The same.

Clinician: What’s the difference between how you feel now versus when we started the session?

Delores: I feel more empowered, like I can make it without him if I choose to. He is no longer steering my ship. I am.

Ideally, there would be time in the session to move directly from the resolution of this present trigger to the future template. Since this not the case, the clinician may choose to help Delores strengthen this positive belief by using future resourcing. The clinician would then move to reevaluation and future template in the following session.
Closure

Clinician: We need to stop for today. The processing we have done today may continue after the session. You may or may not notice new insights, thoughts, memories, or dreams. If so, just notice what you are experiencing. Take a snapshot of what you are seeing, feeling, thinking, and any triggers and keep a log or TICES grid. Then do the Calm (Safe) Place exercise to rid yourself of any disturbance. We can work on this new material next time. If you feel it is necessary, you may call me.

Whether the session is complete or incomplete, Dr. Shapiro recommends that the above closure/debriefing statement be made to the client. A review of stress control skills and strategies can also be considered (see Chapter 2).

Case Example 6d: Breanna

Situation: Client is triggered by an act of love and tenderness of a mother toward her infant daughter.

Type of presentation: Present trigger.

Symptoms: Depression, anxiety, anger, rage.

Issues: Realization of what she missed as a child.

Breanna grew up in abject poverty in a small coal-mining town in West Virginia. Her developmental growth was further hindered by a ruthless, critical father and a mother who had been diagnosed with bipolar disorder years before. She had four older brothers, but they were too busy fending for themselves and offered little support. Because her mother was more absent than present, either laying in her bed most of the days or recovering from her mental illness at the nearest psychiatric unit, Breanna became her mother’s replacement in most phases of her family’s life. At an early age, she learned to cook and clean and do whatever else was expected of her.

Because she grew up poor and in the country, Breanna felt awkward around most people. And she felt alone. She never had many friends as a child, and those she did remember were short-lived. Her home was never a safe or appropriate place to bring other children home to play. Playing was really not much of an option most days. Breanna suffered cruelly under the harsh words and frightening looks of her father’s obvious disapproval. “He just plain didn’t like women.” So Breanna grew up “motherless” and rudderless throughout her childhood and adolescence.

Breanna and the clinician worked for months trying to ease the painful fragments of her neglected and lonely past. She would make leaps of
progress only to slide downhill into the sadness that kept blocking her way. She had plowed through and dissipated the rage and anger from her past and elevated her self-esteem and self-confidence. She was finally becoming comfortable around others and taking risks to be with people.

One day Breanna walked into the clinician’s office and told her how deeply affected she was by watching a mother and a child while she was shopping at a local market. “I just welled up with sadness as I watched how gentle and playful this woman was with her child. I finally knew what was triggering me. It is what I missed as a child.” She never really had a mother to hold her, comfort her, or protect her. Or a father who would do the same. She had no one.

Breanna was realizing that this trigger plagued her often in many types of ways. So it was decided to process the pain associated with this trigger.

**Target:** Watching a mother and child in the grocery store.

**Image:** The image of how gentle and playful a woman was with her child at the grocery store. (*Note:* A positive experience for one person can be a negative one for another.)

**NC:** I am unlovable.

**PC:** I am lovable.

**VoC:** 2 to 3.

**Emotion(s):** Sadness.

**SUD:** 6.

**Body:** Stomach.

**Desensitization**

**Clinician:** Bring up that image (or picture), those negative words “I am unlovable,” and notice where you feel it in your body. Just let whatever happens, happen. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What comes up now?

**Breanna:** I feel sad and lonely.

During reprocessing, it is unnecessary for the client to report all the details of what comes up between sets. The clinician only needs to know what the client reports, even if it does not make sense. If there is a change, say “Go with that” and stay out of the client’s way. What the client reports about an event does not need to be chronological either. In fact, the clinician may actually want to discourage the client from trying to remember the exact details of the event because it can slow the processing.

**Clinician:** Where do you feel it in your body?

**Breanna:** In my heart.
Clinician: Notice that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What is coming up now?

Breanna: I wish someone cared about me. I wish my parents cared about me.

Clinician: Notice that. (Set of BLS) Just push my fingers with your eyes. Good. Take a breath. Let it go. (Pause) What are you noticing now?

In the middle of the BLS, the client’s eyes stopped moving. That is when the clinician said “Just push my fingers with your eyes” to ensure continued eye movement.

It is important to nurture the client through whatever is happening. If using eye movements, the clinician could have also wiggled her fingers up and down while still continuing the bilateral movement. This draws the client’s attention back to the clinician’s fingers and restimulates processing.

Breanna: I’m a kid. I wish this was not my life or life story. I wish I had parents or someone to help me. I wish I had a happy childhood.

Clinician: Go with that. You’re doing fine. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What’s coming up now?

Breanna: I had an image of that day in the grocery store.

Clinician: Go with that. You’re doing fine. (Set of BLS) (She begins to cry uncontrollably)

If a client starts to cry during reprocessing, it is not beneficial to halt the process. When you think she is at a stopping point, ask her to take a breath. If tears or other physical signs of emotion (e.g., reddening of the face, rapid breathing) are present, encourage and support the client to continue processing.

Clinician: (The clinician continues with BLS and waits until Breanna has stopped crying.) Take a breath. (Pause) Let it go. (Pause) What’s coming up now?

Breanna: It’s really hard not to have anyone to help or lean on. I tried to put on a good face.

Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What’s coming up now?

Breanna: When I was a kid, I tried to be so tough and so strong. I don’t feel tough or strong.

Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What comes up for you now?
Breanna: I just seem to be bouncing around with childhood memories. I remember Dad when I was in first grade. He scared me. Everyone did. I was 6, and I was afraid of people. I remember in the second grade my teacher took care of me because my mom didn’t. When I was in the fourth grade, I won the Spelling Bee. I was so proud of myself, but I did not have anyone to tell. I never had any friends. I was such a weird kid. I was so alone.

Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What comes up for you now?

Breanna: I don’t think I am a good person.

Clinician: Notice that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What’s coming up now?

Breanna: I see myself lashing out a lot. I don’t feel like people treat me very well, and I feel like I have to defend myself.

Clinician: Notice that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What’s happening now?

Breanna: I feel the same. I didn’t know what else to do as a kid. I feel sad. I feel like I have lost so much possibility in life… being the weird kid that no one likes. It feels like I am spinning around in a circle, bouncing back from one to the other.

Clinician: Where do you feel it in your body?

Breanna: My lungs and arms.

Clinician: Go with that. (Set of BLS) You’re doing fine. Just ride the wave. Take a breath. (Pause) Let it go. (Pause) What’s coming up now?

Breanna: I can feel it mostly in my arms now. There’s a lot of activity.

Clinician: Notice that. (Set of BLS) Good. Good. Take a breath. (Pause) Let it go. (Pause) What’s happening now?

Breanna: I am feeling hot and tingly. I think I am not a good person.

Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What comes up for you now?

Breanna: I’m grinding my teeth. It’s the same kind of sensation. My chest is tightening up. My throat really hurts.

The clinician continues to stay out of the way and just follows the client through the waves of emotion and physical tension associated with the related memories.

Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What are you noticing now?
Breanna: There’s a raw feeling in my throat…kind of sweet. I’m really a good person even if I am the only person who knows it. I did a really good job of finding my way in this world. I can let it go, and it’s okay. I’m okay.

As the processing begins to shift, resolution (learning) becomes less maladaptive and more and more adaptive.

Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What comes up for you now?

Breanna: I am so happy that I tried and tried and tried until I found the help I needed. I am so proud I gave myself a chance. I have nothing but opportunities and possibilities ahead of me by letting this go. It is not who I am. It is what I survived.

Clinician: When you focus on the original event (incident, experience), what do you get now?

(Reminder: Original incident—Client is triggered by an act of love and tenderness of a mother toward her infant daughter.)

Breanna: I don’t get anything. The memory is a blank.

Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Breanna: I can be loving and gentle with myself. I never allowed myself to be. I think I want to try to be now.

Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What is happening now?

Breanna: This will be a new experience. I’ve never done this before.

Clinician: When you focus on the original event (incident, experience), what do you get now?

Breanna: I feel like I have just met myself for the first time, and it feels good.

Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What comes up for you now?

Breanna: I like myself. No, I can love myself. I am a good person.

Clinician: When you focus on the original event (incident, experience), on a scale from 0 to 10, where 0 is no disturbance and 10 is the worst disturbance you can imagine, how disturbing does it feel to you now?

Breanna: It is definitely a zero.

Clinician: Just go with that. (Set of BLS) Good. You’re doing fine. (Pause) And again, when you focus on the original event (incident, experience), on
a scale from 0 to 10, where 0 is no disturbance and 10 is the worst disturbance you can imagine, how disturbing does it feel to you now?


The clinician facilitates another set of BLS to see what emerges, if anything.

Clinician: Just notice that. (Set of BLS) Take a breath. (Pause) Let it go. What are you getting now?

Breanna: Zero! Zero! Zero!

**Installation**

Clinician: Do the words, “I am lovable” still fit, or is there another positive statement you feel would be more suitable?

Breanna: “I am lovable” feels right.

Clinician: Focus on the original event (incident, experience) and those words, “I am lovable.” From 1, which is completely false, to 7, which is completely true, how true do they feel now?

Breanna: Seven.

A client may report a VoC of 6 and not be able to move beyond it because they do not believe in absolutes. This can be considered an appropriate response under the circumstances, and the clinician may advance to the body scan. Alternatively, the clinician may just ask the client to notice that belief (i.e., “I do not believe in absolutes”) and add another set of BLS. This may allow the VoC to become completely true. Sometimes what appears to be ecological is simply a blocking belief.

Regardless of what VoC the client reports during this phase, the client continues to process. It is possible that other channels of association, blocking beliefs, or feeder memories could still emerge at this level as well as during the body scan.

If a client has difficulty getting to a 7, the clinician may need to determine the ecological soundness of the client’s response, whether the client requires new skills, or explore for the existence of a feeder memory or a blocking belief. In terms of the latter, the clinician may tag the belief and process it as a separate target in another session.

Clinician: Focus on the event (incident, experience) and hold it together with the words, “I am lovable.” (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) On a scale of 1 to 7, how true do those words, “I am lovable,” feel to you now when you focus on the original incident?

Breanna: It feels totally true. I am lovable.

Clinician: Just notice that. (Set of BLS) (Pause) What are you getting now?
The clinician facilitates another set of BLS to see what emerges, if anything.

Breanna: Wow! Totally true!

**Body Scan**

**Clinician:** Now focus on the original event (incident, experience) and those words, “I am lovable” and scan your body from head to toe and let me know if you notice anything. Any place you feel tension, tightness, or unfamiliar or unusual sensations, tell me.

Breanna: I feel good.

**Clinician:** Just notice that. (Set of BLS) (Pause) What are you getting now?

A client may report being exhausted, neutral, or energized after a session. If the exhaustion does not dissipate after several sets of BLS, the clinician may ask, “Do you think this is new information or are you exhausted after the session?” If the client responds “Yes,” to being tired from the session, then the client should be reassured that she has done a lot of hard work, and the closure should include self-care, such as rest or relaxation. If the client is linking into new information and there is not enough time to continue processing, the clinician may do a container to ensure the stabilization of the client before leaving the session.

Breanna: I feel great!

**Clinician:** Hold the event (incident, experience) in mind again and rescan your body. (Pause) What do you get?

Breanna: I have never felt this good.

**Clinician:** You did a great job.

Breanna: I had to say good-bye to the “little me.” (She smiled.) That was weird. The images I got were of me as a kid, but I felt so mature. I said, “Good-bye. You can go.” “Little me” was smiling and waving and telling me, “Everything is going to be okay.” And she faded off into the distance. I felt like I was merging. The last time was weird. I realized that my whole life all I wanted to do was save kittens and people and fix things. I was really here to save myself and to think the only person I need to save is me.

As with Airi and the others mentioned earlier, the clinician may choose to help Breanna strengthen this new learning by using future resourcing. The clinician may ask Breanna if she anticipates a time in the next week when she will want to remember this. If the client’s answer is “yes,” then reinforce with a short, slow set of BLS.
Closure

Clinician: The processing we have done today may continue after the session. You may or may not notice new insights, thoughts, memories, or dreams. If so, just notice what you are experiencing. Take a snapshot of what you are seeing, feeling, thinking, and any triggers and keep a log or TICES grid. Then do the Calm (Safe) Place exercise to rid yourself of the disturbance. We can work on any new material next time. If you feel it is necessary, you may call me.

FUTURE

Future Template—Desired Outcome/Problem Solving

See Case Example 4C: Michael for detailed transcripts of future.

Future Template—Anticipatory Anxiety

Case Example 6e: Jimmy

Situation: The client saw himself as an ordinary guy married to a beautiful woman. He never felt worthy of her or that he quite measured up.

Type of presentation: Anticipatory anxiety.

Symptoms: Insecurity, chronic worry, lack of confidence in the relationship with his spouse.

Issues: Fear of his wife leaving him.

Jimmy and his wife had been in and out of couples counseling for years. His wife, Megan, was a beautiful woman, and Jimmy had always thought he played second fiddle to her. He never felt that he measured up to the romantic notion of the tall and handsome knight in shining armor who could physically and sexually sweep her off her feet.

Jimmy was far from ugly, but he was not exactly stunning either. He was short and stocky, had wavy hair, and thin lips. He thought these characteristics made him unattractive, and this is how he labeled himself. Nonetheless, he wooed and won the woman of his dreams in college. They eventually married and had two beautiful children. Despite his obvious conquest, Jimmy was never confident in his ability to keep his wife. He always thought that, despite her obvious love and devotion to him, she would leave him one day.
After years of assuring Jimmy that she loved him and would not leave him, his wife did walk out on him. She left him with the kids and went to her older sister’s for 3 days. She had grown weary of his chronic worrying and questioning over something that she had no intention of doing. She left in anger and frustration but came back tired and remorseful three days later.

Fear of his wife walking away was Jimmy’s original presenting issue, and he and the clinician worked for weeks cleaning out all the touchstone events (e.g., earlier experiences of failure and not feeling worthy) that set his dysfunction into place and the present triggers that kept it in place. After these successful reprocessing sessions, his relationship with his wife became closer and his confidence in their marriage renewed. Here is the transcript of this session:

**Target:** Possibility of his wife leaving him again.
**Image:** Seeing his wife walking out on him.

**NC:** I don’t matter.
**PC:** I do matter.
**VoC:** 3.
**Emotions(s):** Fear.
**SUD:** 7 to 8.
**Body:** Chest.

**Desensitization**

**Clinician:** Bring up the image (or picture), those words, “I don’t matter” and where you feel it in your body. Just let whatever happens, happen. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What’s happening now?

With every set of BLS, it is the intention to bring the client to a new plateau of processing. The clinician needs to stay alert to the emergence of this new information during each and every set. Watch the client’s face, especially his breathing, eyes, and/or skin color. This is where it may show up first, even before the client realizes that a shift has occurred, such as a lessening of disturbance.

**Jimmy:** I am feeling very alone. I am thinking about how hurt I would feel on my own. It’s like this has all been a big farce.

**Clinician:** Where do you feel it in your body?

**Jimmy:** In my heart. It feels empty.

**Clinician:** Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?
Jimmy: I would feel embarrassed if she left. What do I tell people, and what a fool I would look like.

Clinician: Notice that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What is coming up for you now?

Jimmy: Having to tell everyone. Telling my kids and my mom would be the hardest part. (Jimmy begins to cry.)

Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What’s happening now?

Jimmy: And then the kids would be devastated, especially my five-year old son, Jason.

Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Jimmy: I am thinking about telling my friends, other siblings, and family. It would just be so hard, so hard to do. And where would I be after that? It just didn’t work out, and she doesn’t love me. I feel like a failure.

Clinician: Notice that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What’s coming up now?

Jimmy: How do I recover from that? Would I feel like I could recover from that?

Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What are you getting now?

Jimmy: I am feeling like I would make it, and I would be alright. I don’t feel it in my chest as much. I feel like I would be okay. It’s more about the mechanics of splitting assets and all the other complications.

Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Jimmy: My chest does not hurt nearly as bad.

Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What is coming up for you now?

Jimmy: I feel okay. I feel like I would be alright. I can get through it. No mental pictures.

Clinician: Go with that. (Set of BLS) Let it go. Take a breath. (Pause) What are you noticing now?

Jimmy: I’m having a difficult time concentrating on it. I can see my wife’s face, and she is walking away from me. That would be rough. Moving out. (At this point, the client placed his hand over his heart.)

Clinician: Go with that. (Set of BLS) Let it go. Take a breath. (Pause) What are you getting now?
Jimmy: It just feels manageable… that’s kind of weird. It comes and goes. I guess I would feel embarrassed. I’m tired. I can’t see anything happening. I’m not having the emotion I had before. I keep seeing that I am going to be okay. That’s alright. That’s what keeps coming up. I’m going to be alright. I am worthy of being loved. I see that. My chest feels weird. It’s a little tight, and I am a little sick to my stomach but not much.

Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What are you getting now?

Jimmy: I can see myself with my wife.

Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What’s happening now?

Jimmy: Not a lot. My chest does not hurt.

Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What is coming up for you now?

Jimmy: I can see her face to the side. She is just standing there. She looks like she feels disappointed. My chest feels a little weird.

Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What’s coming up for you now?

Jimmy: I think she is trying to deal with something. That’s what I get. That’s what it is. I’m at my mom’s house for Christmas. I can see my wife. I see all the presents.

Clinician: Notice that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What’s happening now?

Jimmy: I’m sitting in my living room now. Everyone is excited about the presents. Everyone is there.

Clinician: Notice that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Jimmy: I guess I feel like she is not going to leave me. That’s what I feel.

Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What are you getting now?

Jimmy: She’s not going to leave. She never was going to leave.

Clinician: When you focus on the original event (incident, experience, etc.), what do you get now?

When referring to the original event, do not say “image or picture.” The focus at this point in the reprocessing is on the entire incident or experience.

When referring to the original event, the clinician should ensure that the client understands she means the one he is currently targeting.
(Reminder: Original incident—possibility of his wife leaving him again.)

Jimmy: I can’t see. I’m having a hard time concentrating on it. I can see her face. She has a smile on her face. She’s not saying anything.

When a client appears to be distracted, the clinician may ask the client to refocus on the original event (incident, experience). Any time it appears that a client is running around in circles or losing focus, the clinician has the option of taking the client back to the original target so that they have a starting point from which to begin processing again.

It is not always as “cut and dry” deciding when to go back to target or when to check on the SUD scale. The rule of thumb is that a return to target occurs in the final stages of reprocessing if a client’s associations seem to have stopped in a certain channel. A return to target is necessitated to discern additional channels of disturbing information or to ascertain the progression to the Installation and Body Scan phases. When we return to target, we are essentially checking to see how the incident or event is currently stored. However, going back does not necessarily mean that adaptive resolution has occurred. Prematurely going back to the target may interrupt the client’s processing but will not harm him in the process.

Note that, when the clinician takes the client back to the target, she is asking him to go back to the original event (incident, experience)—she does not ask him to focus on the possibility of his wife leaving him. The clinician does not describe the event for the client for several reasons. From the time a client describes his target in any way, the entire memory may begin to change or transform. It begins to lose some of its power over the client. The clinician does not want to interfere with the client getting his power back or run the risk of tampering with the memory by not describing it fully or accurately.

Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Jimmy: She really does love me. I know that now.

Clinician: When you bring up the original event (incident, experience), on a scale from 0 to 10, where 0 is no disturbance and 10 is the worst disturbance you can imagine, how disturbing does it feel to you now?

Jimmy: Let’s say a three. There is some doubt that she will stay in the marriage. Anything is possible.

Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What’s coming up now?

Jimmy: I keep saying, “I’m okay” in my mind. I’m not sure my chest believes it, but it keeps coming up. I see that I’m a good person. I’m worthy. I’m lovable. I see that. I’m liked.
Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What are you getting now?

Jimmy: I am okay. I really am okay.

Clinician: When you focus on the original event (incident, experience), what do you get now?

Jimmy: I see her face. I feel a little twinge in my chest.

Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Jimmy: I see her walking away from me, except she is not moving. She is turning around and walking back toward me. She is hugging me. She says she loves me.

Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What is happening now?

Jimmy: She’s holding me.

Clinician: When you focus on the original event (incident, experience), what do you get now?

Jimmy: I can see her face. She’s smiling…or kind of a half-smile.

Clinician: Go with that. (Set of BLS) Take a breath. Let it go. (Pause) What are you noticing now?

Jimmy: We are both smiling. And we’re holding each other…tightly.

Clinician: When you bring up the original event (incident, experience), on a scale from 0 to 10, where 0 is no disturbance and 10 is the worst disturbance you can imagine, how disturbing does it feel to you now?

Jimmy: It’s a zero. She loves me and wants to grow old with me.

The clinician will be evaluating the degree of change from set to set by monitoring the client’s responses between sets and client-reported changes in emotions and physical sensations. It is unnecessary to take a reading after each set. Remember that increases as well as decreases in a client’s stress responses can indicate processing is occurring.

Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Jimmy: I feel good. I can see her grinning now and walking toward me. She loves me and is going to stay with me. I’m confident of that now.

Clinician: When you bring up the original event (incident, experience), on a scale from 0 to 10, where 0 is no disturbance and 10 is the worst disturbance you can imagine, how disturbing does it feel to you now?

Jimmy: It is still a zero.
**Installation**

Clinician: Focus on the original event (incident, experience). Do those words, “I do matter” still fit, or is there another positive statement you feel would be more suitable?

There are two reasons for asking this question: (a) The positive cognition may have evolved to a more adaptive one since it was first asked during the Assessment Phase; and (b) sometimes during the Assessment Phase the client is unable to come up with an adequate positive cognition. Rather than causing him further discomfort by insisting he verbalize one, the clinician knows there is another opportunity for the client to voice what he would like to believe about himself as he focuses on the original event (incident, experience).

Jimmy: It feels totally appropriate.

Clinician: Focus on the original event (incident, experience) and those words, “I do matter.” From 1, which is completely false, to 7, which is completely true, how true do they feel now?

Jimmy: Six point five.

Clinician: Focus on the event (incident, experience) and hold it together with the words “I do matter.” (Set of BLS) (Pause) On a scale of 1 to 7, how true do the words “I do matter” feel to you now when you focus on the original incident?

Jimmy: Now it’s a seven.

Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) How true do they feel now?

Jimmy: Seven!

**Body Scan**

Clinician: Close your eyes and focus on the original event (incident, experience) with those words, “I do matter,” and scan your body from head to toe for physical discomfort. Any place you feel tension, tightness, or unfamiliar or unusual sensations, tell me.

The body scan is implemented at this stage of the process to ensure that there are no residual aspects of the target still in need of reprocessing.

Jimmy: There is nothing.

Clinician: What does “nothing” mean?

Jimmy: There is no discomfort. I feel calm and relaxed.

Clinician: Go with that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?
After a neutral body scan, the clinician implements an additional set of BLS to ensure a neutral or positive change. If body sensations change in either direction, the clinician will continue to do additional sets until the change is complete.

*Jimmy:* There is no change.

*Clinician:* Hold the event (incident, experience) in mind again and rescan your body. (Pause) What do you get?

*Jimmy:* I still feel nothing.

