Welcome to your EMDR Therapy Training journey! The team providing you with the training, affiliated with The Institute for Creative Mindfulness, hopes that you get the most out of the experience you are seeking. We strive to provide small trainings that are highly interactive. Whether you choose to take just the first few days of this course to determine if EMDR Therapy is for you or if you follow through with the entire Training program, we welcome you!

This is your manual. Dive into it and take all the notes that you might need. It is unlikely that we will be working from a PowerPoint presentation. Rather, we use this manual as a springboard for interaction and conversation. In certain sections, there is more material than we will be able to cover during our time together. However, your instructor will take special care to note which sections can be delved into for independent study after the training. Any handouts that appear in the flow of the manual are provided as clean copies in the appendices and after the course you will be given a link to access them online.

It is not lost on us that training in EMDR Therapy can be an exhausting, sometimes frustrating process. We are here to help you through this journey. You are invited to ask questions throughout the process. The consultation component that exists throughout the training also gives you ample opportunities to have your questions answered, as well as address any learning frustrations that you may be experiencing.

Sincerely,

Jamie Marich, Ph.D., LPCC-S, LICDC-CS, REAT, RYT-200, RMT
(Course Developer) &
The EMDR Therapy Training Team of The Institute for Creative Mindfulness
The Institute for Creative Mindfulness
A Program of Mindful Ohio
www.instituteforcreativemindfulness.com

Dr. Jamie Marich & Affiliates/The Institute for Creative Mindfulness is an Approved Education Provider of the EMDR International Association (EMDRIA): #10002.
EMDR THERAPY TRAINING OVERVIEW

Day 4: Advanced Work with the Standard Protocol

Introduction & Orientations to Second Half of Course 8:00am—8:30am

Issues for the Advanced EMDR Practitioner:
Ethics & Working with Interweaves 8:30am—9:45am

Supervised Practicum:
Working with Interweaves 10:00am—12:00pm

Issues for the Advanced EMDR Practitioner:
Abreaction & Dissociation 1:00pm—2:30pm

Supervised Practicum 2:45pm—4:30pm

Day 5: Special Populations and Situations in EMDR Therapy

Questions and Discussion from Day 4 8:00am—8:30am

Adapting for Special Populations & Situations 8:30am—9:45am

Supervised Practicum Session: 10:00am—12:00pm

EMDR as Approach to Psychotherapy
Case Conceptualization Exercise Part I Phase 8: Re-Evaluation- Enhanced Logistics 1:00pm—2:30pm

Supervised Practicum 2:45pm—4:30pm
Day 6: The Art of EMDR Therapy and Case Conceptualization

Questions and Discussion from Day 5
8:00am-8:30am

The Neurobiology of Trauma:
Implications for EMDR Therapy & AIP Review
8:30am-9:45am

Supervised Practicum Session:
10:00am-12:00pm

Case Conceptualization Exercise Part II
Blocking Beliefs & Treatment Planning

Final Wrap-Up:
The Art of EMDR Therapy &
Continuing Consultation/Training
1:00pm-2:30pm

Supervised Practicum
2:45pm-4:30pm
Prerequisites: Master’s or doctoral degree in a clinical mental health-related field (e.g., counseling, marriage & family therapy, social work, psychology). Master’s level students may be permitted to take the course if The Institute for Creative Mindfulness receives a letter of recommendation from a faculty member ahead of time. Medical professionals (e.g., nurses, physicians) may also be eligible to take the course if they possess a clinical master’s or doctorate degree and if their primary specialty is within mental health. Chemical dependency professionals with a master’s degree or higher may also be eligible to take the course. Pastoral/Christian counselors, art/music/dance therapists may also be eligible if they can show sufficient clinical content on their Master’s level transcripts. In these three specialty scenarios, prior approval is required from the Institute for Creative Mindfulness using the guidelines of the EMDR International Association.

Completion of 4-6 hours of consultation, either in an individual or group format, with an EMDRIA-Approved Consultant following successful completion of the first part of the training (Days 1-3).