**Closure**

*Clinician:* The processing we have done today may continue after the session. You may or may not notice new insights, thoughts, memories, or dreams. If so, just notice what you are experiencing. Take a snapshot of what you are seeing, feeling, thinking, and any triggers and keep a log or TICES grid. Then do the Calm (Safe) Place exercise to rid yourself of the disturbance. We can work on this new material next time. If you feel it is necessary, you may call me.

In Chapter 4, the future template was illustrated using an example of skills building and imaginal rehearsal. After the session, the clinician helped target a positive template that incorporated appropriate future behaviors for Jimmy. A subsequent session followed that included appropriate education, modeling, and imagining, along with processed targeting to help Jimmy respond differently in the future.

*Note:* Anticipatory anxiety is usually processed in the same manner as a past event or present trigger using the standard EMDR protocol.

**Use of the Cognitive Interweave Demonstrated**

### Case Example 6f: Kevin

*Situation:* Kevin felt he had been teased at school as a child and snubbed by his coworkers in his present position.

*Type of presentation:* One cluster of similar events.

*Symptoms:* Uncomfortable in most situations involving other people; depression; recent difficulty going to and staying asleep; difficulty concentrating at work.

*Issues:* His current position requires him to be a team player; he was experiencing difficulty trusting and working alongside his coworkers; he tended to isolate and distance himself from others.
Kevin had just turned 29 years old when he came to therapy. He is a competent worker but prefers to work alone. His recent promotion requires him to work with others more closely. This has become a stumbling block for him. As a child, Kevin felt ostracized by his peers. He did not relate well to others.

The following transcript was created to demonstrate how cognitive interweaves and unblocking and other strategies are introduced and used in a coherent manner. The chosen BLS is eye movement.

**Target:** At age 7, Kevin was placed upside down into a donation bin at school by a group of his classmates.

**Image:** The look on the bystanders’ faces as he lifted himself out of the donation bin.

**NC:** I’m worthless.

**PC:** I am worthwhile.

**VoC:** 2.

**Emotion(s):** Sadness, frustration, confusion.

**SUD:** 10.

**Body:** Stomach, throat.

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**Desensitization**

**Clinician:** Kevin, bring up the image (or picture), those words, “I cannot take care of myself,” and where you feel it in your body. Just let whatever happens, happen. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) What’s coming up now?

**Kevin:** This same group of kids had been teasing me on and off since kindergarten. But it had been mostly verbal up to this time.

**Clinician:** Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. (Pause) What comes up for you now?

**Kevin:** I can feel them crowding around me. I’m feeling faint. I can’t breathe.

**Clinician:** Go with that. (Set of BLS) Good. Good, Take a breath. (Pause) Let it go. (Pause) What are you getting now?

The clinician may address the informational plateau of responsibility/defectiveness first in hope that the plateaus of safety/vulnerability and power/control (or choice) arise spontaneously during the client’s processing of the traumatic memory.
Plateau of Responsibility/Defectiveness

Kevin: I keep seeing the ringleader’s face. There’s a look in his eyes that scares me.

Clinician: Notice that. (Set of BLS) You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What are you getting now?

Kevin: I can’t get rid of the image of his face. I ran into him every week up until I graduated from high school, and he always had the same expression on his face when he chanced to look my way.

Clinician: Where is he now?

This cognitive interweave is an attempt to introduce current safety.

Kevin: He is off to the side of me and watching as the others began to pick on me.

Clinician: Where is he today?

The clinician makes a second attempt to orient to the safety of the present.

Kevin: I heard he went into the military after 9/11 and was deployed to Afghanistan. A couple of years ago, someone told me he was killed while on an enemy raid.

After two successive sets of negative responses with no change, the clinician infused a present referent by reminding the client where the bully is in the present.

Clinician: Go with that. (Set of BLS) Good. That’s it. Take a breath. (Pause) Let it go. (Pause) What’s coming up now?

Kevin: What did I do to deserve it? I always tried to get along with everyone.

Clinician: Go with that. (Set of BLS) Good. That’s it. Take a breath. (Pause) Let it go. (Pause) What’s coming up now?

Kevin: I know he can’t hurt me now. But I always felt like I had done something to make him unhappy.

Clinician: Did you?

Kevin: No, of course not.

Clinician: Whose responsibility was it really?

Kevin: I don’t know. I guess because I was unhappy back then. Like I had done something to deserve it.
Clinician: Did you?
Kevin: I was just a kid. I don’t think so.

After two more successive sets of negative responses with no change, the clinician uses the Socratic method to help shape the client’s thinking processes. Through these easily answered questions, the client was led to a logical conclusion. What the client discovered is that he had projected his anger and unhappiness on another person.

Clinician: Go with that. (Set of BLS) Good. You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What comes up for you now?
Kevin: I can still feel the intensity of his gaze as I focus on him.

Clinician: Where do you feel it in your body?
Kevin: In my stomach and throat.

Clinician: Is there anything you need to say to him?

The clinician provides the client opportunity to express unspoken words and to discharge his negative emotions.

Kevin: Go away. Leave me alone. I just want everyone to leave me alone.

Clinician: Go with that. (Set of BLS) You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What is coming up now?
Kevin: I am feeling much calmer.

Clinician: Go with that. (Set of BLS) That’s it. That’s it. Stay with it. You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

The clinician reinforced the client’s positive processing.

Kevin: I am feeling much more relaxed.

Plateau of Safety/Vulnerability

Clinician: When you focus on the original event (incident, experience), what do you get now?

Kevin: I can picture the other boys. They are all cheering as two of my classmates pick me up and dump me head first into the donation bin in the hall. Everyone is looking and cheering them on. I am so scared. I’m numb. I can’t seem to move.

Clinician: Where do you feel it in your body?
Kevin: All over, but mostly in my stomach.
Clinician: Notice that. (Set of BLS) You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What are you getting now?

Kevin: I’m trying not to cry. I did that day, and they all laughed. I felt humiliated.

Clinician: Notice that. (Set of BLS) (Kevin shook and sobbed uncontrollably) Let whatever needs to come up, come up. It’s okay. (Eye movements are continued) That’s good. Whatever it is, it’s over. You’re safe now. (Clinician changes speed of eye movements) Good. Good. You’re doing fine. Just notice it. Take a breath. (Pause) Let it go. (Pause) What’s happening now?

The client is obviously in distress so the clinician encourages the continuation of the processing by maintaining verbal contact with him and establishing cadence between the eye movements and the words.

The clinician continues the eye movements as long as the client is abre-acting and can tolerate the current affect.

Kevin: I’m overwhelmed with another image. This time of my father dunking my head in the toilet. I must have been four or five. I think he was punishing me for wetting the bed. I thought I was going to drown. He’s drunk. I’m afraid he won’t let me up for air. He’s so angry with me. I can’t get the image out of my head. He’s laughing. I am so afraid. I never saw my father that way before or ever again.

Another channel of association spontaneously emerges.

Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. What are you noticing now?

Kevin: I can’t get him out of my head. He was so big and scary that night.

Clinician: Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. What are you noticing now?

Kevin: No change.

Clinician: Change the image of your father in some way. Can you change his image to a still or black and white photo or something similar?

After two more successive sets of negative responses with no change, the clinician implements a distancing strategy to help the client manage his apparent high level of distress.

Kevin: I changed him into Sponge Bob.

Clinician: Notice that. (Set of BLS) You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What are you getting now?

Kevin: I am afraid my dad is going to do something like that again even though he is remorseful the next morning. He is so apologetic.
Clinician: Go with that. (Set of BLS) Good. That’s it. Take a breath. (Pause) Let it go. (Pause) What’s coming up now?

Kevin: My dad was a good guy. He scared me so badly that night that it was difficult for me to trust him again. From then on, I kept my distance. I never wanted him to hurt me again like that.

Clinician: Notice that. (Set of BLS) You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What are you getting now?

Kevin: He does not look so scary now.

Clinician: Are you still seeing your dad or Sponge Bob?

Kevin: My dad.

If the client were still seeing dad as Sponge Bob, the clinician will need to bring the client back to his dad for more processing. When using a distancing cognitive interweave, it is imperative that the clinician bring the client back to the original event to ensure that the client has completed reprocessing.

Clinician: Go with that. (Set of BLS) Good. Good. Just notice it. Take a breath. (Pause) Let it go. What is coming up now?

Kevin: I am the one laughing at him. He keeps plunging and the more he does, the more the water gushes from the bowl. He can’t hurt me

Clinician: Go with that. (Set of BLS) Good. Good, Take a breath. (Pause) Let it go. (Pause) What are you getting now?

Kevin: I am back to feeling calm and relaxed. I actually felt the fear release and go out the top of my head. He was a good father for the most part. Something just snapped in him that night. He did try to make up for it. It was just hard for me to shake.

Clinician: Go with that. (Set of BLS) Good. That’s it. Take a breath. (Pause) Let it go. (Pause) What’s coming up now?

Kevin: I am remembering some of the good times I had with my father when I let my guard down with him. He really never did hurt me again.

Plateau of Power/Control (Or Choice)

Clinician: When you focus on the original event (incident, experience), what do you get now?

Kevin: At the age of five, I chose to distrust my father. And then I guess it just spread to everyone else.

Clinician: Go with that. (Set of BLS) You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What is coming up now?
Kevin: I felt so helpless and powerless. This is how I feel most of the time with my coworkers even though they have never really done anything to me.

Clinician: Go with that. (Set of BLS) That’s right. That’s right. Go with it. You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Kevin: My biggest fear is that they are all laughing at me. I’m a joke. Just like that little boy whose head was upside down in the toilet bowl.

Clinician: Go with that. (Set of BLS) Good. Good. Just notice it. Take a breath. (Pause) Let it go. What is coming up now?

Kevin: I feel my coworkers are laughing at me behind my back as well.

Clinician: I’m confused. Have you actually seen them laugh at you?

Kevin: Well, no. I just assumed they did. They never had much to do with me.

Clinician: I’m confused, was that about you or about them?

Kevin: Well, I guess that was about me. I keep my distance.

Clinician: Did you make a choice to distance yourself from your classmates as well?

Kevin: I guess I did.

The clinician used a cognitive interweave to help the client distinguish between fantasy and reality (i.e., internal vs. external locus of control).

Clinician: Go with that. (Set of BLS) Good. You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What comes up for you now?

Kevin: I guess I made an unconscious choice to distance myself from others, even my father after he did that to me. From then on, I felt powerless around people.

Clinician: Had your father ever treated you abusively before that night?

Kevin: I don’t think so.

Clinician: Did your father ever treat you abusively after that night?

Kevin: No. He was extremely remorseful when my mother told him the next morning what he had done. He tried to make it up to me. He was always trying to make it up. I guess I chose not to let him.

Clinician: Go with that. (Set of BLS) You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What is coming up now?

Kevin: I didn’t let anyone get close to me. I’m remembering that other kids did try to engage me. I discouraged them. Same thing happened at work. I
discouraged my coworkers from trying to get to know me. I thought they would hurt me, too. I am beginning to understand that I hurt myself by keeping them at a distance. I set myself apart.

**Clinician:** Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. What are you noticing now?

**Kevin:** I am remembering it differently now. The kids were not maliciously teasing me that day. They were trying to engage me. The school had been sponsoring a charitable event. A tornado had touched down in the school district some months before. Local merchants had donated items to be raffled off to help those hardest hit. The donation bin was turned into a collection place for the raffle tickets. The day the winning tickets were to be selected, a couple of the older students picked me up and plunged me into the donation bin head first so I could pick the ticket for the grand prize. No one was laughing at me. They were laughing and cheering in the spirit of the moment. It took me by surprise. It happened so fast. I was so scared and embarrassed in that moment that I ran off and hid.

**Clinician:** Go with that. (Set of BLS) Good. That’s it. Take a breath. (Pause) Let it go. (Pause) What’s coming up now?

**Kevin:** I chose back then to interpret the events in the way I did, and now I can choose differently. It will be difficult, but I can do it.

**Clinician:** Go with that. (Set of BLS) Good. Take a breath. (Pause) Let it go. What are you noticing now?

**Kevin:** I feel more empowered. I see now that my coworkers and team members try to draw me in all the time. It’s not that they don’t like or appreciate me. It’s that I don’t make the effort. I need to make the effort.

**Clinician:** Notice that. (Set of BLS) You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What are you getting now?

**Kevin:** I know it is going to be hard work and scary; and, with your help, I need to make the effort.

**Clinician:** When you focus on the original event (incident, experience) what do you get now?

**Kevin:** I continue to feel strong and empowered. I know what I need to do now to make my life better.

**Clinician:** Go with that. (Set of BLS) You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What is coming up now?

**Kevin:** I am strong and will do this. I can’t live the same way I have all these years closing myself all these years. I made a choice years ago. I can make another choice now.

**Clinician:** When you focus on the original event (incident, experience), on a scale from 0 to 10, where 0 is neutral or no disturbance and 10 is the worst
disturbance you can imagine, how disturbing is the event (incident, experience) to you now?

Kevin: Zero. I feel so much stronger and safer.

Clinician: Notice that. (Set of BLS) You’re doing fine. Take a breath. (Pause) Let it go. (Pause) What are you getting now?

Clinician: When you bring up the original event (incident, experience) on a scale from 0 to 10, where 0 is no disturbance and 10 is the worst disturbance you can imagine, how disturbing does it feel to you now?

Kevin: Zero.

**Installation**

Clinician: Focus on the original event (incident, experience). Do those words, “I can protect myself” still fit, or is there another positive statement you feel would be more suitable?

Kevin: Yes. They fit. And I am going to do just that.

Clinician: Focus on the original event (incident, experience) and those words, “I can protect myself.” From 1, which is completely false, to 7, which is completely true, how true do they feel now?

Kevin: Seven.

Clinician: Notice that. (Set of BLS) Take a breath. (Pause) Let it go. (Pause) How true do they feel now?

Kevin: No change.

**Body Scan**

Clinician: Close your eyes and focus on the original event (incident, experience) and those words, “I can take care of myself.” Now bring your attention to the different parts of your body, starting with your head and working downward. Any place you find tension, tightness, or unfamiliar or unusual sensations, let me know.

Kevin: I feel wonderful. I feel like I have a new beginning.

Clinician: Hold the event (incident, experience) in mind again and rescan your body. (Pause) What do you get?

Kevin: I still feel wonderful.

The clinician may choose to use future resourcing to help Kevin strengthen this new learning by returning to the positive cognition and asking if he anticipates a time in the near future when he will want to be able to remember this. If the response is affirmative, then ask Kevin to just notice that and add a short, slow set of BLS.
Closure

Clinician: The processing we have done today may continue after the session. You may or may not notice new insights, thoughts, memories, or dreams. If so, just notice what you are experiencing. Take a snapshot of what you are seeing, feeling, thinking, and any triggers and keep a log or TICES grid. Then do the Calm (Safe) Place exercise to rid yourself of the disturbance. We can work on this new material next time. If you feel it is necessary, you may call me.

Use of Eye Movement Desensitization (EMD)

Case Example 6g: Harlan

Harlan had only been a deputy in a rural Kentucky county for less than a year. While riding shotgun along with his Sergeant, the two were called to the home of an elderly man and his wife. The wife had become concerned over her husband’s erratic behavior and called 911. By the time the two had arrived on the scene, the elderly man was seen running through the woods, yelling and screaming, all the while brandishing a shotgun. The man kept shouting “They’re out to get me! They’re out to get me!” He shot the gun several times up into the air and then turned the gun on himself. He fired. Harlan’s heart sank to his stomach, and he began to retch violently. He could not force himself to look toward where the old man had been standing. It was several minutes before he learned that the old man had missed his mark and was sitting inside his house drinking coffee while waiting for an ambulance to take him to a local hospital.

It had only been a few days since the event, and Harlan was exhibiting extreme anxiety and other symptoms of an acute stress reaction. The clinician wanted to decrease the symptoms related to the specific event but to contain the reprocessing and not allow the client to link to earlier memories that might be related. So the clinician decided that Eye Movement Desensitization (EMD) might be in order. Here is how the session was set up in terms of this procedure:

Clinician: Often we will be doing a simple check on what you are experiencing. I need to know from you exactly what is going on with as clear feedback as possible. Sometimes things will change, and sometimes they won’t. There are no “supposed to’s” in this process. So just give as accurate feedback as you can as to what is happening without judging whether it should be happening or not. Just let whatever happens, happen. Remember you have a calm (safe) place and a stop signal should you need them.
In the event the client becomes confused or cannot easily accept the rapid changes that are taking place, these instructions become very important. This can be even more true in situations of acute stress where the client may already be experiencing some confusion and difficulty staying present. Often clients may say “This cannot be happening,” “This is too easy,” “I must be doing something wrong,” “I cannot bring the picture back up,” “The picture is changing,” “I no longer see the picture,” or “Am I doing this right?” All the elements identified previously (e.g., picture, cognitive statement, and level of anxiety) may change rapidly, so a client may need reassurance that what is happening during the process is normal and expected.

Clinician: Harlan, today we have decided to reprocess what happened at work. As you focus on it now, is there an image (or picture) that represents the worst part of this memory?

The clinician orients the client to the event (incident, experience).

Harlan: Yes. I just heard the crack of the gunshot. I closed my eyes, and I could not look up at the old man. I froze, and I felt like I went deaf. I could not hear anything except my own retching.

The intrusive fragment identified earlier is the crack of the gunshot.

Clinician: What words about yourself go best with that sound?
Harlan: I am powerless now.

If the client is unable to provide a negative belief, the clinician may suggest some options but only after asking the client to describe his feelings about the past event.

Clinician: What would you prefer to believe about yourself now?
Harlan: I have some power.

Clinician: When you think about this image (or picture), how true does the statement, “I have some power now” feel to you on a scale of 1 to 7, where 1 is completely false and 7 is completely true?
Harlan: Two.

Clinician: Okay. Now bring up the image (or picture) and those words, “I am powerless.” What emotions do you feel now?
Harlan: Just devastated. Totally devastated. How could this happen?

Clinician: Harlan, on a scale from 0 to 10, where 0 is neutral or no disturbance and 10 is the highest disturbance you can imagine, how disturbing does the image (or picture) feel to you now?
Harlan: Ten plus.
Clinician: Okay, now bring up the image (or picture), and the negative belief, “I am powerless,” and notice where you feel it in your body. (Set of 12–24 BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing?

Harlan: I hear that crack of the shotgun and can’t believe he’s done it. I just can’t believe it. I couldn’t look. It made me so sick to my stomach that I started throwing up. I must have been there quite a while. I don’t remember.

Clinician: Ok, you’re doing this just right. Now, if you can, go back to the beginning, the gunshot, what do you notice now?

Harlan: I can hear the shots.

Clinician: And on that scale of 0 to 10, where 0 is no disturbance and 10 is the worst you can imagine, how disturbing is it?

Harlan: It’s still a ten, but it is more distant.

Clinician: Just notice that. (Set of 12–24 BLS) Take a breath. (Pause) Let it go. (Pause). What are you noticing?

Harlan: He fired in the air a couple of times, and then he turned the gun on himself. I could see that, and I thought “No! No! Don’t do it!” But, before I could do anything, I heard the shot. I had to look away. I didn’t want to see it.

Clinician: Ok, that’s good. Go back to the beginning again, the gunshot, what do you notice now?

Harlan: It’s the same. I can hear the shots, but I don’t want to look.

Clinician: And on that scale of 0 to 10, where 0 is no disturbance and 10 is the worst you can imagine, how disturbing is it?

Harlan: It may be a nine.

Note that the clinician is asking for changes in SUD level after every set.

Clinician: Focus again on the event (incident, experience), those words “I’m powerless,” and notice where you feel it in your body. (Set of 12–24 BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Harlan: Still no change.

Clinician: And how disturbing is it on that 0 to 10 scale?

Harlan: Still a nine.

If the client’s SUD level does not decrease after two subsequent passes of BLS, ask: “Did any part of it change? Any change to the sound, your thoughts, or feelings?” “What do you get now?” or “Does anything else come up?”

If the SUD remains unchanged and the client can identify a body sensation in place of the emotion, have the client focus on it and resume processing.
Clinician: So when you bring it up now, has anything changed?

Harlan: Yes. I hear the crack of the shotgun as clearly as I did when we started, but I have this knot in my stomach.

Clinician: And on that scale of 0 to 10, where 0 is no disturbance and 10 is the worst you can imagine, how disturbing is it?

Harlan: It’s about an eight.

Clinician: Ok, just notice that. (Set of 12–24 BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing?

Harlan: It’s getting better. My stomach is better. I guess it was quite a while before the Sarge found me. That’s what he said. Sarge came to get me. Said the old man was inside. He missed and put the gun down and went inside. Go figure.

Clinician: Focus again on the event (incident, experience), those words “I’m powerless,” and notice where you feel it in your body. (Set of 12–24 BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Harlan: I can still hear the shots, but my stomach isn’t in knots. I’m thinking about that old man, running around out there in the woods with a gun. His wife must have been really scared too. I remember once on this other call when the woman was so scared that her boyfriend was going to do something.

Memories that emerge during the processing are usually connected with the targeted memory in some way. The memory may be the same type of event (e.g., mugging, molestation, car accident), may share the same belief statement (e.g., “I am unworthy,” “I am unsafe”), or may involve the same person (e.g., being molested and beaten by father). When using the EMD strategy, the clinician wants to limit these associations rather than follow them, and so the clinician returns the client back to the original target.

Clinician: OK. Let’s focus again on the original event (incident, experience) and notice where you feel it in your body. (Set of 12–24 BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?

Harlan: It’s a lot better. I can hear the Sergeant talking to me, telling me the old man is okay. Telling me he missed the shot and then went into the house. Backup was there with him waiting for the rest of the crises team to come.

Clinician: And on that scale of 0 to 10, where 0 is no disturbance and 10 is the worst you can imagine, how disturbing is it?

Harlan: It’s only about a three.

Clinician: Ok, just notice that. (Set of 12–24 BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing?

Harlan: I guess I learned a big lesson. I need to keep paying attention until everything is under control. I feel pretty silly about that.
Clinician: And on that scale of 0 to 10, where 0 is no disturbance and 10 is the worst you can imagine, how disturbing is it?
Harlan: It’s up a little. Maybe a four.
Clinician: Ok, just notice that. (Set of 12–24 BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing?
Harlan: Everybody has to learn. The guy was about the age and build of my dad. I think I let it get to me. It was a tough call, but everybody has to learn. Guess it was my turn.
Clinician: Focus again on the original event (incident, experience), those words “I’m powerless,” and notice where you feel it in your body. (Set of 12–24 BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?
Harlan: I just kind of ran through the whole thing again. I can see why I got so upset. It makes sense—but I can’t let it happen again. I’ll need to remember this. I was powerless about what he was doing but not about my reaction.
Clinician: And on that scale of 0 to 10, where 0 is no disturbance and 10 is the worst you can imagine, how disturbing is it?
Harlan: I would say a one.
Clinician: Good. Focus again on the event (incident, experience), those words “I’m powerless,” and notice where you feel it in your body. (Set of 12–24 BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?
Harlan: It was a tough call, but I had a good lesson to learn. I’m pretty new at this you know. Only been with the department for a year. Guess it happens to everyone sometime. I learned a lot.
Clinician: Yes. Focus once again on the event (incident, experience), those words “I’m powerless,” and notice where you feel it in your body. (Set of 12–24 BLS) Take a breath. (Pause) Let it go. (Pause) What are you noticing now?
Harlan: I’m feeling pretty good. I can see it all—the way it happened—and am okay.
Clinician: And on that scale of 0 to 10, where 0 is no disturbance and 10 is the worst you can imagine, how disturbing is it?
Harlan: It’s a zero.
Clinician: Good. Let’s just make sure. Bring up that event (incident, experience) one more time. Have you got it? On that scale of 0 to 10, where 0 is no disturbance and 10 is the worst you can imagine, how disturbing is it?
Harlan: It’s zero. It really is a zero.
Clinician: Good. So now when you think of the event (incident, experience), how true do the words, “I have some power” feel to you now from where 1 is completely untrue and 7 is completely true?
Harlan: About a five.
Clinician: Visualize the original image along with those words, “I have some power.” (Set of eye movements) Take a breath. (Pause) Let it go. (Pause) How true does it feel to you now?"

Harlan: Seven. I really do have power over my reaction. That’s the key.

The clinician should repeat the question above and take another VoC measure as long as it continues to increase.

When installation is complete, the clinician would have the client do a body scan. Reprocessing is complete when the SUD = 0, the VoC = 7, and the body scan is clear. Closure follows just as in the standard protocol.

**DERAILMENT POSSIBILITIES**

Derailment possibilities (see Tables 6.1–6.6) have been provided to further assist the clinician with keeping the “train on the track.” The bolded text in these tables represents what a clinician could do to derail the process.

<table>
<thead>
<tr>
<th><strong>TABLE 6.1</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Derailment Possibilities—General</strong></td>
</tr>
</tbody>
</table>

**Not adhering to the fidelity of the protocol.**
Failing to adhere to the EMDR Therapy protocol may result in stalled, derailed, or stopped processing.

**Not identifying and processing etiological events that are the source of the maladaptive behaviors.**
With some exceptions, processing generally follows in this order: past event, present stimuli, and future desired outcome.

**Not assessing the initial target based on the client’s readiness and stability.**
Do not initiate target selection with the client who cannot tolerate high levels of emotion or does not have an appropriate therapeutic relationship with the clinician.

**Beginning a new target session immediately after finishing another.**
Even when the client may have achieved a successful outcome on a targeted event, processing continues. Therefore, it is imperative that the client be provided sufficient opportunity to allow the processing to generalize to other parts of her life. One way to provide an opportunity for the material to generalize is to do a future template for each resolved present trigger.

**Not allowing adequate time within a session to process the targeted material and conduct necessary closure.**
In order for there to be enough time to implement Phases 3 through 7, the recommended amount of time allowed for a reprocessing session is 50 or 90 minutes.
TABLE 6.2
Derailment Possibilities—Between Sets

<table>
<thead>
<tr>
<th>AT THE BEGINNING OF A SET</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Go with that” or “notice that.”</td>
</tr>
</tbody>
</table>

**Failure to say “Notice that” or “Go with that.”**

If the clinician simply begins eye movements (or any other form of dual-attention stimulus), the client may become confused and lose his concentration, or lose his previous train of association. The client usually wants to know what he is to do every step of the way. Instruct and reinstruct at every turn. Be sure to continue to direct the client so he does not get disoriented and lose concentration if he is unsure of what to do next.

**Saying something other than “Go with that” or “Notice that” (e.g., “Let’s pick up where you left off”).**

Keep it simple, consistent, and direct.

**Asking the client to take a breath at the beginning of a set.**

The procedural steps clearly indicate the appropriateness of taking a breath—“Take a breath. Let it go”—at the end of a set of bilateral stimulation. The breath should be taken after a set is completed, not before another set is initiated.

**Directing the client to focus on something specific (e.g., “Let’s go back to where you started”).**

Unless the client becomes distracted or confused or is experiencing some difficulty as to where to start, let the client start where she left off or is at in the moment. Do not return to the original event until the client has come to the end of a channel of association. Simply say “Go with that” or “Notice that.”

**Questioning the subjective nature of the client’s reported change (e.g., “Is it different?”).**

The clinician should not question any reported change by the client because all changes, however slight, are indicative of information processing. Any efforts to obtain more information could possibly derail the client’s processing.

**Instructing the client to focus on what her body is processing by regularly and repeatedly asking about physical sensations or emotions.**

It is inappropriate to ask the client to focus on her body by saying “Focus on the pain in your gut,” “the tightness in your chest,” “on your temple,” or “on the spasms in your leg.” This leads the client to consistently focus only on body sensations. If there is nothing extraneous going on (e.g., distraction, confusion, rambling) with the client, simply direct her to “Go with that” or “Notice that.”

(continued)
TABLE 6.2  (continued)
Derailment Possibilities—Between Sets

Describing the image, feelings, sensations reported by the client at the end of the set before saying “Go with that” (e.g., “Focus on what you said about your brother running around the house in his underwear”). In order for the client’s process to flow, it is imperative that the clinician simply say “Go with that” or “Notice that” and nothing else.

AT THE END OF A SET

“Take a breath. [Pause]. Let it go. What are you noticing now?”
“What do you get now?”
“What came up for you now?”
“What’s happening now?”

Directing the client back to something other than the targeted event after a channel of association has been depleted. If the client’s original event was when the German shepherd bit him, do not say “Go back to the tightness in your chest” or “when your brother hit you in the elbow when you were five.” The clinician should say “When you go back to the original event (incident, experience), what are you noticing now?”

Failing to say “Good” (or something similar) at the end of each set. Leaving this out would not derail the client’s process, but it certainly tends to provide the client reinforcement, encouragement, and reassurance in terms of her process and progress.

Redirecting the client back to the original event (incident, experience) when associations continue to emerge. There are only a few reasons to have the client return to target: (a) the client is distracted and/or is initially experiencing difficulty getting started; (b) the client begins to ramble; (c) the clinician becomes distracted or confused; or (d) the client has come to the end of a channel of association. One of the primary reasons the client may initially experience difficulty starting the process is that he believes he is supposed to stay focused on the image/target. The image/target is meant to be the “starting” not “staying” point.

Saying “Go with that” when the client responds to “What are you noticing now?” by saying “Nothing” or not responding at all. In this case, it is okay to ask for details, such as changes in the initial image, thoughts, emotions, or physical sensations. Respond by asking “When you think of the event (incident, experience), what do you get?”

Asking something other than “What are you noticing now?” (e.g., “Any changes?” “Is your chest still tight?” “How are you feeling?”). “What are you noticing now?” or something similar is sufficient.

(continued)
TABLE 6.2  (continued)
Derailment Possibilities—Between Sets

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Filling in the blanks or probing for details when the client is unable or struggles to verbalize what has occurred during reprocessing.</td>
<td>If the client cannot or experiences difficulty verbalizing what has occurred during a set, just allow her to “Go with it.” It is important not to cause the client any undue distress during the process, and it is not always necessary for the clinician to know exactly where the client is in her process.</td>
</tr>
<tr>
<td>Encouraging dialogue.</td>
<td>Unless processing is stuck, the clinician should not explore or probe for further information on a particular information plateau. As long as shifts continue to occur, the client should be instructed to go with the cognition that was verbalized in the previous set. Simply allow the client to state what is happening at the time a set ends. Additional dialogue is not necessary or appropriate.</td>
</tr>
<tr>
<td>Saying “What do you see?” or “What are you feeling?” at the end of a set.</td>
<td>During reprocessing, shifts of any kind may occur—in the image, emotions or body sensations, perspectives, or attitudes, as well as the emergence of insight. For that reason, the clinician should say “What are you noticing now?” or something similar. The clinician should be as nondemanding as possible. Allow the client to determine what is most salient in the moment so that his processing may continue unimpeded.</td>
</tr>
<tr>
<td>Commenting, analyzing, interpreting, summarizing, restructuring, or reflecting in terms of what the client says between sets.</td>
<td>Stay out of the client’s way. This is the client’s experience, and the clinician should respect and allow her process to unfold by saying nothing or as little as possible between sets. “What are you noticing now?” provides an opportunity for the clinician to check in with the client to determine her overall condition, notice any new information that may have surfaced, and assess any information that emerged to determine if the client is appropriately processing the information so that a more adaptive plateau may evolve.</td>
</tr>
<tr>
<td>Asking for specific information.</td>
<td>In an effort to remain neutral and allow the client his process, the clinician should be deliberately vague and open-ended in all inquiries. The clinician does not need to know the content. What she needs to know is that the client’s process is shifting and changing as new associations may emerge.</td>
</tr>
<tr>
<td>Making unnecessary cognitive interweaves.</td>
<td>Cognitive interweaves should be a strategy of last resort. Use sparingly and rarely.</td>
</tr>
</tbody>
</table>
TABLE 6.2  (continued)
Derailment Possibilities—Between Sets

<table>
<thead>
<tr>
<th>Intervening with unnecessary questions and goals.</th>
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</thead>
<tbody>
<tr>
<td>If the clinician has questions or goals to establish, it is advisable to wait until the end of the EMDR session to do so.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Distracting the client by bringing up any issues unrelated to the image/target.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The hallmark of reprocessing is to “Stay out of the way.” Allow the client the power and ability to follow her own flow of associations. Do not bring up any issues or information that is unrelated to what is being reprocessed by the client in the moment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Embarking on any discussions as to whether the client’s memory is real or not.</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is irrelevant whether the client’s memory of events is real or not. It is how it is stored and perceived that is important. Again “stay out of the client’s way.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Distancing the client from the memory (e.g., train metaphor) when it is evident that he can tolerate his emotions and still remain in the present.</th>
</tr>
</thead>
<tbody>
<tr>
<td>This statement is worth repeating. “Stay out of the way.” If it is evident that the client is effectively tolerating whatever emotions he is exhibiting at the time, it is important to allow him to do so without interruption, distraction, or direction from the clinician.</td>
</tr>
</tbody>
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TABLE 6.3
Derailment—Intense Emotional Responses

<table>
<thead>
<tr>
<th>Stopping the reprocessing when the client obviously continues to process negative associations.</th>
</tr>
</thead>
<tbody>
<tr>
<td>When the client is experiencing intense emotions, it is indicative that the processing continues. Distress and intense emotions the client is experiencing will resolve more quickly if the clinician continues the bilateral stimulation until it has subsided.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Talking while the client is experiencing an intense emotional response.</th>
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</thead>
<tbody>
<tr>
<td>Instead of trying to distract the client from this distress, it is suggested that the clinician offer support and encouragement to help the client tolerate his experience (e.g., “Good. You’re doing fine.” “It’s over. You’re safe now.” or “It’s in the past”).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Introducing a state-shift prematurely rather than continuing the reprocessing (e.g., breathing, safe place).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Again, it is important “to stay out of the way.” If shifts and changes continue to occur with the client’s processing, simply say “Go with that” or “Notice that.”</td>
</tr>
</tbody>
</table>

(continued)
TABLE 6.3  (continued)
Derailment—Intense Emotional Responses

<table>
<thead>
<tr>
<th>Failing to stop the reprocessing completely when the client requests.</th>
</tr>
</thead>
<tbody>
<tr>
<td>In this case, the clinician is encouraged to simply give the client a break and then return to reprocessing as soon as the client indicates she is able. If the client continues the request, stop immediately and do a container or other stabilization exercise. It is important not to push the client beyond her level of tolerance.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Not consulting the client’s physician in the case where the client reports a serious medical problem (e.g., pregnancy, a cardiac or respiratory condition) as part of his clinical landscape.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Because of the possibility of high levels of emotional response, the client’s physician should be contacted before reprocessing is commenced under these and other medical circumstances.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Not assessing the client’s current life situation before reprocessing is begun.</th>
</tr>
</thead>
<tbody>
<tr>
<td>High levels of emotional response are possible in any session. Therefore, the clinician must assess the client’s current life responsibilities (e.g., work presentation scheduled immediately after a reprocessing session) prior to reprocessing. The clinician may also wish to assess the client’s degree of psychological support before and after each session (e.g., if the client is scheduled to go on a long-term business trip, the clinician may want to schedule reprocessing upon the client’s return).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Allowing the client to leave the clinician’s office during or immediately after an unresolved abreactive response.</th>
</tr>
</thead>
<tbody>
<tr>
<td>If a trauma is insufficiently processed, relatively high levels of disturbance may still continue and increase even after the session ends. Adequate time needs to be taken to debrief and to allow the client to restore her sense of equilibrium before allowing her to leave the office. A closure procedure (e.g., Safe (Calm) Place, Lightstream Technique) should be agreed upon and in place before any processing has taken place. This procedure should be adequate enough to help the client contain affect and control and to help return her to a relative state of calm before leaving the clinician’s office. Alternate arrangements may need to be made for transportation in the event the client is unable to drive safely. In some cases, it may be necessary to see the client later in the day or even later in the week to assure a continued sense of calm and mastery. The clinician may also call the client later in the week to check on her progress.</td>
</tr>
</tbody>
</table>
### TABLE 6.4
Derailment Possibilities—Emotions and Body Sensations

<table>
<thead>
<tr>
<th>EMOTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>“When you bring up that picture and those words (negative cognition), what emotion(s) do you feel now?”</td>
</tr>
</tbody>
</table>

**Identifying the emotions without first pairing them with both the image and the negative cognition.**
Follow the Assessment Phase in the order prescribed.

**Discussing or naming the emotions for the client (e.g., “Are you feeling sadness or anger rather than regret?”).**
Stay out of the client’s way. Allow him to identify and describe his own experience.

**Not being attuned to the amount of emotional distress the client may be experiencing during reprocessing.**
The clinician should be attending to the client at all times during processing.

**Allowing the client to provide a SUD score on positive emotions.**
In this case, the clinician will need to remind the client that she is only rating disturbing or negative emotions.

**Targeting a new emotion in reference to a subsequent one.**
If a new emotion emerges, it should be targeted solely on its own. If the client reports anger, do not add a reference to previous emotions by asking, “Are you still feeling frustrated and confused?”

**Failing to target smells or sounds in successive sets.**
If smells or sounds emerge, the clinician should target them in subsequent sets.

**Accepting emotions that the client felt at the time of a disturbing event.**
The emotions solicited are those felt at the time of the assessment, not those the client experienced at the time of the event. Take care to discern when the client felt the emotions he is reporting—then or now.

**Failing to utilize advanced strategies when the client begins looping.**
Looping is an indication that the client is experiencing high levels of disturbance and continues to report the same images, emotions, or body sensations. When looping occurs, the clinician may use a variety of strategies (e.g., strategies for blocked processing, cognitive interweaves) to mimic processing.
### TABLE 6.4  (continued)
Derailment Possibilities—Emotions and Body Sensations

<table>
<thead>
<tr>
<th>Failure Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Failing to debrief the client on the possibility of intense emotions emerging.</strong></td>
<td>During the Preparation Phase, the clinician should briefly explain the possibility of intense emotions arising during processing. Explain that they are manifestations of old material. For example, the client may be experiencing fear during a session even though there is no immediate danger.</td>
</tr>
<tr>
<td><strong>Asking for emotions in reference to the past.</strong></td>
<td>Elicit the emotions as the client is experiencing them “in the now.”</td>
</tr>
<tr>
<td><strong>Attempting to remove a negative emotion that may either be appropriate in a particular situation or an impetus to an appropriate reaction.</strong></td>
<td>The client with a snake phobia may exhibit irrational anxiety and fear at seeing a video of a recoiling snake on television. If, on the other hand, she was experiencing the same emotions while standing in front of a snake while out in the woods, this could be appropriate emotion under the circumstance, and EMDR processing could not remove them.</td>
</tr>
<tr>
<td><strong>Redirecting the client back to an associated emotion when he reports a physical sensation.</strong></td>
<td>If the client reports something other than an emotion(s), go where he goes.</td>
</tr>
<tr>
<td><strong>Stopping the client after she has identified only one emotion.</strong></td>
<td>There may be many emotions associated with the image/target.</td>
</tr>
<tr>
<td><strong>Encouraging the client to judge or fear his emotions.</strong></td>
<td>The client should be encouraged to just notice his emotions.</td>
</tr>
<tr>
<td><strong>Failing to address emotions as they emerge.</strong></td>
<td>A wide variety of emotions may sequentially emerge as the client is processing an event. When this happens, it is appropriate to ask, “Where do you feel it in your body?” Target the answer in the subsequent set.</td>
</tr>
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<table>
<thead>
<tr>
<th><strong>BODY SENSATIONS</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>“Where do you feel that (i.e., SUD) in your body?”</td>
<td></td>
</tr>
<tr>
<td><strong>Asking “What do you feel?”</strong></td>
<td>The only relevant information is the location of the negative physical sensation in the client's body.</td>
</tr>
<tr>
<td><strong>Treating a sensation that the client consistently reports in her head as an actual physical sensation.</strong></td>
<td>Treat it as a metaphoric construct instead.</td>
</tr>
<tr>
<td><strong>Asking the client what the body sensation(s) is.</strong></td>
<td>It is not necessary for the clinician to ask for a description of a body sensation.</td>
</tr>
</tbody>
</table>

(continued)
TABLE 6.4  (continued)
Derailment Possibilities—Emotions and Body Sensations

Dismissing the client’s report of numbed, blocked, or separated body sensations.
The clinician should pay attention to any response that denies body awareness or lack of feeling that simultaneously reveals a physical sensation. Redirect the client by saying “Where do you feel blocked?” (i.e., in his body) and continue the BLS. Continue to reassure the client by explaining that this is part of the therapeutic process.

Dismissing the client’s inability to identify a body sensation.
In this case, it is suggested that the clinician adjust subsequent instructions by directing the client to focus on other components of the target.

Failing to have the client verbalize unspoken words as a target to successive sets.
Certain types of body sensations (e.g., tension or tightness in the throat or jaw) can indicate the presence of unspoken words (e.g., “Stop!”). It may represent something the client wished she could have said and could not say at the time of a traumatic event. When this occurs, encourage the client to say aloud whatever unspoken words that arise during processing.

Continuing eye movements in the same direction when the client reports dizziness, pain, or nausea, or if no movement at all.
If the client reports any of these conditions after two sets, changing the direction of the eye movements may cause the physical sensations to shift.

Failing to educate the client on the skill of identifying body sensations.
As a result of a continuing disturbance or a belief that needs cannot be fulfilled, the client may have learned to separate himself psychologically from his body. If the client encounters difficulties identifying a body sensation, the clinician may provide gentle instruction by saying, “You report a level of disturbance of ____ (fill in the blank). Where do you feel the ____ (fill in the blank) in your body?” If the client remains unable to respond, simply say, “Close your eyes and notice how your body feels. Now I will ask you to think of something; and, when I do, just notice what changes in your body. Okay, notice your body. Now, think of (or bring up the picture of) the memory. Tell me what changes. Now add the words [the clinician states the negative cognition]. Tell me what changes.”

(continued)
TABLE 6.4 (continued)
Derailment Possibilities—Emotions and Body Sensations

<table>
<thead>
<tr>
<th>Dismissing a small change in body sensations. All changes in body sensations are significant and should be targeted in subsequent sets. This will help the client become more aware of other sensations in her body.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dismissing body sensations that represent an inhibited movement of any kind (e.g., a need to punch or kick). When this occurs, the clinician may openly encourage the client's physical movement during progressive sets (e.g., kicking the air or punching a pillow).</td>
</tr>
<tr>
<td>Continuing eye movements when the client reports eye pain. If eye pain is reported by the client, stop the eye movement and continue with an alternate form of BLS. Unless the pain is simple fatigue, the client should be encouraged to have clearance by a physician before resuming eye movements.</td>
</tr>
<tr>
<td>Assuming all physical sensations are targets for subsequent sets. Physical sensations can also be products of the current moment (i.e., pain associated with a heart attack or stroke). Always be open to this possibility.</td>
</tr>
<tr>
<td>Attempting to remove a negative physical sensation that is caused by something other than a targeted event. During a body scan, the client may report physical symptoms that are unrelated to the targeted event and cannot be reprocessed (e.g., hunger pains).</td>
</tr>
<tr>
<td>Directing the client to focus on physical sensations reported in past sets. Direct the client to focus instead on wherever the sensation currently resides in the body.</td>
</tr>
<tr>
<td>Ascertaining what the client’s body sensation feels like or ascribing a meaning to it. Shifts in body sensations (i.e., pain shifting upward from stomach to chest to throat) indicate that processing of information is taking place. As it shifts, direct the client to focus on the new location. There is no need to have the client describe it and tell you what it means to him.</td>
</tr>
<tr>
<td>Interpreting for the client what body sensations are connected to. Body sensations may be connected to an emotion(s) that arises during processing, may be the same sensations experienced at the time of the original trauma, or may be a nonspecific physical resonance of the negative cognition. Refrain from interpreting for the client and simply say, “Go with that” or “Notice that.”</td>
</tr>
</tbody>
</table>
“When you go back to the original memory, what are you noticing now?”

Saying “When you go back to the original image/picture, what are you noticing?”

There is an important distinction between “original image/picture” and “original event (incident, experience).” During the Assessment Phase, the questions are directed toward the original image/picture. During the reprocessing phases (i.e., desensitization, installation, and body scan), the client is directed to focus on the original event (incident, experience). As reprocessing progresses, the original “image (or picture)” may have faded or resolved and other associative memory networks may have surfaced. The goal here is to desensitize and bring adaptive resolution to all associated channels of information.

Saying “What do you think?” or “What do you feel?” after instructing the client to go back to the target.

The only question the clinician should ask when instructing the client to go back to target is, “When you go back to the original memory, what are you noticing now?” The primary reason for returning to the target is to determine if there are additional channels of dysfunctional information linked to the original memory. In some cases, however, the client may appear to provide an “endless stream of associated distinct memories” (Shapiro, 2001). In this case, only after a series of 10 to 15 memories have been revealed sequentially should the client be returned back to the target. This is a common occurrence with war veterans.

Bringing the client back to target when she is in the middle of processing an association.

This is another “stay out of the way” situation. As long as there are shifts and changes in images, emotions, thoughts, and physical sensations, the primary instruction the clinician gives is “Go with that” or “Notice that.” If the client appears distracted or seems to have gone off-target, the clinician may want to bring the client back to target to get her back on the tracks.

Asking for a SUD level before cleaning out all channels of association (i.e., going back to the target as needed).

All possible channels of association should be exhausted before asking for a SUD.

Describing the client’s initial target/event anywhere during Phases 3 to 8.

Once reprocessing commences, the original image (or picture) begins to fade as well as reprocessed channels of association.

(continued)
### TABLE 6.5 (continued)
Derailment Possibilities—Going Back to Target

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failing to return to target after two sets of neutral or positive sets</td>
<td>When the client’s associations appear too diffuse or when the client or a therapist appears to be “lost” in terms of the processing.</td>
</tr>
<tr>
<td></td>
<td>When any of the circumstances described above occur, it is necessary for the clinician to return the client back to target.</td>
</tr>
<tr>
<td></td>
<td>Going back to target immediately after a positive thought(s) or emotion(s) has emerged.</td>
</tr>
<tr>
<td></td>
<td>It is important to strengthen any positive thought(s) or emotion(s) that emerge that are adaptive for the client before returning to target.</td>
</tr>
<tr>
<td></td>
<td>If negative and positive thoughts or emotions emerge simultaneously, focus on the negative.</td>
</tr>
</tbody>
</table>

### TABLE 6.6
Derailment Possibilities—SUD Measurement During the Desensitization Phase

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asking for the SUD on a scale of 1 to 10.</td>
<td>Correct scale is 0 to 10.</td>
</tr>
<tr>
<td>Eliciting a SUD without first going back to the original image/target.</td>
<td>The clinician measures the client’s current level of disturbance SUD only after redirecting the client back to the original event (incident, experience) and after all associated events appear to have been processed. This is to ensure that all levels of negative associations related to the original event (incident, experience) have been integrated, resolved, and flushed out.</td>
</tr>
<tr>
<td>Asking for the SUD without going back to target after two consecutive sets of neutral passes.</td>
<td>Only after the clinician has redirected the client back to target and initiates two more consecutive sets of bilateral stimulation where the client reports “no change” or positive responses does the clinician take a SUD measurement.</td>
</tr>
<tr>
<td>Eliciting a rating on positive emotions.</td>
<td>Be sure that only disturbing emotions are being rated.</td>
</tr>
<tr>
<td>Making the assumption that the client’s SUD level is zero based on her responses.</td>
<td>It is important to always ask the question, “How disturbing does it feel now?”</td>
</tr>
</tbody>
</table>
TABLE 6.6 (continued)
Derailment Possibilities—SUD Measurement During the Desensitization Phase

Asking for the VoC measurement before the Desensitization Phase has been completed.
Follow the eight phases in order (i.e., history-taking and treatment planning, preparation, assessment, desensitization, installation, body scan, closure, and reevaluation). The Desensitization Phase, in all cases, precedes the Installation Phase (i.e., verification and installation of the positive cognition).

Ending the Desensitization Phase before SUD = 0.
Exceptions: (a) The session is incomplete; or (b) ecological validity has been established.

Asking “What prevents it from being 0?” each time the client is brought back to target.
This question should be asked when the client’s SUD level does not get any lower than a 2 and only after the body sensations (i.e., “Where do you feel it in your body?”) have been processed.

Or asking the client the same question above when the SUD remains relatively high (e.g., 5).
“What prevents it from being 0?” should only be asked when the client is blocked at a SUD of 1 or 2, which indicates that there may be blocking beliefs or feeder memories impeding processing. A higher SUD level than this is indicative that there is more material that needs to be processed. If this is the case, the first question the clinician should ask is “Where do you feel it in your body?”

Continuing on to the Installation Phase while the SUD equals 2 or higher.
Unless the session is incomplete or there is ecological validity, the preferred SUD is 0.

Rating SUD on one emotion when several have been given.
While the SUD is rated after obtaining the related emotion(s), the rating is on the entire target assessment, not just on the emotions. From 0, which is neutral or no disturbance, to 10, which is the worst disturbance you can imagine, how disturbing does it feel to you now?
Following is an explanation as to why a clinician should not have done what he did, or what he should do instead.

**SUMMARY**

Understanding and self-efficacy achieved at the end of a session by each of the clients discussed in this chapter are the hallmarks of a successful EMDR session (Shapiro, 2001). Remember that typically less than half of a clinician’s reprocessing sessions occur without having to implement some type of clinical guidance or strategies to unblock stalled processing. In either case, the result is the same—a client’s previously reported negative images, affect, cognitions, and physical sensations related to a stated trauma become weaker or nonexistent, less colorful, less intense, or however the client happens to describe them. The validity of the client’s negative overall response to the trauma becomes absorbed and replaced by the vividness of his positive images, affect, cognitions, and physical sensations of the same event. The client becomes more empowered, stable, secure, and has a stronger sense of self.

Remember, EMDR Therapy is not for everyone. Some problems presented by a client may be remediated simply by using other means—education, stress management, or problem solving. Others may require reprocessing of dysfunctionally stored material. If a client does present with dysfunctional patterns of response, these should obviously be addressed first and, in some cases, the success of the reprocessing may increase the assimilation of new skills and eliminate the need for other means of treatment.

**CONCLUSION**

Since its introduction in 1989, the positive treatment effects of EMDR Therapy are experienced worldwide by clients who have suffered from anxiety, depression, obsessions, phobias and panic, stress, relationship conflicts, addictions, chronic and phantom limb pain, and grief, among others. Thousands of clinicians have been trained worldwide in this efficacious method since its inception, but some of them have chosen not to practice EMDR Therapy. They chose to continue using their previously learned treatment methods. Some may have deemed EMDR Therapy not a good fit with their current therapeutic model, work setting, or clinical population. Or, perhaps, managed care or limited sessions appeared to render EMDR Therapy impractical or impossible. Whatever the reason, the desire in writing this Primer is to help newly trained EMDR Therapy practitioners keep on track and to offer a refresher for those who have not consistently used EMDR Therapy in their practices.
The intent of the Primer is to provide a learning tool to assist newly trained and previously EMDR-trained clinicians to better understand the basic principles, protocols, and procedures of EMDR Therapy. This Primer is a substitute neither for formal EMDR training nor for Dr. Shapiro’s basic text, *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols and Procedures, Second Edition* (2001).

Now that you have reached the end of the Primer, you are encouraged to go back and reread Dr. Shapiro’s basic text. Read other texts written and/or edited by Dr. Shapiro (1997, 2002, 2009–2013) as you continue to enrich your understanding of EMDR Therapy. Over the past 26 years, numerous skilled clinicians, researchers, and students have also written books, articles, and dissertations and have presented papers on EMDR Therapy at major trauma conferences worldwide.

Hopefully, your understanding of EMDR Therapy has been enriched and deepened and your excitement and commitment to use it with your clients have increased. If it has been many years since you were trained in EMDR Therapy and you are reading this Primer because EMDR Therapy is something you are considering to initiate with your clients in the future, it would be advisable to seek the training again and obtain consultation from an EMDRIA-Approved Consultant. Whatever the case, it is hoped that your interest in and enthusiasm for EMDR Therapy have been rekindled and that you have learned something along the way and had fun while doing it.
Appendices
Appendix A

Definition of EMDR

It is crucial that clinicians trained in Eye Movement Desensitization and Reprocessing (EMDR) Therapy be familiar with the definitions of EMDR formulated by the EMDR Institute and the EMDR International Association (EMDRIA). These definitions can facilitate finding your own words for explaining EMDR Therapy to your clients.

The following explanation of EMDR Therapy comes from the EMDR Institute’s website (see www.emdr.org):

For Clinicians

EMDR is a psychotherapy treatment that was originally designed to alleviate the distress associated with traumatic memories (Shapiro, 1989a, 1989b). Shapiro’s (2001) Adaptive Information Processing (AIP) model posits that EMDR facilitates the accessing and processing of traumatic memories and other adverse life experience to bring these to an adaptive resolution. After successful treatment with EMDR, affective distress is relieved, negative beliefs are reformulated, and physiological arousal is reduced. During EMDR Therapy the client attends to emotionally disturbing material in brief sequential doses while simultaneously focusing on an external stimulus. Therapist-directed lateral eye movements are the most commonly used external stimulus but a variety of other stimuli including hand-tapping and audio stimulation are often used (Shapiro, 1991). Shapiro (1995, 2001) hypothesizes that EMDR facilitates the accessing of the traumatic memory network, so that information processing is enhanced, with new associations forged between the traumatic memory and more adaptive memories or information. These new associations are thought to result in complete information processing, new learning, elimination of emotional distress, and development of cognitive insights. EMDR Therapy uses a three-pronged protocol: (1) the past events that have laid the groundwork for dysfunction
are processed, forging new associative links with adaptive information; (2) the current circumstances that elicit distress are targeted, and internal and external triggers are desensitized; (3) imaginal templates of future events are incorporated to assist the client in acquiring the skills needed for adaptive functioning.

For Laypeople

EMDR is a psychotherapy that enables people to heal from the symptoms and emotional distress that are the result of disturbing life experiences. Repeated studies show that by using EMDR people can experience the benefits of psychotherapy that once took years to make a difference. It is widely assumed that severe emotional pain requires a long time to heal. EMDR Therapy shows that the mind can in fact heal from psychological trauma much as the body recovers from physical trauma. When you cut your hand, your body works to close the wound. If a foreign object or repeated injury irritates the wound, it festers and causes pain. Once the block is removed, healing resumes. EMDR Therapy demonstrates that a similar sequence of events occurs with mental processes. The brain’s information processing system naturally moves toward mental health. If the system is blocked or imbalanced by the impact of a disturbing event, the emotional wound festers and can cause intense suffering. Once the block is removed, healing resumes. Using the detailed protocols and procedures learned in EMDR training sessions, clinicians help clients activate their natural healing processes.

Twenty positive controlled outcome studies have been conducted on EMDR. Some of the studies show that 84% to 90% of single-trauma victims no longer have posttraumatic stress disorder (PTSD) after only three 90-minute sessions. Another study, funded by the HMO Kaiser Permanente, found that 100% of the single-trauma victims and 77% of multiple-trauma victims no longer were diagnosed with PTSD after only six 50-minute sessions. In another study, 77% of combat veterans were free of PTSD in 12 sessions. There has been so much research on EMDR that it is now recognized as an effective form of treatment for trauma and other disturbing experiences by organizations such as the American Psychiatric Association, the WHO, and the Department of Defense. Given the worldwide recognition as an effective treatment of trauma, you can easily see how EMDR would be effective in treating the “everyday” memories that are the reason people have low self-esteem, feelings of powerlessness, and all the myriad problems that bring them in for therapy. More than 100,000 clinicians throughout the world use the therapy. Millions of people have been treated successfully over the past 25 years.

EMDR Therapy is an eight-phase treatment. Eye movements (or other bilateral stimulation) are used during one part of the session. After the clinician has determined which memory to target first, he asks the client to hold
different aspects of that event or thought in mind and to use his eyes to track the therapist’s hand as it moves back and forth across the client’s field of vision. As this happens, for reasons believed by a Harvard researcher to be connected with the biological mechanisms involved in REM sleep, internal associations arise and the clients begin to process the memory and disturbing feelings. In successful EMDR Therapy, the meaning of painful events is transformed on an emotional level. For instance, a rape victim shifts from feeling horror and self-disgust to holding the firm belief that, “I survived it and I am strong.” Unlike talk therapy, the insights clients gain in EMDR result not so much from clinician interpretation, but from the client’s own accelerated intellectual and emotional processes. The net effect is that clients conclude EMDR Therapy feeling empowered by the very experiences that once debased them. Their wounds have not just closed, they have transformed. As a natural outcome of the EMDR therapeutic process, the clients’ thoughts, feelings, and behavior are all robust indicators of emotional health and resolution—all without speaking in detail or doing homework used in other therapies.

**Treatment Description**


EMDR involves attention to three time periods: the past, the present, and the future. Focus is given to past disturbing memories and related events. Also, it is given to current situations that cause distress, and to developing the skills and attitudes needed for positive future actions. With EMDR Therapy, these items are addressed using an eight-phase treatment approach.

**Phase 1**

The first phase is a history-taking session(s). The therapist assesses the client’s readiness and develops a treatment plan. Client and therapist identify possible targets for EMDR processing. These include distressing memories and current situations that cause emotional distress. Other targets may include related incidents in the past. Emphasis is placed on the development of specific skills and behaviors that will be needed by the client in future situations.

Initial EMDR processing may be directed to childhood events rather than to adult-onset stressors or the identified critical incident if the client had a problematic childhood. Clients generally gain insight on their
situations, the emotional distress resolves, and they start to change their behaviors. The length of treatment depends upon the number of traumas and the age of PTSD onset. Generally, those with single-event adult-onset trauma can be successfully treated in less than 5 hours. Multiple-trauma victims may require a longer treatment time.

**Phase 2**

During the second phase of treatment, the therapist ensures that the client has several different ways of handling emotional distress. The therapist may teach the client a variety of imagery and stress reduction techniques the client can use during and between sessions. A goal of EMDR is to produce rapid and effective change while the client maintains equilibrium during and between sessions.

**Phases 3 to 6**

In Phases 3 to 6, a target is identified and processed using EMDR procedures. These involve the client identifying three things: (1) The vivid visual image related to the memory. (2) A negative belief about self. (3) Related emotions and body sensations.

In addition, the client identifies a positive belief. The therapist helps the client rate the positive belief as well as the intensity of the negative emotions. After this, the client is instructed to focus on the image, negative thought, and body sensations while simultaneously engaging in EMDR processing using sets of bilateral stimulation. These sets may include eye movements, taps, or tones. The type and length of these sets is different for each client. At this point, the EMDR client is instructed to just notice whatever spontaneously happens.

After each set of stimulation, the clinician instructs the client to let his or her mind go blank and to notice whatever thought, feeling, image, memory, or sensation comes to mind. Depending on the client’s report, the clinician will choose the next focus of attention. These repeated sets with directed focused attention occur numerous times throughout the session. If the client becomes distressed or has difficulty in progressing, the therapist follows established procedures to help the client get back on track.

When the client reports no distress related to the targeted memory, she is asked to think of the preferred positive belief that was identified at the beginning of the session. At this time, the client may adjust the positive belief if necessary, and then focus on it during the next set of distressing events.

**Phase 7**

In Phase 7, closure, the therapist asks the client to keep a log during the week. The log should document any related material that may arise. It
serves to remind the client of the self-calming activities that were mastered in Phase 2.

**Phase 8**

The next session begins with Phase 8. Phase 8 consists of examining the progress made thus far. The EMDR treatment processes all related historical events, current incidents that elicit distress, and future events that will require different responses.

A more elaborate and descriptive definition for clinicians provides information on the goals of EMDR in a psychotherapeutic framework. It includes explanation of the AIP model, which serves as the theoretical foundation for the EMDR approach, the specifics of the methodology, and the fidelity of EMDR (see www.emdria.org):

**EMDRIA Definition of EMDR**

*Date of adoption 5/26/03, 10/18/03; Revised 10/25/09, 06/23/11, 12/07/11, 2/25/12*

1.0A. **Purpose of Definition**—This definition serves as the foundation for policy development and implementation of EMDRIA’s programs in the service of its mission. This definition is intended to support consistency in EMDR training, standards, credentialing, continuing education, and clinical application, while fostering the further evolution of EMDR through a judicious balance of innovation and research. This definition also provides a clear and common frame of reference for EMDR clinicians, consumers, researchers, the media, and the general public.

1.0B. **Definition**—EMDR is an evidence-based psychotherapy for PTSD. In addition, successful outcomes are well-documented in the literature for EMDR treatment of other psychiatric disorders, mental health problems, and somatic symptoms. The model on which EMDR is based, AIP, posits that much of psychopathology is due to the maladaptive encoding of and/or incomplete processing of traumatic or disturbing adverse life experiences. This impairs the client’s ability to integrate these experiences in an adaptive manner. The eight-phase, three-pronged process of EMDR facilitates the resumption of normal information processing and integration. This treatment approach, which targets past experience, current triggers, and future potential challenges, results in the alleviation of presenting symptoms, a decrease or elimination of distress from the disturbing memory, improved
view of the self, relief from bodily disturbance, and resolution of present and future anticipated triggers.

**BI. Foundational Sources and Principles for Evolution**—Shapiro’s (2001) AIP model guides clinical practice, explains EMDR’s effects, and provides a common platform for theoretical discussion. The AIP model provides the framework through which the eight phases and three prongs (past, present, and future) of EMDR are understood and implemented. The evolution and elucidation of both mechanisms and models are ongoing through research and theory development.

**BII. Aim of EMDR**—In the broadest sense, EMDR is an integrative psychotherapy approach intended to treat psychological disorders, to alleviate human suffering, and to assist individuals to fulfill their potential for development, while minimizing risks of harm in its application. For the client, EMDR treatment aims to achieve comprehensive treatment safely, effectively, and efficiently, while maintaining client stability.

**BIII. Framework**—Through EMDR, resolution of traumatic and disturbing adverse life experiences is accomplished with a unique standardized set of procedures and clinical protocols which incorporates dual focus of attention and alternating bilateral visual, auditory, and/or tactile stimulation. This process activates the components of the memory of disturbing life events and facilitates the resumption of AIP and integration. The following are some of the AIP tenets which guide the application of EMDR, that is, planning treatment and achieving outcomes:

**BIIIa.** Adverse life experiences can generate effects similar to those of traumatic events recognized by the *Diagnostic and Statistical Manual of Mental Disorders* (APA, 2000) for the diagnosis of PTSD and trigger or exacerbate a wide range of mental, emotional, somatic, and behavioral disorders. Under optimal conditions, new experiences tend to be assimilated by an information processing system that facilitates their linkage with already existing memory networks associated with similarly categorized experiences. The linkage of these memory networks tends to create a knowledge base regarding such phenomena as perceptions, attitudes, emotions, sensations, and action tendencies.

**BIIIb.** Traumatic events and/or disturbing adverse life experiences can be encoded maladaptively in memory resulting in inadequate or impaired linkage with memory networks containing more adaptive information. Pathology is thought to result when AIP is impaired by these experiences which are inadequately processed. Information is maladaptively encoded and linked
dysfunctionally within emotional, cognitive, somatosensory, and temporal systems. Memories thereby become susceptible to dysfunctional recall with respect to time, place, and context and may be experienced in fragmented form. Accordingly, new information, positive experiences, and affects are unable to functionally connect with the disturbing memory. This impairment in linkage and the resultant inadequate integration contribute to a continuation of symptoms.

**BIV. EMDR Psychotherapy Guidelines:** EMDR procedures facilitate the effective reprocessing of traumatic events or adverse life experiences and associated beliefs, to an adaptive resolution. Specific procedural steps are used to access and reprocess information which incorporates alternating bilateral visual, auditory, or tactile stimulation. These well-defined treatment procedures and protocols facilitate information reprocessing. EMDR utilizes an eight-phase, three-pronged approach to treatment that optimizes sufficient client stabilization before, during, and after the reprocessing of distressing and traumatic memories and associated stimuli. The intent of the EMDR approach to psychotherapy is to facilitate the client’s innate ability to heal. Therefore, during memory reprocessing, therapist intervention is kept to the minimum necessary for the continuity of information reprocessing.

**BIVa.** Based on available relevant research, treatment fidelity to the eight phases (Shapiro, 2001) produces the best results. However, in certain situations and for some populations, the following procedures may be implemented in more than one way as long as the broad goals of each phase are achieved.

**BIVai.** In the **Client History Phase (Phase 1)**, the clinician begins the process of treatment planning using the concept of incomplete processing and integration of memories of adverse life experiences. The clinician identifies as complete a clinical picture as is prudent before offering EMDR reprocessing. The clinician determines the suitability of EMDR Therapy for the client and for the presenting problem and determines whether the timing is appropriate. Based on the presenting issue, the clinician explores targets for future EMDR reprocessing from negative events in the client’s life. The clinician prepares a treatment plan with attention to past and present experiences, and future clinical issues. It is also important to identify positive or adaptive aspects of the client’s personality and life experience. The clinician may need to postpone completing a detailed trauma history when working with the client with a complex trauma history until the client has developed adequate affect regulation skills and resources to remain stable. The clinician may need to address any secondary gain issues that might prevent positive treatment effects.
BIVaii. In the **Preparation Phase (Phase 2)**, the clinician discusses the therapeutic framework of EMDR with the client and gives sufficient information so the client can give informed consent. The therapist prepares the client for EMDR reprocessing by establishing a relationship sufficient to give the client a sense of safety and foster the client’s ability to tell the therapist what s/he is experiencing throughout the reprocessing. The client develops mastery of skills in self-soothing and in affect regulation as appropriate to facilitate dual awareness during the reprocessing sessions and to maintain stability between sessions. Some clients may require a lengthy preparation phase for adequate stabilization and development of adaptive resources prior to dealing directly with the disturbing memories. It may be important, especially for those clients with complex trauma, to enhance the ability of the individual to experience positive affect through promoting the development and expansion of positive and adaptive memory networks, thus expanding the window of affect tolerance, and stimulating the development of the capacity for relationship.

BIVaiii. In the **Assessment Phase (Phase 3)** the clinician identifies the components of the target/issue and establishes a baseline response. Once the memory or issue (with a specific representative experience) has been identified, the clinician asks the client to select the image or other sensory experience that best represents it. The clinician then asks for a negative belief that expresses the client’s currently held maladaptive self-assessment that is related to the experience, a positive belief to begin to stimulate a connection between the experience as it is currently held with the adaptive memory network(s) and the validity of the positive belief, utilizing the seven-point Validity of Cognition (VOC) scale. Finally, the clinician asks the client to name the emotions evoked when pairing the image or other sensory experience and the negative belief, to rate the level of disturbance utilizing the 0 to 10 Subjective Units of Disturbance (SUD) scale and to identify the location of the physical sensations in the body that are stimulated when concentrating on the experience.

BIVaiiv. During the **Desensitization Phase (Phase 4)** the memory is activated and the clinician asks the client to notice his/her experiences while the clinician provides alternating dual-attention stimulus. The client then reports these observations. These may include new insights, associations, information, and emotional, sensory, somatic, or behavioral shifts. The clinician uses specific procedures and interweaves if processing is blocked. The desensitization process continues until the SUD level is reduced to 0 (or an ecologically valid rating). It is important during this phase
to assist the individual in maintaining an appropriate level of arousal and affect tolerance.

**BIVav.** In the **Installation Phase (Phase 5)**, the therapist first asks the client to check for a potential new positive belief related to the target memory. The client selects a new belief or the previously established positive cognition. The clinician asks him or her to hold this in mind, along with the target memory, and to rate the selected positive belief on the VOC scale of 1 to 7. The therapist then continues alternating dual-attention stimulus until the client’s rating of the positive belief reaches the level of 7 (or an ecologically valid rating) on the VOC Scale.

**BIVavi.** In the **Body Scan Phase (Phase 6)**, the therapist asks the client to hold in mind both the target event and the positive belief and to mentally scan the body. The therapist asks the client to identify any positive or negative bodily sensations. The therapist continues dual-attention stimulus when these bodily sensations are present until the client reports only neutral or positive sensations.

**BIVavii.** The **Closure Phase (Phase 7)** occurs at the end of any session in which unprocessed, disturbing material has been activated whether the target has been fully reprocessed or not. The therapist may use a variety of techniques to orient the client fully to the present and facilitate client stability at the completion of the session and between sessions. The therapist informs the client that processing may continue after the session, provides instructions for maintaining stability, and asks the client to observe and log significant observations or new symptoms.

**BIVaviii.** In the **Reevaluation Phase (Phase 8)**, the clinician, utilizing the EMDR standard three-pronged protocol, assesses the effects of previous reprocessing of targets looking for and targeting residual disturbance, new material which may have emerged, current triggers, anticipated future challenges, and systemic issues. If any residual or new targets are present, these are targeted and Phases 3 to 8 are repeated.

**BV.** Innovation, Flexibility, and Clinical Judgment as Applied to Particular Clients or Special Populations.

**BVa.** To achieve comprehensive treatment effects a three-pronged basic treatment protocol is generally used so that past events are reprocessed, present triggers desensitized, and future adaptive outcomes explored for related challenges. The timing of addressing all three prongs is determined by client stability, readiness, and situation. There may be situations where the order may be altered or prongs may be omitted, based on the clinical picture and the clinician’s judgment.
BVs. As a psychotherapy, EMDR unfolds according to the needs, resources, diagnosis, and development of the individual client in the context of the therapeutic relationship. Therefore, the clinician, using clinical judgment, emphasizes elements differently depending on the unique needs of the particular client or the special population. EMDR treatment is not completed in any particular number of sessions. It is central to EMDR that positive results from its application derive from the interaction among the clinician, the therapeutic approach, and the client.

(Editor’s note: EMDRIA’s definition of EMDR has not been updated since the publication of *Diagnostic and Statistical Manual of Mental Disorders* [5th ed.; DSM-5; American Psychiatric Association, 2013] or since EMDR was renamed EMDR Therapy.)
GROUNDING

When an individual is grounded, it says three things. An individual who is grounded is in his body, is present, and is available to experience anything that happens.

Being grounded means “being in your feet.” It means being rooted to the ground. It means being solid, stable, and empowered. An individual has the ability to ground himself anywhere. He can ground himself in nature by gardening, for instance, or with anything that anchors or connects him to the earth. Being with animals is grounding. Walking, hiking, running, or just stomping or wiggling your feet on the floor is grounding. Simply moving your feet may compress the energy in your feet and serve to ground you. Being grounded gives one an energetic connection to the earth. Anything that gives you a sense of the earth beneath your feet is grounding.

During the Preparation Phase, along with a brief introduction to Eye Movement Desensitization and Reprocessing (EMDR) Therapy, try teaching the client to ground and breathe correctly before leading him into the Calm (Safe) Place or Sacred Space exercises. The exercise that follows is one of the easiest and quickest ways to teach clients how to ground.

Grounding Exercise

Close your eyes. Try to relax and imagine thick tree roots growing out of the soles of your feet and shooting down into the ground as deeply as you can possibly imagine. Take them to the earth’s core. Find something to wrap the roots around (e.g., a tree root, a rock) so that you feel drawn tight and taut against the earth. The earth has an energy field just like you and I. As you inhale into your diaphragm (see sections Diaphragmatic Breathing and Chin Mudrā), draw the earth’s energy up through these roots, up through
the soles of your feet, and up into the rest of your body. You may actually feel it. It may feel cool, warm, pulsating, tingly, and/or your feet may start to feel heavier. Continue to do this until you can feel the earth’s energy pulsating throughout your body.

When the client is ready, ask, “How does it feel? What is the difference between now and before you began this exercise?” Ask the client to practice this grounding exercise daily or until it becomes second nature.

The aforementioned exercise is taught so that clients can remain grounded all the time. For clients who may present as unstable, dissociative, disoriented, or disregulated, it may be necessary to have a repertoire of grounding exercises. These techniques may be successfully employed in sessions when the client is disregulated or unable to maintain dual awareness (i.e., past vs. present). Clients may be panicky, disoriented, demonstrate signs of overwhelm, or just freeze. In these cases, techniques are employed that bring the client back to the present situation in the clinician’s office. The clinician may play ball with the client using a wadded up piece of paper, a tissue, or a pillow. The clinician’s voice will also be an invaluable tool in bringing the client back into the present moment, as will reminding the client to breathe or to feel the room with all of her five senses. Ask the client to smell the air (or provide an essence for her to smell such as peppermint or lavender), have her touch the fabric of the chair, or listen to the noise of the traffic outside. Ask the client to count, add, subtract, multiple numbers, or count backward. Any of these tasks will require the client to shift her focus of attention from affective to a cognitive focus of attention.

Outside the session, the client may ground herself by taking a bath or shower, eat or drink something, call someone, chew gum, stomp feet on the ground, or any number of other activities that involve all five senses.

**DIAPHRAGMATIC BREATHING**

Diaphragmatic breathing is the way that we breathe when we are born. It is the manner in which we need to breathe in order to maintain a balance of oxygen and carbon dioxide. This assists the body in maintaining a relaxed state and staving off perpetual anxiety. Diaphragmatic breathing is effective with clients in reducing stress-related symptoms, anxiety, depression, and fatigue. Along with the grounding exercise, breathing from the diaphragm can give the client a big boost in terms of overall health, elevated self-esteem, and a sense of well-being.

Not surprisingly, many clients are shallow or chest breathers. They breathe into and through their chests rather than into their diaphragms. Many may present stressed out and anxious or report mind chatter. In an effort to help alleviate these symptoms, retraining clients to breathe diaphragmatically can be effective.

When we are in danger, our autonomic, automatic response is to inhale quickly into our chest as a signal to all our senses to go on hyperalert. This
is a startle response. We become more alert, tense, and hypervigilant until the danger is over. The body’s natural response is to then return to breathing from the diaphragm and into a state of relaxation.

Clients who present as chest breathers are often in a hypervigilant state and will need to retrain themselves to breathe into their diaphragm as a way of lessening the stress, anxiety, tightness, and tenseness with which they present.

**Breathing Exercise**

The client should be sitting comfortably in a chair. His knees should be bent, and his feet flat on the floor.

Try to relax your shoulders, head, and neck as much as possible. Now place your right hand on your diaphragm and your left hand on your upper chest. This will allow you to better feel your diaphragm move as you breathe. Your diaphragm is just below your rib cage and above the stomach. It will rise as you inhale and fall as you exhale. Breathe in through your nose and out through your mouth. Inhale and hold your breath for a slow count of five, and exhale on another slow count of five. Repeat two or more times. There is to be no movement in your chest or lower abdomen. The key is motionlessness in these two areas. Breathe in your nose and out your mouth. Breathe smoothly, slowly, and evenly.

**Note:** When clients are first introduced to this exercise, they may have a tendency to breathe too deeply and get light-headed. At first, the diaphragmatic breathing may not feel comfortable. Clients may also experience tiredness after only a few minutes of breathing in this way. Although the benefits of this type of breathing are immediate, it needs to be practiced. It is suggested that clients practice this exercise three to four times daily for 5 to 10 minutes.

**CHIN MUDRĀ AS AN ALTERNATIVE TO TEACHING CLIENT DIAPHRAGMATIC BREATHING**

The mudrā (i.e., yoga of the fingers; a hand posture) exists in many traditions, including Indian, Buddhist, or Japanese. The chin mudrā is one of the most commonly used and recognized of the mudrās (literally meaning, “Gesture of Wisdom”) and it is used here as an alternative to teaching diaphragmatic breathing. It is created by lightly touching the thumbs and index finger of each hand to form a zero (see Figure B.1) and extending the other three fingers outward, but not so rigid (Carroll, 2013). The hands are
placed palms down on the thighs and knees. When used, this mudrā activates and redirects the client’s breathing back to the diaphragm.

As this mudrā activates the diaphragm, this becomes a quick test to see if the client is a chest or a diaphragm breather and it allows the client to instantly notice the emotional and physical differences between the two types of breathing. Instruct the client to breathe deeply through her nose as she notices the air enter the back of her throat and to feel her belly as her diaphragm expands, pushing the abdominal wall. Encourage the client to practice it until diaphragmatic breathing becomes the more natural way.

ANCHORING IN THE PRESENT

The present moment is the only moment that counts. If you are truly in the moment, you are not being pulled back into the past or drawn into the future. It is the space between the past and the future where time can stand still. This is an important concept for the client to experience, enjoy, and understand. The following exercise is designed to engage the client in the moment and serves as a precursor to better understanding mindfulness. In this space, the client may experience calm, clarity, safety, security, strength, and hope that his life can be different.

This exercise can be conducted routinely with clients. Make sure the client is sitting comfortably and erect in a chair with his feet firmly planted on the ground and then instruct him to do the following:

Close your eyes and become aware of what is going on around you. Feel your feet. Move them. The best way to ground yourself quickly is to feel your feet. Can you feel your socks? (Pause) Can you feel the innersoles of your shoes? (Pause) Can you feel the rug under your feet? (Pause) Can you feel the concrete under the rug? (Pause) Can you feel the hardness under your feet? (Pause) How about what is under the concrete? (Pause) Can you feel the coldness of the damp earth beneath the concrete? (Pause) Now feel the texture of the upholstery of the chair on which you are sitting. (Pause) Feel it. Take it in. (Pause) Can you feel the foam under the fabric? (Pause) Can you feel the wood structure that supports the chair? (Pause)
Listen to the sound of my voice as I talk. Listen to what other sounds you can hear. Can you hear the sound of the overhead fan? (Pause) Can you hear the traffic outside? (Pause) Can you hear the sound of voices in the hall outside? (Pause) What else can you hear? (Pause) Listen to all the sounds that you were consciously unaware of 30 seconds ago.

Take a breath. What do you smell? Feel the cool air in your nostrils. How does it feel? What do you smell? Taste the saliva in your mouth. Feel what your skin feels.

Please open your eyes now and look around. What shapes do you see? (Pause) Look at the colors, shapes, patterns, designs, and textures of everything in the room. (Pause) Count 10 things in the room that are blue. (Pause) Now count 10 things that are red. (Pause)

How are you feeling? Are you feeling differently than before we started this exercise?

Seeing or, in this case, feeling is believing. An important offshoot of this exercise is that the client has an opportunity to feel the difference between living in the present versus living in the past or future. Once the client appears to be fully present, ask her to notice how it feels and report her experience of being here. Then ask her to focus on a disturbing event in her past. “How does that feel?” Have her come back to the present. Then ask her to focus on something disturbing that may be happening in the future. “How does that feel?” Often the client is able to experience what it is truly like to be “in the present.”

**CALM (SAFE) PLACE**

(Shapiro, 2001, pp. 125–126; 2006, p. 45; 2013a, pp. 29, 84)

Dr. Shapiro (2001) recommends the use of the Calm (Safe) Place exercise throughout the EMDR process. It assists in preparing the client to process traumatic events, to close an incomplete session, and to help equalize or stabilize the client’s distress in session if the information that emerges is too emotionally disruptive. It is called a calm (safe) place because some clients have been traumatized to such a high degree that it is not ecologically possible for them to even imagine that a “safe” place could exist. Any positive state that is accessible to the client can be substituted for the words “calm” or “safe.” This process, if successful, and strengthened by bilateral stimulation (BLS), also serves to introduce the client to BLS in a comfortable way before the BLS is used on disturbing material.

It is important to instruct clients extensively on the correct use of the calm (safe) place and its potential effects. For instance, if disturbing events arise during the Calm (Safe) Place exercise, they may halt processing and cause the client to shift cognitively, emotionally, or physiologically. Or, they may increase the current distress level in some clients. And, when a disturbing
event is paired with BLS, there is the potential for intensifying negative affect with which the client presents or activate the processing of the client’s presenting issue (Shapiro, 2001). As with any technique utilized with the client, use caution. A scripted version of the Calm (Safe) Place exercise follows:

**Identify the Image**

*Clinician:* Bring up a place, some place real or imagined, that feels calm (safe). Can you think of such a place? A mountaintop or beside a babbling stream, perhaps? Or on a beach? Where would it be?

*Client:* Oh, that’s easy. When I was looking over the Urubamba Valley in Peru from Machu Picchu.

The client is asked to visualize or create a place where she can find calm and safety.

**Identify the Associated Emotions and Sensations**

*Clinician:* Good. Focus on this calm (safe) place—everything in it. What sights, sounds, and smells, if any, come up for you? What are you noticing?

*Client:* It is so calm and peaceful up there. I could stay there forever.

The client focuses on the image, the feelings evoked by the image, and where she feels it in her body.

**Enhancing the Sensations**

*Clinician:* Good. Concentrate on this image and where you feel the pleasant sensations in your body. Allow yourself to connect to and enjoy them. As you are concentrating on these images, follow my fingers. (Pause) How do you feel now?

*Client:* I am feeling calm and peaceful and safe as well.

The clinician uses guided imagery to enhance the calm (safe) place by stressing the positive feelings and sensations being experienced by the client.

The BLS utilized with the calm (safe) place is slow and consists of 4 to 6 passes.

*Clinician:* Good. Focus on that and follow my fingers once more. (Pause) What do you notice now?

*Client:* The sensations have strengthened and deepened.
If positive feelings come up, continue with soothing guided imagery and the positive feelings and sensations expressed by the client, along with additional sets of BLS (4–6 passes). Keep repeating as long as the client’s sensations continue to be enhanced (i.e., “Bring up your Calm (Safe) Place and those pleasant sensations.”).

**Establishing a Cue Word**

**Clinician:** Good. Is there a word or phrase that might represent your calm (safe) place?

The client is asked to identify a single word or phrase that best represents her calm (safe) place.

**Client:** “Sacred.”

**Clinician:** Focus on the word “sacred” and notice positive feelings that arise when you do. Focus on those sensations and the word “sacred” and follow my fingers. (Pause) What do you notice now?

The clinician verbally enhances the positive feelings and sensations identified by the client with slow short sets of BLS (4–6 passes).

**Client:** I feel like I am in a sacred cocoon.

Repeat the aforementioned instruction, along with short sets of BLS (4–6 passes) in an attempt to further enhance the positive feelings experienced by the client. Continue as long as the positive feelings keep being enhanced.

Because the clinician does not want to expose the client to premature linkages to trauma material, the clinician does not implement BLS after this point.

**Self-Cuing Instruction**

**Clinician:** Now do the same thing on your own. Say the word “sacred” and notice what you feel and follow my fingers.

**Cuing With Disturbance**

**Clinician:** Think of a minor annoyance. (This disturbance is about a 1 or 2 on a 10-point scale where 10 = the worst and 0 = calm or neutral. Higher levels of disturbance may cause the client to be unable to successfully use the calm
[or safe] place.) Perhaps something that happened this week. Now go to your calm (safe) place and notice how it feels. Bring up the word “sacred” and notice if there are shifts in your body sensations. What did you notice?

If a negative shift occurs, the clinician will attempt to guide the client through the process until a shift to positive emotions and sensation occurs.

Client: I felt my whole body kind of sink when I focused on a conflict I had with my boss earlier in the week. When I repeated the word “sacred” to myself, I felt uplifted and strong.

**Self-Cuing With Disturbance**

Clinician: Good. Now bring up another mildly annoying event (i.e., SUD 1–2). Bring up the word “sacred” on your own and notice changes in your body as you do.

Client: Same thing happened as before. I just feel so strong and impenetrable.

At the end of the exercise, instruct the client to use her cue word and calm (safe) place every time she feels even a little annoyed between sessions. The client can keep track of this by keeping what is called a TICES (i.e., trigger, image, cognition, emotion, and sensation) Log (Shapiro, 2001, 2009–2014). Clients are also alerted that attempts to use their calm (safe) place when they are experiencing high levels of disturbance may not work, especially when they are learning this process. The process will work better as they gain more skill with practice. See Appendix C for an explanation of the TICES Log.

There are some cautionary elements for the clinician:

1. The initial development of a calm (safe) place may be disturbing to the client and increase his levels of distress. If this does occur, reassure the client that it is not unusual for this to happen. Then immediately assist the client in developing another calm (safe) place or initiate another self-regulating exercise.

2. Pairing the BLS with the development of the calm (safe) place has the ability to bring some clients to high levels of negative affect very quickly. For example, the client may be in the process of developing a calm (safe) place in a meadow, and suddenly the image of the rapist appears as a dark figure overshadowing it. In cases like this, try to develop a place that continues to be safe and/or calm to her, probably a different place, as the current place has been “intruded” upon by distressing material. It is sometimes useful to tell the client that this is her own space, real or imaginary, where no one else or no other thing is allowed to intrude. It is just for them.
3. Negative associations may also emerge when the calm (safe) place is developed and the BLS is introduced. For example, the client who happens to be a policeman is preparing to reprocess a memory of seeing his partner shot in a shoot-out with a gang member. Upon introducing BLS to his newly developed calm (safe) place, a memory of exchanging gunfire with a group of marauding student protesters emerges. When this happens, the clinician can assist the client in developing another calm (safe) place.

SACRED SPACE

This Sacred Space exercise was developed by the author as an alternative to calm (safe) place. Clients who have been severely abused or have experienced horrifying life events sometimes have a difficult time finding an external calm (safe) place. This exercise provides them with an opportunity to create such a place internally where no one else has tread and no one else knows where it is or what it is.

Grounding the Client in the Moment

Place your feet flat on the floor and, if possible, keep your eyes closed throughout the duration of this exercise. Become aware of your surroundings and your sense of self in them. Pay attention to your breathing. Imagine that you have big, thick tree roots growing out of the soles of your feet. Shoot them down as deep into the earth as you can possibly imagine. Wrap these roots around anything you can imagine (e.g., a root, rock) so that you are drawn taut and tight against the floor beneath your feet. Let them anchor you to the earth. Like ourselves, the earth possesses an energetic field and, as you inhale, draw the earth's energy up the roots, up through the soles of your feet, and up into the rest of your body. With each breath, this energy can travel further and further up your body until you can feel it at the top of your head. You may actually feel the energy. It may feel cool, warm, tingling, or you may not feel it at all. It does not matter. Breathe like this until you can feel your breath tingle in your torso and upper extremities. Breathe evenly and consistently.

Finding Sacred Space

Take the essence of who you are at this moment in time and go inside your body, starting at the top of your head and go to the tips of your toes, in search of what is called a sacred space. This is a space that you will create where you can go when you are in need of solace or solitude,
Appendix B

comfort or calm, safety or support. It can be anywhere in your body. I do not want or need to know where it is as I want this to remain your own very special place. [Option: If you cannot find a sacred space, just pick a space that you feel might be appropriate.] Take your time, and when you are finished just say, “OK.”

Preparing the Sacred Space

Wait patiently and silently until the client indicates by saying, “OK” or in some way that she has located an appropriate spot in her body for a sacred space. When she has done so, instruct the client as follows:

Now prepare your sacred space. Bring into this space anything and everything that you might need to help resolve the issues you bring here today. If you need courage, faith, strength, or peace, bring these into your sacred space. Anything and everything. The sky is your limit. Paint it, texture it, design it, and furnish it. Make this sacred space as comfortable as you can possibly make it. Take your time. When you are finished, just say, “OK.”

Getting Comfortable in Sacred Space

Once the client has indicated that she has finished preparing her sacred space, invite her to go there.

Now go to your sacred space. Nestle down among the things you have placed there. This is your sacred space, and you should be comfortable in it. When you are comfortable, just say, “OK.”

Preparing the Way for Wisdom’s (or Guidance’s) Message

Imagine a bright light coming through your forehead creating a channel to your sacred space. Through this channel graciously and respectfully invite wisdom (or guidance) into your sacred space. Wisdom (or guidance) may come in any form. It may come in the form of a book, a picture, an object, a symbol, a person, or a group of persons. When wisdom (or guidance) is there, just say, “OK.”

Listening for Wisdom’s (or Guidance’s) Message

Wisdom (or guidance) has brought you a very special message today. Graciously and respectfully ask wisdom (or guidance) for that message. When you have it, just say, “OK.” (Pause)
Note: If the client does not answer, prompt her by saying, “Just say the first thing that comes to your mind.” When the client indicates that she has the message, say,

“What is the message?”

Make sure you write it down and say,

“Now graciously and respectfully thank wisdom (or guidance) for the message, and remember that wisdom (or guidance) may come any time it is called into your sacred space.”

Remarkably, most clients do hear messages, such as “I can make it,” “I can do this,” “I know what I have to do now,” or “I am in the right place.”

Closing the Sacred Space

And, realize as you leave here today, you take this space with you. It is your very own special space. No one knows where it is but you. This is your special place. You can go there often. Go there when you are in need of comfort or calm, solace or solitude, safety or support. When you are ready, you may open your eyes.

This Sacred Space exercise can be a very empowering experience. The sacred place becomes the client’s safe place, a place for silence, a retreat. It is a place where the client can go to resettle her mind, gather her strength, and regain her footing.

Note: Use BLS throughout the entire exercise. The BLS is slow and consistent. During the actual EMDR Therapy session, the client can be instructed to go to her sacred space in the same way that others use the calm (safe) place.
Appendix C

EMDR Therapy Scripts

RESOURCE DEVELOPMENT STEPS—AFFECT MANAGEMENT AND BEHAVIOR CHANGE

(Shapiro, 2013, pp. 70–71)

1. **Resource**
   Client identifies the needed resource or affect management skill. Examples: calm place, container, breathing technique, courage, focus, and so on.

2. **Image**
   Client images a time, activity, or place (real or imagined) when that resource had been successfully used.

3. **Emotions and sensations**
   Client focuses on image and feelings and identifies location of positive sensations associated with the resource.

4. **Enhancement**
   Clinician verbally enhances the resource with guided imagery stressing its positive behavior, feelings, and sensations.

5. **Bilateral stimulation**
   Once enhanced, add several brief sets of bilateral stimulation (BLS 6–8 slow passes).

   “Bring up your resource and those pleasant feelings.” (BLS 6–8 slow passes.)
Repeat several times if process has enhanced client’s positive feelings and sensations. If not positive, consider returning to step 1 and identify another resource.

6. **Cue word**
   Have client identify a word or phrase that represents the resource. Use that word/phrase to verbally enhance the pleasant feelings and sensations. Once fully accessed, further enhance by using a short set (BLS 6–8 slow passes). If positive, repeat several times. If negative, return to step 1 and consider an alternative coping skill.

7. **In order to avoid premature linkage with trauma material, no BLS is used from this point on.**

8. **Self-cuing**
   Instruct client to repeat procedure on her own, bringing up the image of the resource and its positive emotions and sensations.

9. **Cuing with disturbance**
   Have the client think of a recent, mild disturbance then instruct her to imagine how using her resource would have helped in managing the situation. Guide client through the process until she is able to experience positive emotions and sensations.

10. **Self-cuing with disturbance**
    Without any help from the clinician, have the client think of another mild, recent disturbing event, imagining using the resource and experiencing positive emotions and sensations.

11. **Keep a TICES Log**
    A TICES log is used to evaluate the effectiveness of the calm (safe) place or any other stress management strategy being used by the client.

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**CONTAINER EXERCISE**

At the end of an incomplete session, the client is encouraged to “contain” whatever aspects of their trauma that still linger. This entails the client placing their residual trauma in a container of their choice.

Containers may be as simple as a box, a jar, or vase or as complex as a safe that is thrown into the bottom of the ocean, key box buried in their backyard, or having it bound by bubble wrap and duct tape and placed in the closet.

Some clients may wish to place a sign on the container stating, “Do not open until next session” to lessen their contact with the thoughts of the trauma between sessions. Others, who are unable to visualize with any success, may wish to write whatever they are upset about on a piece of paper and place it in a box or put it into a drawer. And still others may wish
to leave residue of the nearly reprocessed trauma in the therapist’s office. The container visualization may be reinforced and strengthened with slow, short sets of BLS. For a more comprehensive example of this container exercise see Murray (2011).

Dr. Shapiro (2001) suggests using vertical eye movements when closing an incomplete session because of the calming effect they appear to produce.

**BREATHING SHIFT**

(Shapiro, 2006a, p. 46; 2013a, pp. 72–73)

Here is a scripted version of the breathing shift:

**Clinician:** Bring up a positive memory… a memory that is a good or happy memory.

**Client:** Okay.

**Clinician:** Just notice where your breath starts and then place your hands over it.

**Client:** Okay.

**Clinician:** (Pause) Just notice how it feels. Good. (Pause) Bring up a memory with a low level of disturbance. (Pause) Notice how your breath changes. (Pause) Place your hand over the location where you feel the change. (Pause) Now place your hand where you had it before and deliberately change your breathing pattern accordingly.

If this technique does not cause the disturbance to dissipate, try something else (e.g., spiral technique).

**SPIRAL TECHNIQUE**

(Shapiro, 2006a, p. 46; 2013, p. 73)

A scripted version of the spiral technique follows:

**Clinician:** Bring up a disturbing memory and concentrate on body sensations that emerge. This is an imaginal exercise, so there are no right or wrong responses.

**Client:** Okay.

**Clinician:** When you think of the original event (or incident), on a scale from 0 to 10, where 0 is neutral or no disturbance and 10 is the worst disturbance you can imagine, how disturbing is the event (or incident) to you now?

**Client:** Nine.
Clinician: Where do you feel it in your body?

Client: In my stomach.

Clinician: Concentrate on what you are feeling in your body. Imagine that the feelings are energy. If the energy is going in a spiral, what direction is it going? Clockwise? Or counterclockwise?

Client: Clockwise.

Clinician: Good. Focus on the feelings and change the direction of the spiral to counterclockwise. Just notice what happens as you do.

Client: Okay.

Clinician: What happens?

Client: The sensations seem to be lessening.

If this technique is working, the client’s sensations may dissipate and the Subjective Units of Disturbance (SUD) level may drop. If it does not work, try something else (e.g., breathing shift).

LIGHTSTREAM TECHNIQUE

(Shapiro, 2013, p. 72)

A stress management strategy the clinician can use with the client is the Lightstream Technique. Utilizing this technique, the clinician asks the client to concentrate on an upsetting body sensation and helps the client identify the shape, size, color, temperature, texture, and sound, by asking, “If it had ______ (fill in the blank), what would it be?”

Example: Sam is talking about his mother and is getting more and more upset. He keeps getting cramps in his chest as he continues to talk. The therapist instructs Sam to focus on the cramps in his stomach. The clinician says, “If it had a shape, what would it be? (Pause) If it had a size, what would it be? (Pause) If it had a color, what would it be? (Pause) If it had a temperature, what would it be? (Pause) If it had a texture, what would it be? [Pause] If it had a sound, what would it be?” (Pause) What is your favorite color you associate with healing?” (Shapiro, 2012)

The clinician then says, “Imagine that this favorite colored light is coming in through the top of your head and directing itself at the shape identified above in your body. Let’s pretend that the source of this light is the cosmos, so the more you use, the more you have available. The light directs itself at the shape and resonates, vibrates in and around it. And, as it does, what happens to the shape, size, or color?”

If the client reports that the shape is changing in any way, the clinician will repeat a version of the underlined portion below of this technique and
ask the client for feedback until the shape has disappeared entirely. When the shape has changed or disappears, the negative bodily sensations usually change or disappear as well. After the bodily sensations start to feel better, direct the light to every portion of the client’s body; and give the client a positive statement for peace and calm. On the count of five, bring the client to external awareness.

**Lightstream Transcript**

Ask client to concentrate on upsetting body sensations.

Identify the following by asking, “If it had a _____ (fill in the blank), what would it be?”

- a. shape
- b. size
- c. color
- d. temperature
- e. texture
- f. sound (high pitched or low)

■ Ask, “What favorite color do you associate with healing?”

■ Say, “Imagine that this favorite colored light is coming in through the top of your head and directing itself at the shape in your body. Let’s pretend that the source of this light is the cosmos, so the more you use, the more you have available. The light directs itself at the shape and resonates, vibrates in and around it. And, as it does, what happened to the shape, size, or color? “If the client gives feedback that it is changing in any way, continue repeating a version of the underlined portion and ask for feedback until the shape is completely gone. This usually correlates with the disappearance of the upsetting feeling. After it feels better, bring the light into every portion of the person’s body, give him a positive statement for peace and calm until the next session. Ask the client to become externally aware at the count of five.

The Lightstream Technique is a combination of ancient meditation and recent Neurolinguistic Programming strategies that help ease stress for most clients.

**FUTURE TEMPLATE**

**Future Template Script**

(Shapiro, 2012, pp. 63–64)

**Introduction**

*We have worked on past experiences relating to your presenting problem, as well as the present situations that have triggered your distress.*
Today, I’d like to suggest that we work on how you will respond in the future to similar situations.

A. Desired Outcomes Steps

1. **Identifying the future situation** (i.e., previously identified recent experience or present trigger).
   
   Identify a future situation and a positive belief you would like to have about yourself in that situation.

2. **Run the movie.**
   
   While holding the positive belief about yourself in mind, run the movie of the situation as you would like to be able to respond, from beginning to end. Let me know if there are any parts of the movie that are uncomfortable or challenging.

3. **What are you noticing now?**
   
   a. If the client’s response is POSITIVE, run movie of adaptive responses(s), adding BLS sets as long as positive response is strengthening.
   
   b. If the client’s response is NEUTRAL, ask for clarification (lacks familiarity, need for a plan). Generate with client desired response; run movie of desired response with sets of BLS until client has a positive response.
   
   c. If client’s response is NEGATIVE, focus on body sensations; add sets of BLS until client response is neutral. Elicit from client desired response and run movie with sets of BLS until client has achieved a positive response.

   If negative associations arise, the clinician may need to return the client to reprocessing.

4. **Install PC to validity of cognition (VoC) = 7**
   
   Hold your positive belief with that situation. On a scale of 1–7, how true does it feel? Install to VoC of 7 with BLS.

B. Problem-Solving Situation Steps

1. **Create a problem-solving situation.**
   
   I’d like you to think of some challenge you may experience in that situation.

2. **What are you noticing now?**
   
   Positive: Add BLS sets as long as additional positives are reported.
Negative: Focus on body sensation and add BLS until sensations dissipate.

3. Install PC to VoC = 7 with each situation.

Hold your positive cognition with that situation. On a scale of 1–7, how true does it feel now? Install VoC = 7 with BLS.

See Figures C.1 and C.2 for the steps to these two important processes.

**STEPS FOR RECENT TRAUMATIC EVENTS PROTOCOL**

(Shapiro, 2012, pp. 66–67)

The Recent Traumatic Events Protocol was designed for use with single traumatic events that have occurred within two to three months (maybe longer) and in situations characterized by a lack of safety.

The standard EMDR protocol referred to throughout this entire Primer: (a) focuses on an entire traumatic memory; (b) focuses on an image (or picture) that is representative of the entire memory; and (c) results in the entire memory being reprocessed as it generalizes to other associative channels of information which arise throughout the processing. What Dr. Shapiro discovered when working with clients from the 1989 San Francisco Bay Area earthquake is that processing the most traumatic part of a memory did not necessarily generalize to other parts of the same memory. As the clients were able to provide a serial description of the event, it was clear to Dr. Shapiro that the memory had consolidated at some level. But, because the treatment effect did not generalize to other associative parts of the memory, they were not “integrally linked” (Shapiro, 2001).

With this in mind, Dr. Shapiro developed the Recent Traumatic Events Protocol to account for the differences in processing of a more distant memory versus a more recent one. After providing a narrative account of the event, the client will target each disturbing aspect separately using the standard protocol in the Assessment Phase (i.e., image, negative cognition, positive cognition, VOC, emotions, and SUD) and through to the Installation Phase. In a recent event, it is not unusual for the image to present as a sound or a smell.

All aspects of client selection and preparation are the same as in the standard protocol. It may be necessary to provide some preparation or stabilization skills before completing the history-taking. It is also important to determine if the client has had any earlier trauma that may get reactivated by reprocessing with the standard protocol.
A
Client runs a “movie” of an imaginal anticipated event with a person, situation, or place or performing some future action.

B
Positive physical and/or cognitive reaction.
Go to M.

If client reports

C
Negative physical and/or cognitive reaction.
Go to E.

D
No disturbance. Go to J.

Clinician determines if reprocessing of an earlier (feeder) memory is needed before proceeding. If so, go to H. Otherwise, go to G.

F
Clinician determines if appropriate skills or training are needed. If so, go to I. Otherwise, go to G.

G
Clinician determines if disturbance is marginal because of the nonfamiliarity (anticipatory). Go to J.

H
Reprocessing earlier memory and present stimuli before proceeding
Go to A.

Go to K

I
Clinician provides the client with the necessary skills and training.
Go to A.

Go to K

J
Directly address current disturbance by processing with standard NC, PC, emotion, and physical sensation. Go to A.

Go to K
From H, I, and J

Client imagines adaptive behavior and/or response and identifies empowering PC, emotion, and positive sensation. Go to L.

L
Process and reinforce positive associations with bilateral stimulation. Go to M.

M
Run movie and inoculate with some challenging elements. Go to N.

N
Reevaluate and resolve if disturbance exists. Go to O.

O
Reevaluation - Termination

FIGURE C.1 Future template flow chart: Skills building and imaginal rehearsal.
1. **Obtain a narrative history**
   The clinician asks the client to relate the details of the event in narrative form.

2. **Target the most disturbing aspect of the memory**
   As the client is providing a narrative, the clinician records each separate event identified by the client.

3. **Target the remainder of the narrative in chronological order**
   At this point, the clinician needs to target each of the chronological events in the client’s narrative. If she were to have identified one of the events to be more disturbing than the rest, the clinician would target this one first and then the remainder as they occurred during the telling of her story. Each target is treated separately in terms of the standard EMDR procedure up to the Installation Phase, being mindful to exclude the body scan for each. The body scan is initiated only after the last target of this traumatic event has been identified and addressed so that all the associated negative physical sensations can be eliminated.

4. **Visualize entire sequence of the event with eyes closed**
   Once all the separate events in the narrative have been identified and reprocessed, the client is asked to visualize the entire sequence of the event from start to finish.
If something disturbing arises and it is still disturbing, the clinician may implement the EMDR procedure through to the Installation Phase again with this most recent disturbance. Once this has been processed, the clinician would then ask the client to visualize the entire sequence of the event once again to see if further disturbances arise. If so, the client would reprocess each disturbance that surfaces using the standard EMDR procedure.

5. **Visualize entire sequence of events with eyes open**
   When the client has run the experience through and no distressing material comes up, have her run the experience coupling it with the positive cognition visualizing the entire sequence of the event one more time with her eyes open. Then initiate a long set of BLS. The client is asked to scan the experience mentally and to give the “stop” signal when her processing has been completed.

6. **Conclude with body scan**
   Once this open-eyed visualization has been completed, the body scan is done.

7. **Process present triggers**
   Process all present triggers (e.g., causes of startle responses, avoidance of locations similar to where the event occurred, nightmares, or any negative reminders of the experience).

8. **Create future template**
   Before treatment is complete, create a future template for each present trigger. Create a future template of desired responses for coping in the future. Include accessing the positive cognition, additional resources or skills, or new information.

**TICES LOG**

(Shapiro, 2001, p. 429)

The TICES log (i.e., trigger = image, cognitions, emotions, and sensations) is a log the client is asked to keep between sessions to record disturbing experiences. The log provides a means of informing the clinician what occurred with the client after the reprocessing session. What got activated? What, if anything, was disturbing? What did the client notice when he got triggered? What changed? What is unresolved? The client is instructed at the end of each session to record his experiences in this log. Once this is done, the client is instructed to use one of the self-control techniques learned in his therapy to dissipate the remaining disturbance.

At the end of each session, the clinician may remind and instruct the client to utilize the TICES log in the following manner: “The processing
we have done today may continue after the session. You may or may not notice new insights, thoughts, memories, or dreams. If so, notice what you are experiencing and record it in your TICES log. Use the Calm (Safe) Place exercise to rid yourself of disturbance. Remember to use a relaxation technique daily. We can work on this new material next time. If you feel it is necessary, call me” (Shapiro, 2001).

The recommended format for the client’s weekly log report is demonstrated in Table C.1, TICES Log (Shapiro, 2001).

As the titles of the columns indicate, the client is asked for only brief descriptions of any disturbing experiences encountered between sessions. Note that the order of the titles in the columns mirrors the information needed to target an event in a subsequent session in the Assessment Phase of EMDR Therapy. Thus, the TICES log acts as a clinical aid for both the clinician and the client. It also trains the client to break the disturbance down into its attendant parts and provides brief descriptors to remember and relate to the clinician the details of the experience in the event future processing is needed.

The TICES log provides an outcome measure for every session of reprocessing. It is a self-report measurement that may demonstrate movement in every session. This is valuable information for the clinician and client.

### TREATMENT PLANNING GUIDE

In 2006, Dr. Shapiro proposed the conceptual framework for defining appropriate targets for treatment utilizing EMDR reprocessing. This Treatment Planning Guide (TPG) follows a three-pronged approach (past, present, future) that allows for the identification of the presenting problem (i.e., the presenting issue), critical incident, and any previous contributing incidents or memories that continue to feed the client’s present dysfunction (i.e., the cause), the present symptoms (i.e., dysfunctional negative emotions, physical sensations, behavior, or belief), present triggers, current manifestations (i.e., flashbacks, nightmares), and the future template.

The Treatment Planning Guide is one of many methods (e.g., timeline, genogram) designed to assist in the development of a treatment plan for EMDR Therapy. Dr. Shapiro (2006) originally conceptualized the TPG to
assist clinicians in identifying targets: past events (first, worst, and other contributing experiences) that continue to fuel the client’s current pathology, current triggers that remain due to second-order conditioning, and desired outcomes or preparation for potential challenges clients may face in the future relating to their presenting issues. Figure C.3 outlines the flow of the TPG.

**TREATMENT PLANNING GUIDE (TPG)**

Specific event where client experienced presenting complaint

Elicit recent examples of present complaint

Elicit current NC and PC

### PAST EVENTS

- Identify touchstone event (if one) and other contributing memories utilizing:
  - Direct Questioning
  - Floatback
  - Affect Scan

- Reprocess touchstone event using Phases 3–8

- Determine if remaining memories exist and are still disturbing. If so, reprocess each using Phases 3–8

### PRESENT TRIGGERS

- Identify and reprocess remaining triggers, situations, and people and address any residual physical sensations or urges (usually identified during history-taking, reprocessing, and re-evaluation) using Phases 3–8

### FUTURE TEMPLATE

- Identify and reprocess desired outcome and potential future challenges for each trigger identified previously

### REEVALUATION

- If symptom resolution, then determine if the client’s symptoms have been eliminated or decreased

- If comprehensive treatment, determine if main themes been successfully integrated into client’s current life

### SUCCESSFUL EMDR REPROCESSING SESSION

**FIGURE C.3** Treatment Planning Guide: AIP-informed treatment planning flow chart.
Presenting Issues

Clients seek therapy for many reasons. Presenting issues can be incident- or symptom-focused, simple or complex. Examples of the reasons clients come to therapy are myriad: relationship difficulties, acute stress disorder, posttraumatic stress disorder, eating disorders, recent trauma (such as a motor vehicle accident or sexual assault), difficulties with assertiveness or communication, self-defeating behaviors, psychosexual issues, work-related issues, chronic pain or illness, childhood sexual, physical, or emotional abuse. Symptoms with which clients present may include depression, anxiety, panic, fears or phobias, bereavement and loss, unresolved anger, low self-esteem, negative self-image, loss of confidence, loss of meaning, and/or stress. The presenting issues are generally identified in the History-Taking and Treatment Planning Phase.

It is around the presenting complaint (problem) that the TPG is structured and formulated. In some cases, there may be more than one presenting issue; and a TPG should be completed for each issue. Consider the case of Clara:

Six months ago, Clara met Harry; and they fell deeply in love. Harry has been pressing Clara more and more insistently to marry him. Clara is having difficulty resisting the urge to flee. She loves Harry and does not want to lose him.

Clara is commitment phobic. She has had one long-term relationship since she graduated from college 15 years ago. After five years of dating Roger and nearing a marriage proposal, she abruptly terminated their relationship without any reasonable explanation. That was five years ago. In the meantime, Clara has settled for or pursued inappropriate or unattainable partners. She frequently entered into instant relationships or fled any relationship that felt like a stable, enduring union. Clara’s biggest fear is fear of betrayal from a loved one.

When Clara was a child, she was close to her father. She remembers standing patiently and watchfully by the living room window in the early evenings waiting to see his car round the bend on his way from work. She would wait for him to open the door to the garage and fling herself joyfully into his arms. They would play and sing and read books together every night before she had to go to bed.

Clara’s mother died while giving birth to her. From the moment of her birth, her aunt became her surrogate mother. Unfortunately, the aunt was mean and sultry and resentful that she had to take care of Clara rather than have children of her own.

One day, Clara waited and waited for her father’s car to round the bend. It kept getting darker and darker and still no father. Her father never came that day. He had a head-on collision with a semi-tractor trailer and was seriously injured. As his recovery was long and burdened with numerous setbacks, her aunt assumed full responsibility for Clara’s care. Throughout
long months of worry, Clara watched helplessly and hopelessly as her father quickly deteriorated and sunk into a deep depression from which he never fully recovered. He remained sullen and unavailable. As a result, Clara became distant and disconnected from her father and aunt and immersed herself in her school activities. She felt alone and betrayed by her father’s condition and their loss of relationship.

Clara’s relationship with her aunt was no better. Her aunt’s anger and resentment worsened with the increased responsibility for Clara’s care. She would often say to Clara, “I don’t know what I did to deserve this. I have no life because of you.” When Clara was fourteen or fifteen, her aunt went into a fit of rage when Clara spilled soda on the living room carpet. Her aunt screamed at her, “I wish you were dead.”

The talk of a long-term relationship or marriage terrifies her. The mere mention of the word “marriage” causes her to flinch uncontrollably. Whenever a man talks of having a future with her, Clara initially freezes up, removes herself from his company, and flees as fast as she can. She becomes anxious as well at the idea of any long-term contract—leases, mortgages, and so on.

### Treatment Planning Guide (TPG) Script

**Presenting Issue (Complaint)**

**Clinician:** Clara we had determined last week that we would directly take a look at your fear of commitment today. Is this still agreeable?

**Clara:** Yes.

**Incident**

**Clinician:** Tell me a specific recent situation where you had experienced anything related to your fear of commitment.

**Clara:** On our six month anniversary, Harry began talking about our future together.

**Clinician:** What picture represents the worst part of that incident?

**Clara:** I literally froze and did not say anything. I was quiet all the way home. I could not speak.

**Negative Belief**

**Clinician:** What words go best with the picture that express your negative belief about yourself now?

**Clara:** I don’t deserve love.
Positive Belief

Clinician: When you bring up that picture, what would you like to believe about yourself now?

Clara: I deserve love.

Note: Clinician may also elicit the emotions(s) and physical sensation(s) associated with the image (or picture) in the event the floatback technique is needed to identify the touchstone event.

First Incident (Touchstone Memory)

Clinician: What is the first incident in your life when you thought you did not deserve love?

Clara: I was twelve when my father was involved in an automobile accident. My father was never the same. I lost my best friend. I lost my first love.

Use direct questioning initially to find the earliest event accessible that laid the groundwork for the client’s present pathology.

If the client is unable to identify a touchstone event but has identified a negative cognition which appears to be a significant element of the presenting issue (or the present event is not fully accessed), the clinician may use the floatback technique (Browning, 1999; Zangwill, 1997) to help identify it. And remember, there is not always a touchstone event.

The negative cognition is not necessarily needed in order to identify a touchstone event. An adaptation of Watkins and Watkins (1997) affect scan has been developed to utilize when the negative cognition is unclear. The affect scan is utilized when the negative cognition is sketchy; the current memory is already accessible at a high level of disturbance; and when time is an issue.

Worst Incident

Clinician: If not the time with your father, what is the worst incident when you thought you did not deserve love?

Clara: My mother died while giving birth to me. I was denied and didn’t deserve her love either. I got her sister instead.

Other Incidents

Clinician: Were there other incidents in your life when you believed you did not deserve love?

Clara: When I was thirteen my aunt became upset and frustrated with me, more than usual this time. I don’t remember exactly what had happened,
but the words she screamed at me still burn in my ears. She said, “I don’t know what I did to deserve this. I have no life because of you.”

**Clinician:** Can you think of any other incidents where you believed you did not deserve love?

**Clara:** Again, when I was around fourteen or fifteen, I had spilled a can of soda on the carpet. My aunt became irate with me and yelled, “I wish you were dead.”

**Clinician:** Are there any other events in your life when you believe you did not deserve love?

**Clara:** The only other one I can think of that still causes emotional upset is the breakup with Roger.

**Future Desired Outcomes**

**Clinician:** How would you like to see yourself successfully handling relationships in the future?

**Clara:** I would like to be comfortable and agreeable when Harry talks about our long-term future together. I would like to be able to picture a long life with him.

**Treatment Plan**

**Clinician:** Well it seems like we have identified several incidents in your past that would be appropriate to address using EMDR Therapy. Generally, I suggest starting with the earliest incident. However, since both occurred when you were very young, we have some choices. When you think of each incident, what incident gives a feeling most similar to the situation with Harry?

**Clara:** The one with my father. I love Harry and my father so much.

**Clinician:** Okay, we will start addressing that disturbing memory involving the loss of your father at our next session. Once this has been resolved, we will check back and see if the memory of your mother dying still has a negative emotional charge. If it does, we will work with this memory as well.

Table C.2 provides the clinician with a summary of the steps to an AIP-Informed Treatment Plan for Clara.

The Treatment Planning Guide is a good conceptual tool for teaching the newly trained EMDR Therapy clinician to think strategically in terms of past, present, and future when developing a treatment plan.
Cautionary Note

As mentioned earlier, the Treatment Planning Guide is one of many ways to conceptualize and develop an EMDR treatment plan. In developing the TPG, it is not an unusual occurrence for the client’s distress to be activated during this process. If activation occurs, additional self-soothing measures may need to be taught and used, or another means of gathering the data may need to be considered.

Symptom Reduction vs. Comprehensive Treatment?

When developing an initial treatment plan, the clinician may use different criteria and/or history-taking strategies for symptom reduction than he may when developing a plan for more comprehensive treatment. Symptom reduction focuses on a specific symptom(s) or a specific disorder(s) while a comprehensive treatment plan addresses the client’s entire clinical picture. Clients may present themselves for therapy requesting only symptom reduction. Occasionally, once the symptoms are reduced, they may elect to switch to request comprehensive therapy. Table C.3 focuses on the similarities and differences in these treatment plans and Table C.4 illustrates the differences between the clinical presentations of simple and complex post-traumatic stress disorder (PTSD).
A phobia is an irrational fear response to a situation which often poses little or no danger. If the client cannot avoid the feared object or situation, she may experience panic and fear, rapid heartbeat, shortness of breath, tunnel vision, trembling, a strong desire to flee, or worse. Phobias generally form after some type of traumatic event. For instance, Tanisha was in an
### TABLE C.4
Treatment Planning Guide: PTSD vs. Complex PTSD

<table>
<thead>
<tr>
<th>SINGLE INCIDENT PRESENTATION</th>
<th>MULTIPLE ISSUES/SYMBOLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single-event trauma or one cluster of events</td>
<td>Multiple-event trauma or multiple cluster of events</td>
</tr>
<tr>
<td>Recent trauma</td>
<td>Diffuse presentations</td>
</tr>
<tr>
<td>Acute stress</td>
<td>Diagnoses: Complex PTSD, addictions, compulsive disorders, personality disorders</td>
</tr>
<tr>
<td>Specific presenting problem (e.g., negative irrational belief, pattern of behavior, affects, physical sensations, or people, situations, or specific time periods)</td>
<td>In taking comprehensive history of early trauma or symptoms clusters across various contexts: May need to provide stabilization skills, affect regulation skills, and resource development prior to or in tandem with history taking</td>
</tr>
<tr>
<td>Circumscribed set of experiences (or problem, acute or long-standing) in a time-limited context</td>
<td>a. Investigate client’s history of early abuse/neglect and its impact on the client’s psychosocial development, family relationships, school performance, social development, etc.</td>
</tr>
<tr>
<td>Diagnoses (e.g., Adjustment Disorder, ASD, PTSD)</td>
<td>b. Explore history of disrupted attachments</td>
</tr>
<tr>
<td></td>
<td>c. Assess negative impact on self-esteem</td>
</tr>
<tr>
<td></td>
<td>d. Examine secondary/tertiary loss/gain issues</td>
</tr>
</tbody>
</table>

**Targets:**

**Single PTSD** *(i.e., symptoms stem from a critical incident)*

*Present manifestation of the problem* (e.g., flashbacks, nightmares)

*Primary event* (e.g., raped late at night within the last six months), including *aftermath of identified trauma* (e.g., invasive medical procedures after a rape) and *feeder memories* (e.g., previous assaults or rapes)

**Targets:**

**Complex PTSD** *(i.e., presents with multiple traumatic memories, attachment disruptions, more complex diagnoses or issues)*

*Present manifestation of the problem* (e.g., isolates; feels too clingy; unable to trust people, especially men)

*Touchstone memories*, if any (e.g., raped by maternal uncle at age five)

(continued)
earthquake when she was 8 when she was trapped under debris before firemen could dig her out. As a result, she developed a phobia of enclosed spaces (i.e., claustrophobia). She is unable to tolerate elevators, closets, and windowless rooms. Even tight clothing caused her to go into a panic. In the case of phobia, it is important to identify and reprocess the ancillary and antecedent events.

EMDR has been found to be highly effective in dealing with phobias. An adaptation of the EMDR trauma protocol is outlined below for use with phobias. Figure C.4 provides a visual representation to the step involved in the Phobia Protocol.

**Steps for Processing Phobias**

Prior to reprocessing, the clinician needs to educate his client about her symptoms and to address any secondary gain issues that may be present.

1. Teach client self-control techniques to deal with client’s “fear of fear.”
2. Identify and reprocess targets (in this order):
   a. Ancillary or antecedent events that contribute to the phobia (e.g., precipitating event may be separate from the actual phobic response).
What events were occurring at the time of the first phobic response that may have contributed to the development of the phobia? Do any childhood experiences exist which might have contributed to the fear being experienced by the client? Ask, “What happened or was happening just prior to experiencing this fear for the first time?” “Did you experience these same feelings or physical sensations before the onset of your phobia?”

b. Memories related to the phobia should be reprocessed in the following order: first, worst, and most recent.

c. Any associated present stimuli (e.g., any people, places, situations, or events that trigger the fear response) and physical sensations or other manifestations of fear (e.g., fear symptoms, such as hyperventilation) should be reprocessed. Ask, “What triggers your fear response?” “What are your fear symptoms in terms of this phobia?” or “What are the internal triggers?”
3. Incorporate a positive template for a fear-free future action.
4. Create a contract for action.
5. Run a mental videotape of the full sequence:
   a. Instruct the client to close her eyes and run a mental videotape of participating with every aspect of the feared situation. If any anxiety or physical discomfort arises, instruct the client to open her eyes and reprocess that aspect. Restart the video from the beginning. Continue to do this until every aspect of the situation that causes anxiety or physical discomfort has been reprocessed and the client can view the entire experience without any disturbance. If no disturbance, go to Step 6.
6. Complete processing of targets revealed between sessions – Reevaluation. Instruct the client to maintain a TICES log between sessions. Often additional targets can be identified from the log.

In all cases, be sure to conclude with a rehearsal of the feared situation with stimuli in the real world. Prepare the client to expect some anxiety during this transitory period of real-life exposure and to use a log and self-control technique: There is no failure; it is only feedback.

Dr. Shapiro (2001) stresses the importance of reprocessing the phobic events in terms of first, worst, and most recent for the following reasons: (a) First—assumes it includes all stimuli pertinent to the onset of the fear and its associated physiological responses; (b) Worst—assumes that it includes exacerbating stimuli; and (c) Most Recent—assumes the second-order conditioning has caused the stimuli to become more potent. It is also necessary to address the issue of anticipatory anxiety if it exists.

Note: In terms of EMDR Therapy, Dr. Shapiro no longer distinguishes treatment differences for specific or process phobias. Each is processed using the steps outlined earlier. In addition, this same protocol may be used to treat anxiety.
Informed consent, like Eye Movement Desensitization and Reprocessing (EMDR) Therapy, is a process, not an event. It is a two-way communication process whereby the clinician provides information and encourages the client to ask questions or make comments. It is important that the clinician create an environment in which the client can make informed choices as to the types of treatments—medical, psychological, or otherwise—in which she chooses to engage.

The criteria for informed consent have been defined over the years by such organizations as the American Medical Association and the American Psychological Association. It is a process of communication that serves as an ethical obligation and a legal requirement. An informed choice is a voluntary decision based on information provided by the clinician, understanding by the client, and a discussion of available options. Informed consent is introduced in the Preparation Phase of EMDR Therapy. In terms of EMDR Therapy and informed consent, Dr. Shapiro (2001) strongly recommends that the following criteria be explained thoroughly and in a way that the client can understand: (a) EMDR Therapy and how it works; (b) the nature and purpose of EMDR Therapy and its procedural steps; (c) treatment effects; (d) the possibility of emotional disturbance before, during, and after reprocessing; (e) the risks and benefits; and (f) alternative treatments and their risks and benefits.

Prior to implementing reprocessing, the client agrees to the treatment as explained by the clinician. In cases where legal proceedings are imminent, further caution needs to be taken. If legal proceedings may be an option, Dr. Shapiro (2001) further suggests:

1. It is important for the EMDR Therapy clinician to be familiar with the nature of memory and be aware that memory records not what the client remembers but what the client perceives.
2. The client may not be able to access a vivid picture of the event after reprocessing. Memories tend to fade or even disappear as they become less intense after reprocessing. For example, the client may have forgotten the color of a perpetrator’s clothing and other finer details of the traumatic event. If court proceedings are a possibility, the client’s legal counsel is contacted prior to reprocessing because the quality of the client’s memories can be further degraded by the reprocessing of the traumatic event.

3. The client may not be able to access the event again with extreme emotion (i.e., EMDR processing can take away the intense negative emotional charge associated with the event).

4. The client may also be able to access more information than he had previous to processing. The images that were originally remembered may be more vivid and contain more detail. In addition, a heightened level of emotion may occur when the client is reprocessing highly charged information associated with the event. What is remembered is not necessarily factual as the legal system would define it. It is valid to the client and reflects what was stored in the client’s memory at the time of the event. However, it may be what was perceived, not necessarily what is factual.

5. The process may tend to be compared to hypnosis by the court.

6. In the case of the client in recovery from substance abuse, relapse may be a possibility when he accesses information from highly charged memories or other reprocessing information that arises from the targeted traumatic events.

The client has the right and the clinician has an ethical obligation to ensure that she is fully informed regarding EMDR Therapy. This includes information on what the client may or may not expect if it is used as part of her treatment (e.g., possibility of high levels of distressing emotions during processing, memory may fade or disappear, affect around memory may change, shift in recall of details, information that emerges may not be accurate, mechanisms or behaviors used to cope with the distress at the time of the original memory may be reactivated), possible responses, and additional information that paints a picture of why EMDR Therapy is used, how it works, and what the treatment effects may be.

Informed consent allows the client to make an informed decision based on the facts that are presented to her before agreeing to EMDR Therapy. This also includes relating the legal ramifications if there is a pending lawsuit. In this instance, it is important to discuss court involvement in terms of how memory works with EMDR Therapy and other forensic issues (i.e., fading or disappearing memories, lack of intense emotional affect when discussing the events, and the emergence of more information surrounding the event and the accuracy of it) that can emerge as a result of EMDR processing. In all cases, the clinician or the client needs to consult with the
client’s legal counsel to ensure that all the necessary details of the event have been fully investigated and all notes and depositions have been completed pre-Phases 3–6. It is unwise to initiate reprocessing prior to consultation with the client’s attorney.

The client is also informed of the high levels of emotion that may occur during this process, as well as the possible emergence of new or unexpected memories. In addition, the client will need to be aware of the potential processing difficulties or benefits encountered if she also presents with a history of substance abuse. In some cases, an addiction can be reactivated by processing. In others, it may decrease, especially if the trauma identified and processed is a contributing factor to the client’s past substance abuse or relapses.
EMDR, EMDR RESEARCH FOUNDATION, TRAUMA RECOVERY/EMDR-HAP, AND THE EMDR INSTITUTE: WHAT IS THE DIFFERENCE?

Understanding the ownership and relationship between the original organizations that arose in the 1990s and 2000s to oversee Eye Movement Desensitization and Reprocessing (EMDR) Therapy’s functioning across all boundaries is of importance to all EMDR Therapy clinicians. Figure E.1 graphically defines the important differences between EMDR International Association (EMDRIA), the EMDR Institute, and Trauma Recovery/EMDR-Humanitarian Assistance Programs (HAP).

**EMDR International Association (EMDRIA)**

The EMDR International Association (EMDRIA) is a 501(c)6 nonprofit membership association founded in 1995 to establish, maintain, and safeguard standards of training, research, and practice for EMDR Therapy. EMDRIA is comparable to the American Psychiatric Association, American Psychological Association, or American Counseling Association. This association’s mission is to be “a membership organization of mental health professionals dedicated to the highest standards of excellence and integrity in EMDR.” EMDRIA’s Web site can be found at www.emdria.org. EMDRIA was the first of the Regional EMDR Associations. As of this writing, the additional Regional Associations include EMDR Europe, EMDR IberoAmerica (Central and South America), EMDR Canada, and EMDR Asia.
EMDR Research Foundation (ERF)

The EMDR Research Foundation (ERF; changed from EMDRIA Foundation in 2011) is an independent 501(c)3 nonprofit association founded in 2006 that is dedicated to the promotion of quality, unbiased research in EMDR Therapy. The Foundation is funded by voluntary contributions. Information about the Foundation can be found at http://www.emdrresearchfoundation.org.

FIGURE E.1 EMDR Therapy and Associated Organizations in the United States.
Trauma Recovery/EMDR-HAP

Trauma Recovery (changed from EMDR-HAP in 2013) was the brainchild of Dr. Francine Shapiro. It is also a 501(c)3 nonprofit organization that offers EMDR Therapy training to mental health professionals in Third World countries, as well as domestic community mental health agencies, for free or for a reduced fee. Trauma Recovery/(EMDR-HAP) is an international volunteer network of mental health providers dedicated to alleviate human suffering resulting from man-made and natural disasters. It is funded by private donations. The website for Trauma Recovery/(EMDR-HAP) is www.trauma-recovery.org.

EMDR Institute, Inc.

The EMDR Institute, Inc. is the first “for profit” EMDR Therapy training organization incorporated in the early 1990s by Dr. Francine Shapiro to meet the increasing demands of EMDR Therapy training. Other than university-approved training programs, the EMDR Institute remained the sole deliverer of EMDR Therapy training for many years. After the publication of her first book, *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures* (1995), the number of EMDR Therapy training programs proliferated rapidly around the world. The Institute continues to be the longest running and best known of all the training programs. Institute training schedules can be found at its website (http://www.emdr.org).

FRANCINE SHAPIRO LIBRARY (FSL)

Created and developed by Barbara J. Hensley, EdD, the Francine Shapiro Library (FSL) was presented to the EMDR Therapy community at the 12th annual EMDRIA Conference in Phoenix, Arizona, in September 2008. Named after the originator and developer of the Adaptive Information Processing (AIP) model and EMDR Therapy, the library is the world’s premier electronic repository and largest assemblage of EMDR citations. The library was hosted by Northern Kentucky University as a service to EMDRIA.

Special thanks go to the following individuals for helping this library become a reality: Irene Giessl, EdD, co-founder of the Cincinnati Trauma Connection; Marilyn Schleyer, PhD, Assistant Professor, and other faculty members at Northern Kentucky University; and Scott Blech, former Executive Director, EMDRIA. As of the fall of 2014, the EMDR International Association became the new host of the Library. The link for the FSL is as follows: http://emdria.omeka.net. Thanks to Michael Wells, Northern Kentucky University Systems Librarian, and Josh Kramer, IT Consultant, for helping in this transition.
RESOURCES DEVELOPMENT AND INSTALLATION (RDI)

Although not covered at length in this Primer, stabilization and ego strengthening are not to be overlooked. They are an inherent and important part of the Preparation Phase of EMDR Therapy, especially for difficult and challenging clients, those who are unstable or inadequately resourced, dissociative clients, and clients with low affect tolerance. These topics deserve separate focus and intense study by the clinician.

Resource Development and Installation (RDI) is an effective intervention in the initial stabilization phase of treatment with Complex Posttraumatic Stress Disorder (PTSD)/Disorders of Extreme Stress Not Otherwise Specified (DESNOS). RDI is similar to hypnotherapeutic ego strengthening methods and is compatible with Dialectical Behavior Therapy (DBT) and other relationally and skill-focused methods of resource development. RDI is an EMDR-related protocol focused on strengthening the connections to resources in the client’s positive (i.e., functional) memory network while not intentionally stimulating the client’s negative (i.e., dysfunctional or traumatic) memory networks. “Again, the inclusion of bilateral stimulation in the protocol appears to lead to spontaneous, rapid increases in affective intensity within an initially selected memory network and to rich, emotionally vivid associations to other functional (positive) memory networks. These increases in intensity of positive emotion and new functional associations bring additional ego-strengthening material into consciousness” (Korn & Leeds, 2002). Unlike the EMDR protocol, RDI uses fewer (6–12) and slower sets of bilateral stimulation to facilitate the aforementioned.

There are no published, controlled studies of RDI currently available, but there are articles on RDI that discuss it as an effective intervention for stabilization. Clinicians trained in EMDR Therapy are encouraged to reference the following resources for RDI:


As a precursor to RDI, see:

This publication is currently self-published and available through Mentor Books.

**DISASSOCIATIVE DISORDERS**

**Clinical Signs and Symptoms of Dissociative Disorders**

Dissociation is something we all experience at some level. We may “lose ourselves in a book” or not be able to recall the details of our car ride to work or school (i.e., highway hypnosis) or find ourselves daydreaming while watching television or mowing the lawn (i.e., zoning out, auto-pilot mode). In these instances, we tend to lose touch with our present surroundings. Everyone experiences these forms of dissociation at one time or another.

More severe forms of dissociation develop as an effective coping/defense mechanism for some individuals with repeated exposure to overwhelming and life-threatening events (i.e., abuse, violence, war) with extreme physical, emotional, and/or sexual abuse in childhood being the most common cause. Derealization, depersonalization, and dissociative identity disorder (DID) constitute the most severe form of dissociation.

A full explanation of dissociation is beyond the scope of this Primer.

Refer to the following references for clinical signs and symptoms of dissociative disorders:


In addition, there are resources available that deal with dissociation and EMDR by Catherine Fine, PhD; Carol Forgash, LCSW; Gerald Puk, PhD; Sandra Paulsen, PhD; and others. Search the FSL for these valuable resources.

**Dissociative Experiences Scale (DES)**

Both authorized versions of the Dissociative Experiences Scale (DES) are self-report measures that assess the degree and types of dissociative experiences. The DES is used primarily as a *screening* device for identifying major dissociative pathology and secondarily as a research tool. It is not meant to be utilized as a *diagnostic* tool. Depending on when and by whom the clinician was trained, some EMDR Therapy training manuals contain copies of the DES. If not, the clinician may refer to the following resources for an explanation and/or copies of the DES for use with their clients.

The Colin A. Ross Institute for Psychological Trauma provides an excellent description of the DES at www.rossinst.com/dissociative_experiences_scale.html.

For further reading, refer to the following citations:


There is a reproducible copy of the DES-II in this article. Serving as a manual for the DES-II, this article summarizes data on psychiatrically healthy and clinical samples.

Copies of both versions of the DES can be purchased online from the Sidran Foundation at www.sidran.org/store or by contacting the Foundation at the following address:

Sidran Foundation
200 East Joppa Road, Suite 207
Baltimore, MD 21286–3107
Scoring the DES

The original DES used a visual analog scale that required the client to mark their responses along a numerically anchored 100-millimeter line. The item responses range from 0% (i.e., “This never happens to you.”) to 100% (i.e., “This always happens to you.”). The newer form of the DES is easier to score in that the responses are made by circling a percentage ranging from 0% to 100% at 10% intervals. The DES-II uses an 11-point Likert scale.

Total scores for both scales can be obtained by averaging the scores of the 28 items. It yields a score in the range of 0 to 100.

Interpreting the DES

Generally, the higher the score, the more likely the diagnosis of a dissociative disorder. More specifically, the better the likelihood that dissociation exists.

The DES is available in several different languages.

EGO STATE THERAPY

For more information on Ego State Therapy, you are encouraged to access the following resources:


For formal training in trauma and dissociation, contact the International Society for the Study of Trauma and Dissociation (www.isst-d.org).

SCHEMA THERAPY

Jeffery Young developed Schema Therapy for use in the treatment of personality disorders, most especially borderline personality disorder (Young, Klosko, & Beck, 1994). For more information, refer to the following resources:


The research so heavily emphasized and encouraged by Dr. Shapiro since her famous walk in the park in the late 1980s has repeatedly proven the efficacy of Eye Movement Desensitization and Reprocessing (EMDR) Therapy. It has become the treatment of choice for various trauma centers and mental health groups around the world. It may be helpful for clinicians to have familiarity with the growing number of endorsements given to EMDR Therapy by the leading international health associations. Table F.1 describes the organizations to date that have included EMDR Therapy in their International Treatment Guidelines for Trauma, particularly posttraumatic stress disorder.

A wide variety of research studies have been implemented using various treatment aspects and protocols as their focus since its initial development. Many of these studies support EMDR Therapy as an empirically validated treatment of trauma. Several types of research models are utilized. Among these are meta-analyses (see Table F.2), randomized clinical trials (see Table F.3), and nonrandomized studies (see Table F.4).
<table>
<thead>
<tr>
<th>Table F.1: International Guidelines</th>
</tr>
</thead>
</table>

(continued)
TABLE F.1  (continued)  
International Guidelines


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TABLE F.2  
Meta-Analyses of EMDR


# TABLE F.3
## Randomized Clinical Trials

<table>
<thead>
<tr>
<th>Reference</th>
<th>Title and Details</th>
</tr>
</thead>
</table>

(continued)
### TABLE F.3 (continued) Randomized Clinical Trials

<table>
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<tr>
<th>Study</th>
<th>Authors</th>
<th>Description</th>
<th>Reference</th>
</tr>
</thead>
</table>
### TABLE F.3  (continued)

#### Randomized Clinical Trials

<table>
<thead>
<tr>
<th>Study</th>
<th>Description</th>
<th>Reference</th>
</tr>
</thead>
</table>

(continued)
TABLE F.3  (continued)
Randomized Clinical Trials


TABLE F.4
Nonrandomized Studies


(continued)
|---|

(continued)
### TABLE F.4  (continued)  
**Nonrandomized Studies**

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Title</th>
<th>Journal/Website</th>
</tr>
</thead>
</table>
Appendix G

History of EMDR Therapy

See Table G.1 for truncated history of Eye Movement Desensitization and Reprocessing (EMDR) Therapy.

<table>
<thead>
<tr>
<th>TABLE G.1</th>
<th>History of EMDR Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1987</strong></td>
<td></td>
</tr>
<tr>
<td>Dr. Francine Shapiro took her historic “walk in the park” in Los Gatos, California. As a result she discovered the effects of spontaneous eye movements on memory quality. Along with the eye movements, she added other elements, including a cognitive component, and developed procedures around the effects and called it Eye Movement Desensitization (EMD).</td>
<td></td>
</tr>
<tr>
<td><strong>1988</strong></td>
<td></td>
</tr>
<tr>
<td>Shapiro began conducting research and introducing EMD to the world. She conducted her first presentations on EMD to professional organizations in the United States. She traveled to Israel to introduce EMD to various researchers.</td>
<td></td>
</tr>
<tr>
<td><strong>1989</strong></td>
<td></td>
</tr>
</tbody>
</table>

(continued)
<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>Shapiro opened an office and began working at the Mental Research Institute (MRI) in Palo Alto, California.</td>
</tr>
<tr>
<td></td>
<td>EMDR Institute was established. It was originally operated out of the Mental Research Institute and later relocated to Pacific Grove, California. The EMDR Institute is now located in Watsonville, California.</td>
</tr>
<tr>
<td></td>
<td>Shapiro presented her first workshops on EMD to licensed mental health professionals in San Jose and Palo Alto, California.</td>
</tr>
<tr>
<td></td>
<td>Shapiro trained the first EMD research teams at the University of Pennsylvania and Veteran's Affairs Medical Center in Philadelphia.</td>
</tr>
<tr>
<td></td>
<td>Shapiro was invited to present a EMD training at the International Society for Traumatic Stress Studies (ISSTS) Annual Conference in New Orleans, LA.</td>
</tr>
<tr>
<td></td>
<td>Concerned that clinicians would attempt to learn EMDR through journal articles, Shapiro incorporated training restrictions with Institute facilitators asking them not to train other clinicians in EMDR until her text was published (Shapiro, 2001).</td>
</tr>
<tr>
<td></td>
<td>At the annual conference of Association for Advancement of Behavior Therapy, Dr. Shapiro presents her EMD research.</td>
</tr>
<tr>
<td></td>
<td>Joseph Wolpe declared EMD to be a “breakthrough” in the treatment of PTSD.</td>
</tr>
<tr>
<td></td>
<td>Other forms of bilateral stimulation were discovered (i.e., tones, taps) and utilized.</td>
</tr>
<tr>
<td></td>
<td>The first Part 2 weekend training (then called Intermediate training) was instituted and was held in San Jose, California.</td>
</tr>
<tr>
<td>1991</td>
<td>EMD becomes Eye Movement Desensitization and Reprocessing (EMDR) to recognize the shift from desensitization to information processing.</td>
</tr>
<tr>
<td></td>
<td>Recognizing that the effects of EMD extended beyond those accounted for by desensitization, Shapiro focused on information processing theories based on Accelerated Information Processing (AIP) as a better explanation.</td>
</tr>
<tr>
<td></td>
<td>The first trainings in Paris, Amsterdam, and El Salvador were also held. EMDR Network Association was formed.</td>
</tr>
<tr>
<td></td>
<td>The EMDR Networker, the first EMDR-specific publication, was published and distributed to all members of the Network. There was a membership fee at the time that included the above publication and an annual directory.</td>
</tr>
<tr>
<td></td>
<td><em>(continued)</em></td>
</tr>
</tbody>
</table>
Composed of clinicians from the Mental Research Institute (MRI) and others, an EMDR ethics and professional issues committee was created to fortify and regulate training requirements and restrictions. EMDR-trained clinicians created specialized protocols for dissociative disorders and critical incidents. The first humanitarian trainings were provided by Institute trainers to local clinicians in Nicaragua.

Wolpe publishes an independent study on EMD.


1992

The first EMDR conference was sponsored by EMDR Network Association in San Jose California. Clinicians came together to teach applications of EMDR Therapy for various populations and presenting problems beyond the standard protocol.

EMDR training was brought to Australia.

1993

The EMDR Institute was incorporated. Robbie Dunton is its first Administrative Coordinator.

The first randomized clinical trial was published using a veteran sample with PTSD:


The distinguished *Scientific Achievement in Psychology Award* was presented to Shapiro by the California Psychological Association.

EMDR training was brought to Canada.

1994

Humanitarian trainings were provided by Institute trainers (Steve Silver, PhD, Gerald Puk, PhD, and Susan Roger, PhD) to local clinicians in Croatia (Zagreb) and Sarajevo (Bosnia and Herzegovina) during the war. A position paper was published by the EMDR Dissociative Disorder Task Force (Catherine Fine, PhD, Marilyn Luber, PhD, Sandra Paulsen, PhD, Gerald Puk, PhD, Curt Rouanzion, PhD, and Walter Young, MD).

EMDR training was brought to England.
### TABLE G.1 (continued)
**History of EMDR Therapy**

#### 1995

Shapiro published her first EMDR textbook. This book introduced a detailed explanation of her theory of the Accelerated Information Processing (AIP) model.


Because of the independent research support and the clinical standards articulated and published in this text, the previous imposed restrictions placed on EMDR-trained clinicians were lifted. EMDR-trained clinicians could now train other clinicians who were not previously trained in the model.

The first randomized clinical trial on EMDR treatment of civilian PTSD is published. This paper provided evidence of EMDR’s efficacy in the treatment of posttraumatic stress disorder (PTSD).


Born out of the EMDR community’s response to the Oklahoma City bombings, the EMDR Humanitarian Assistance Program (EMDR-HAP, Sandra Wilson, PhD) was created.

The EMDR International Association (EMDRIA) was formed. EMDRIA is a membership organization that replaced the EMDR Network. Carol York was the first Director and Steve Lazrove the first President. It had 473 charter members at the time of its creation.

Protestants and Catholics were brought together in Belfast, Northern Ireland, with its first EMDR-HAP training.

EMDR training was brought to Germany in 1995.

EMDR Institute, Inc., became a CEU provider.

EMDR was used in Japan by Masaya Ichii after an earthquake. At this time, the EMDR training manual was translated into Japanese.

#### 1996

EMDR trainings were conducted in Argentina, Columbia, and South Africa. The EMDRIA Newsletter is first published.

EMDRIA held its first conference in Denver, Colorado.

Francine Shapiro received a Humanitarian Assistance Award from the EMDR International Association.

#### 1997

EMDR trainings were conducted in Mexico, Guatemala, Brazil, Chile, and Japan.

(continued)
After Hurricane Pauline ravaged the western coast of Mexico, the EMDR Integrative Group Treatment Protocol (i.e., butterfly hug) was developed by members of EMDR-HAP and the Asociacion para Ayuda Mental en Crisis.

Shapiro and Forrest wrote the first book on EMDR that was written specifically for the lay person.


Barbara Korzun, PhD, becomes the HAP’s first Response Coordinator.

EMDR-HAP conducts trainings in Bogota, Columbia.

The first study in an HMO setting was conducted.


1998

EMDR Association of Australia and EMDR Association of Canada were formed.

The Clinical Division of the American Psychological Association recognized EMDR as “probably efficacious for civilian PTSD.”


A randomized clinical trial on the treatment of military veterans was published. This study demonstrated that 12 sessions of EMDR resulted in 77% remission of PTSD diagnosis.


The first meta-analysis comparing EMDR and other cognitive behavioral therapies was published. This study reported equivalent effects and less treatment for EMDR Therapy.


EMDR-HAP trained local clinicians in Bangladesh and India.

Barbara Korzun, PhD, becomes HAP’s first Executive Director.

1999

EMDR Europe was formed.

EMDR training was brought to India after the Gujarat earthquake and Turkey after the earthquake in Marmara.

(continued)
The first training in Turkey occurred after an earthquake. The first randomized clinical trial involving adult survivors of sexual abuse was published. This study demonstrated that EMDR was superior to routine treatment.


Professional development programs were created by EMDRIA, including programs for EMDRIA Credit, EMDRIA Certification Program, and EMDRIA-Approved Consultant programs.

EMDRIA Latino America is formed.

### 2000

The International Society for Traumatic Stress Studies finds EMDR efficacious for PTSD.


Led by Israeli EMDR-HAP volunteers, the first training of Palestinian clinicians from the Gaza Strip was held.

EMDR Europe held its first conference in Utrecht, the Netherlands.

HAP responds to the shootings in Columbine, Colorado.

### 2001

Shapiro published the second edition of her first book which explained the change from Accelerated Information Processing model to the Adaptive Information Processing model.

After 9/11 EMDR-HAP launched a major initiative in its service to victims of families, survivors, and first-responders. It was during the aftermath of 9/11 that EMDR-HAP attempted the first model of a trauma recovery network.

Also in response to 9/11, EMDR-HAP conducted refresher courses for clinicians in New York, New Jersey, and Washington, DC.

EMDR-HAP TPO (Transcultural Psychological Organization) Project in France trained French-speaking clinicians in Algeria and Africa.

The United Kingdom proclaimed that the best evidence of efficacy was reported for EMDR, exposure, and stress inoculation.


EMDR-HAP trainings are conducted in Palestine.

### TABLE G.1  (continued)

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>The first training in Turkey occurred after an earthquake.</td>
</tr>
<tr>
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</tr>
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<td>Professional development programs were created by EMDRIA, including programs for EMDRIA Credit, EMDRIA Certification Program, and EMDRIA-Approved Consultant programs.</td>
</tr>
<tr>
<td>EMDRIA Latino America is formed.</td>
</tr>
</tbody>
</table>

(continued)
Shapiro was presented the International Sigmund Freud Award for Psychotherapy by the City of Vienna in conjunction with the World Council of Psychotherapy.

As one of the first of many recommendations by various national health councils for EMDR treatment of PTSD, the Israeli National Council for Mental Health recommended EMDR as one of three therapies recommended for treatment of terror victims.


Reporting positive treatment effects with elementary school children who were victims of Hurricane Iniki, the first randomized study of EMDR with children who had been diagnosed with PTSD was published.


A study was published that demonstrated that EMDR may reduce behavioral problems in conduct disordered boys.


Resource Installation and Development demonstrated preliminary evidence for effectiveness in the stabilization phase in the treatment of complex PTSD.


Another study was published that demonstrated that more rigorous studies utilizing EMDR produced larger effects; that treatment fidelity correlated with effect size.


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**TABLE G.1 (continued)**

<table>
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<tr>
<th>Year</th>
<th>Event</th>
<th>Reference</th>
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</thead>
</table>
Appendix G

TABLE G.1 (continued)
History of EMDR Therapy

There were two randomized clinical trials published that showed relatively comparative effects between cognitive behavioral therapies (CBT) and EMDR for adult PTSD. EMDR demonstrated some superiority and had no homework. One study reported that participants used fewer treatment sessions with EMDR (Power et al., 2002).


Shapiro's third book is published:

2003

Robert Gelbach becomes EMDR-HAP's second Executive Director.
CREST listed EMDR as one of the treatments of choice for EMDR in Northern Ireland.
EMDR-HAP expands trainings to mental health nonprofit agencies.
EMDR and CBT both designated as treatments of choice for PTSD by the Dutch National Steering Committee in their guidelines for mental health care.
Sweden recommended CBT and EMDR as the treatments of choice for PTSD.

(continued)
The American Psychiatric Association recommended EMDR as an effective treatment for trauma.


**USA Department of Veterans Affairs & Department of Defense**

recommended EMDR placed in the “A” category as “strongly recommended” for the treatment of trauma.


EMDR-HAP expanded humanitarian assistance trainings to clinicians at the U.S. Veteran’s Administration and Defense Department.


In a randomized clinical trial involving sexually abused Iranian girls, EMDR and cognitive behavioral therapy (CBT) were found effective, although the preliminary findings did suggest that EMDR may be more efficient. Jaberghaderi, N., Greenwald, R., Rubin, A., Zand, S. O., & Dolatabadim, S. (2004, September–October). A comparison of CBT and EMDR for sexually abused Iranian girls. *Clinical Psychology and Psychotherapy, 11*, 358–368. doi:10.1002/cpp.395

The NIMH-sponsored Web site, Therapy Advisor, lists EMDR as an empirically validated treatment for PTSD.

EMDR is considered the treatment of choice by French National Institute of Health and Medical Research, Paris, France.


**2005**

NICE stated that EMDR is one of the empirically supported treatments of choice.


(continued)
EMDR-HAP institutes training projects in Sri Lanka, Thailand, and India following a tsunami in Southeast Asia.

EMDR-HAP trains 240 clinicians and serves 600 first-responders in response to the aftermath of Hurricanes Katrina and Rita.


The EMDRIA Foundation was incorporated as a Texas Corporation. The original Board members were Wendy Freitag, President, Jim Gach, and Rosalie Thomas.

### 2006

According to a single case study published, preliminary evidence was provided that EMDR may prove effective in the treatment of borderline personality disorder.


Positive effects of EMDR reported with studies evaluating large-scale treatment after natural disasters.


At the annual EMDR International Conference in Philadelphia, PA, Francine introduces *New Notes on Adaptive Information Processing*.


EMDR-HAP conducts Gulf Coast trainings in response to hurricanes Katrina and Rita.

EMDR-HAP commences the Trauma Recovery Networks (TRN) Project.

(continued)
TABLE G.1 (continued)
History of EMDR Therapy

2007

EMDR IberoAmerica Association was formed which is currently composed of 17 member countries: Argentina, Brazil, Chile, Columbia, Costa Rica, Ecuador, El Salvador, Iberian Peninsula, Guatemala, Mexico, Nicaragua, Panama, Portugal, Puerto Rico, Spanish Caribbean, Uruguay, Venezuela.

A Cochrane Review recognized EMDR as an efficacious treatment for PTSD.


Springer publishes the first issue of the *Journal of EMDR Practice and Research*.

EMDR is shown to be more successful in achieving sustained reductions in PSTD. First study comparing EMDR to pharmacological treatment for PTSD shows EMDR to be more successful in achieving sustained symptom reductions in PTSD in the first study comparing pharmacological treatment to EMDR.


EMDR-HAP conducts trainings in Indonesia, Lebanon, Kenya, and Philippines.

Handbook of Family Therapy Processes was published.


Curriculum requirements for Basic EMDR Training were established by EMDRIA.

The 2nd study of EMDR was funded by NIMH.

2008

The Francine Shapiro Library (FSL) was introduced at the annual EMDRIA Conference in Phoenix, Arizona, by the Library’s creator and curator, Dr. Barbara Hensley. Originally hosted by Northern Kentucky University, the FSL is a comprehensive electronic resource for journal articles and other references related to EMDR.

In recognition of the development and the contributions of EMDR Therapy, Shapiro receives a State of Connecticut General Assembly and the City of New Haven Board of Alderman official citations.

EMDR Institute contracts with AMEDD to conduct military trainings.

(continued)
TABLE G.1 (continued)
History of EMDR Therapy

2009

Presented by the American Psychological Association Division 56, Shapiro received the Award for Outstanding Contributions to Practice in Trauma Psychology.

The first issue of the Japanese Journal of EMDR Practice and Research is published.

During the EMDR-Europe Association annual meeting, plans were made for the establishment of an EMDR-Asia Association in 2010.

Initiatives in Africa and the Middle East were launched by EMDR-HAP.

The International Society for Traumatic Stress Studies (ISSTS) Practice Guidelines endorses EMDR.


EMDR-HAP conducts trainings in Rwanda to work with survivors of the 1994 genocide.

EMDR celebrated its 20 year anniversary at the annual EMDRIA Conference in Atlanta, Georgia.

2010

The first Asian EMDR Conference, titled “Building Bridges Between East & West Through EMDR,” was held in Bali, Indonesia.

EMDR Asia is established at its first Asian conference.

EMDR-HAP conducts trainings in China in response to the earthquake in Chengdu and in collaboration with clinicians in Ethiopia with HELP for Children Orphanage. They also trained Iraqi clinicians in Jordan as well as clinicians in Kenya. EMDR-HAP plays a role in coordinating French and Belgium clinicians to train Haitians in response to major earthquake.

The California Evidence-Based Clearinghouse for Child Welfare Trauma Treatments for Children supports trauma-focused CBT and EMDR as “well-supported by research evidence.”

EMDR-HAP trains Iraqi clinicians in Jordon, clinicians in collaboration with Help for Children Orphanage in Ethiopia, and clinicians in Kenya.

2011

Carol Martin becomes EMDR-HAP’s third executive director.

The EMDRIA Foundation was renamed the EMDR Research Foundation.

Sarah Haley Memorial Award for Clinical Excellence at the ISTSS 27th Annual Meeting: Social Bonds and Trauma Through the Life Span to the EMDR Humanitarian Assistance Programs.

EMDR-HAP conducts trainings in Tuscaloosa, Alabama, and Joplin Missouri in response to tornadoes.

(continued)
TABLE G.1  (continued)
History of EMDR Therapy

SAMHSA’s National Registry of Evidence-Based Programs and Practices (NREPP) recognizes EMDR as an evidence-based practice in the treatment of PTSD and its symptoms (anxiety and depression) and has stated that EMDR aids in the improvement of overall mental health functioning.


2012

Dr. Shapiro wrote and published *Getting Past Your Past*.

TRN/EMDR-HAP chapters respond to Hurricane Sandy in New York, Connecticut, and New Jersey.

2013

World Health Organization (WHO) recognizes EMDR as a psychotherapy recommended for children, adolescents, and adults with PTSD.

EMDR-HAP changes its formal name to Trauma Recovery/EMDR Humanitarian Assistance Programs (TRN/EMDR-HAP).
The first Masters in Science (MSc) in EMDR was validated at the University of Worcester (UK) with the help of Derek Farrell, PhD.

TRN/EMDR-HAP chapters respond to a shooting in Newtown, Connecticut, fires in Arizona and California, a tornado in Oklahoma, and a typhoon in the Philippines.

2014

EMDR celebrated its 25-year anniversary at the annual EMDRIA Conference in Denver, Colorado.
The Francine Shapiro Library comes home to EMDRIA.
The United Nations Committee on Non-Governmental organizations recommended that the United Nations Economic and Social Council grant EMDR-HAP Special Consultative Status.

Dr. Francine Shapiro renamed EMDR to EMDR Therapy to recognize it officially as a distinct integrative psychotherapeutic approach.

TRN/EMDR-HAP chapters respond to the Boston Marathon bombing and to the Oso mudslide in Washington.

Note: Special thanks to Robbie Dunton for providing and/or verifying the accuracy of the above history of EMDR Therapy.
Glossary

*Adverse life experiences.* These types of traumatic events may be more subtle and tend to impact one’s beliefs about self, others, and the world. Adverse life experiences are those that can affect our sense of self, self-esteem, self-definition, self-confidence, and optimal behavior. They influence how we see ourselves as a part of the bigger whole. They are often ubiquitous (i.e., constantly encountered) in nature and are stored in state-dependent mode in our memory network. Formerly referred to as small “t” traumas.

*Affect scan.* The client is asked to focus on the most recent memory of an event as a starting point for floating back into time through similar memories to find the original memory or cause of the client’s presenting problem/issue. The affect scan (Shapiro, 1995: independently developed and without the hypnotic/reliving component contained in Watkins & Watkins, 1971) is probably the easiest and quickest way to get to the touchstone event and can be the most powerful.

*Ancillary targets.* These types of targets are contributory factors that may lead to blocked processing. Blocking beliefs and feeder memories are ancillary targets.

*Back to target.* Instructing the client to return to the original incident/event currently being processed.

*Bilateral stimulation (BLS).* BLS is any stimulation, visual, auditory, or kinesthetic that addresses both the left and right sides of the brain in sequence. EMDR processing neutralizes negative events by means of bilateral stimulation.
**Blocking belief.** A blocking belief is a belief that stops the processing of an initial target. This type of belief may resolve spontaneously during reprocessing or may require being targeted separately.

**Channels of association.** Within the targeted memory, events, thoughts, and physical and emotional sensations may spontaneously arise or arise when the client is instructed to go back to target (i.e., return to the original event, incident, image, incident, etc.). These are called channels of association and may arise any time during the reprocessing phases (i.e., 3–6).

**Circumstances.** Situations that stimulate a disturbance.

**Cluster memories.** These memories form a series of related or similar events and have shared cues, such as an action, person, or location. Each event is representational or generalizable to the other. These nodes are not targeted in the sessions in which they have been identified. The clinician usually keeps an active list of any nodes that arise during reprocessing and reevaluates them at a later date to see if further treatment is necessary.

**Developmental trauma.** Events that occur over time and gradually affect and alter the client’s neurological system to the point that it remains in a traumatic state. This type of trauma may cause interruptions in a child’s natural psychological growth.

**Dual awareness.** This is what Dr. Shapiro calls “dual focus of attention” (2001). It allows the client to maintain a sense of present awareness and for the client’s internal processes to function without interference during reprocessing.

**Ecological validity.** Appropriate to the client given her present circumstances.

**Eye Movement Desensitization (EMD).** EMD is a simple desensitization technique whose primary focus is on reducing the anxiety, and the primary modality is behavioral. Dr. Shapiro changed the name of EMD to EMDR in 1990 to reflect the information processing mechanism involved as well as the cognitive and emotional restructuring nature of the method.

**Fears.** Fear in the processing of targeted information can become a blocking mechanism. It stalls the process. Dr. Shapiro identified fears to include fear of the clinical outcome of EMDR Therapy or the process itself, fear of going crazy, fear of losing good memories, and fear of change. Fear of the process can be readily recognized whenever a client begins to identify elements of EMDR Therapy that appear to be problematic for her (2001). Also check to ensure that any expressed fears of the process are not related to secondary gain.

**Feeder memory.** This type of memory has been described by Dr. Shapiro (2001) as an inaccessible or untapped, earlier memory that contributes to
the client’s current dysfunction and that subsequently blocks the reprocessing of it.

**Flashforward.** A technique used to address the client’s irrational fears.

**Floatforward.** A technique used to help clients to identify and cope with unspecified future fears.

**Floatback Technique.** If the client is unable to identify the touchstone through direct questioning, the clinician’s next option is to use the floatback technique developed by William Zangwill (Browning, 1999; Young, Zangwill, & Behary, 2002) to elicit the past event that is responsible for the client’s current dysfunction. The floatback is an imagery exercise that acts as a bridge to earlier dysfunctional memories.

**Future desired state.** The third prong of EMDR focuses on targeting a positive template that will assist in incorporating anticipatory events. This stage may involve teaching the client assertiveness skills, modeling good decision-making, or having the client imagining future situations, such as coaching people to help them respond more appropriately.

**Internal or external triggers.** Internal and external cues that are capable of stimulating dysfunctionally stored information and eliciting emotional or behavioral disturbances.

**Inverted** (Hofmann, 2009) or **Reverse** (Adler-Tapia, 2012) **Protocol.** Simply reversing the order of processing from past, present, future to future, past, present to help the more unstable client to reduce his symptoms so that he is able to work on past events. These protocols work well with more fragile clients.

**Negative cognition (NC).** This is the negative self-belief associated with the unprocessed and dysfunctional negatively stored incident/event.

**Node.** In terms of the AIP model, a node is an associated system of information (i.e., associatively stored material). It is a pivotal place among physiologically associated material. Associated channels may consist of specific events or dreams; a person; an actual, fantasied or projected event, whether actual, fantasized, or projected; or some aspect of experience, including a body sensation or a specific thought. Example: If the client’s presenting issue is her response to a coworker’s unpredictable outbursts, there may be a constellation of associated experiences linked to it. If she reacts with fear or anger, there may be a constellation of associated experiences that are linked to it. These events may be linked to previous experiences with the coworkers or with a sibling or a friend. In order for the client to react and respond to these outbursts appropriately, it is necessary to clean out all the associated channels connected to the node. A node is also a touchstone or a primary, self-defining life event.

**Original target.** Selected node out of which all negative associated channels of information emerge.
**Peelback memory.** A peelback memory usually occurs when a touchstone has not been identified and, during reprocessing, other associations begin to “peelback” to expose prior disturbing memories. There is often confusion between a progression and a peelback memory. A peelback memory is an earlier unsuspected memory while a progression is any new associated memory.

**Positive cognition (PC).** The positive belief which reflects the client’s desired direction of change.

**Positive template (imaginal future template development).** A process where the client uses the adaptive information learned in the previous two prongs to ensure future behavioral success by incorporating patterns of alternative behavioral responses. These patterns require the client to imagine responding differently and positively to real or perceived negative circumstances or situations or significant people.

**Polar shift.** A polar shift occurs when a negative emotion is replaced by a positive one in the early part of the processing (e.g., client is crying and then laughs).

**Progression.** While processing an identified target, another target may emerge that may be salient to the client’s clinical picture. If this memory does not resolve during the current processing, the clinician should take note of this for possible processing at a later date.

**Primary events.** These are standalone events that may emerge during the history-taking phase and treatment planning, reprocessing, and reevaluation phases as well as over the course of treatment itself. Dr. Shapiro (2001) defines these as events that have the greatest significance or that have been identified by the clinician as representing critical areas of dysfunction to the client.

**Secondary gain.** A secondary gain issue has the potential of keeping a presenting issue from being resolved.

**Second-order conditioning.** A classical conditioning or Pavlovian term that refers to a situation in which a previously neutral stimulus (e.g., associating a bell with light, “second” order) is paired with a conditioned stimulus (e.g., associating a bell with food, “first” order) to produce the same conditioned response as the conditioned stimulus. In other words, he is using a previously successful conditioned stimulus (i.e., the bell) as the unconditioned stimulus (i.e., the light) to provide further conditioning to produce the same conditioned response.

**Set.** Round trip passes of eye movements.

**Shock trauma.** Involves a sudden threat that is perceived by the central nervous system as overwhelming and/or life threatening. It is a single episode traumatic event.

**Starburst effect.** This occurs when multiple events come out during processing.
State change. A state change is momentary or transitory. A state change is a change of mind. It instills a sense of hope in the client. A state change also requires the use of coping mechanisms to continue the change.

Subjective Units of Disturbance (SUD). Measures the level of distress associated with an incident/event.

Target. Incident/event selected for reprocessing in the Assessment Phase.

Three-pronged protocol. Past events, present triggers, future template selected for processing.

Touchstone memory. A memory that lays the foundation for the client’s current presenting issue or problem. This is the memory that formed the core of the maladaptive network or dysfunction. It is the first time the client may have believed, “I am not good enough” or that this conclusion was formed. The touchstone event often, but not necessarily, occurs in childhood or adolescence. Reprocessing will be more spontaneous for the client if the touchstone events can be identified and reprocessed earlier in the treatment.

Trait change. A trait change reflects a permanent change and, as such, requires no coping mechanisms. With a trait change, the client changes how he sees or views the event and, as a result, can experience it differently.

Trauma. Trauma can be defined as any event that causes an unusually high level of emotional stress and has a long-lasting negative effect on a person. However, it is the client’s subjective emotional experience of an event that determines whether it was traumatic, not the objective facts of the event itself. In short, any situation or event that leaves the client feeling overwhelmed and unable to cope in the present may be defined as traumatizing, regardless of whether physical harm was involved. So it is important to ask the client, “Is the trauma still disturbing?” when developing an AIP-informed treatment plan.

Validity of cognition (VoC). Measurement of how true the selected PC feels when paired with the target incident/event.

Wellsprings of disturbance. This phenomenon is indicative of “the presence of a large number of blocked emotions that can be resistant to full EMDR processing” (Shapiro, 2001) and is often caused by the existence of an extensive negative belief system. A wellspring is similar to a feeder memory in that both are feeding the emerging emotions. Clients who are resistant to therapy or who seek therapy involuntarily at the urging of someone else (e.g., therapy is court-ordered or requested by a persistent and threatening spouse) are most susceptible to this phenomenon. They are in therapy because of someone else and possess no desire to report or deal with any feelings (Shapiro, 2001).


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