Required Reading (per EMDRIA)


Suggested Reading & Resources (from The Institute for Creative Mindfulness)

General Trauma Reading


EMDR-Related Resources


**Videos**


**Websites**

Institute for Creative Mindfulness
EMDR Therapy Video Resources
http://www.instituteforcreativemindfulness.com/video-resources.html

Trauma Made Simple: The Official Book Website
Complimentary Trauma Stabilization Videos & Recordings
www.traumamadesimple.com

The Trauma Therapist Project (Dr. Guy MacPherson)
Resources for Trauma Therapists
www.thetraumatherapistproject.com

EMDR Humanitarian Assistance Programs/Trauma Recovery
www.emdrhap.org

International Society for the Study of Trauma & Dissociation
www.isst-d.org
# Table of Contents

## Day 4: Advanced Work with the Standard Protocol

**Issues for the Advanced EMDR Practitioner: Ethics & Working with Interweaves** .......................................................... 11
*EMDR International Association Code of Conduct* .............................................. 11
*Interweaves* ........................................................................................................ 13
*Implementing Interweaves* ................................................................................ 14
*Common Scenarios for Using Interweaves* ......................................................... 15
*Case Conceptualization Treatment Plan: EMDR Therapy Approach* .................. 17

## Day 5: Special Populations and Situations in EMDR Therapy

**Adapting for Special Populations & Situations in EMDR Therapy** ...................... 25
*Various Uses of the Term Protocol in EMDR Therapy Culture* ............................ 26
*Modifications and Special Populations/EMDRIA Definition of EMDR* ................. 29
*EMDR & Children: Suggestions from the Training Team* .................................... 33
*EMDR & Couples: Suggestions from the Training Team* .................................... 34
*Addictions & Compulsive Behaviors: Suggestions from the Training Team* ........ 35
*Greatest Hits List of Addiction-Specific Beliefs* .................................................. 36
*Sexual Abuse Survivors: Suggestions from the Training Team* .......................... 37
*Complex PTSD: Suggestions from the Training Team* ....................................... 38
*Dissociative Clients: Suggestions from the Training Team* .................................. 39
*Military & Public Safety: Suggestions from the Training Team* .......................... 40
*Recent Events Targeting Sequence Modifications* ............................................. 41
*Current Anxieties/Behaviors Targeting Sequence Modifications* ....................... 42
*Phobia Targeting Sequence Modifications* ........................................................ 43
*Illness & Somatic Disorders Targeting Sequence Modifications* ....................... 44
*Grief & Bereavement Targeting Sequence Modifications* ................................... 45
*Self-Use Suggestions* .......................................................................................... 46
*Specialized Scripted Protocol Books* .................................................................... 47
*Useful EMDR Casebooks* .................................................................................... 47

**EMDR as Approach to Psychotherapy: Conceptualizing Cases & Linking Sessions** 49
*Case Conceptualization Exercise, Part I* ............................................................. 49
*The Art of Checking Back in and Planning the Next Move (Re-Evaluation Phase 8)* 50
*Starting a New Session in EMDR Therapy* ........................................................ 50
*Checking Back in on a Completed Target (Flowchart)* ....................................... 51
*Checking Back in on an Incomplete Target (Flowchart)* ..................................... 51
*Re-Evaluation as Treatment Plan Review* .......................................................... 52
*Simple Targeting Sequence List for Clinical Tracking* ........................................ 53
*Simple Conceptualization Sheet for Clinical Tracking & Re-Evaluation* .......... 54
The Neurobiology of Trauma: Implications for EMDR Therapy ................................................................. 59
Triune Brain Basics (REVIEW) .................................................................................................................. 61
EMDR & Connections to Triune Brain Model .......................................................................................... 63
From Bessel van der Kolk in The Body Keeps the Score ........................................................................ 64
The Adaptive Information Processing Model (Review from Part I) ...................................................... 65
Clinical Implications of the AIP Model & EMDR Case Conceptualization ........................................... 67
Explaining EMDR Therapy to a Client ...................................................................................................... 69
Case Conceptualization & Treatment Planning: Final Notes ............................................................... 71
Common “Blocking Beliefs:” Implications for Targeting Sequences in Treatment Planning ................ 71
Case Conceptualization Exercise, Part II .................................................................................................. 72
Final Wrap-Up: The Art of EMDR Therapy & Continuing Consultation/Training .................................. 77
Qualities of a Good EMDR Therapist ...................................................................................................... 77
Following the Training ............................................................................................................................ 79
Consultation Documentation Form ........................................................................................................... 82

References .................................................................................................................................................. 83

SPECIAL SECTION: Practicum Worksheets ............................................................................................. 85
Worksheet Set 1 ......................................................................................................................................... 87
Worksheet Set 2 ......................................................................................................................................... 111

Appendix A: Clean Copies of Worksheets & DES .................................................................................. 135
Appendix B: Mindfulness-Informed Activities for Preparation, Stabilization, and Resourcing .............. 157
Appendix C: Resources for Purchasing Equipment for EMDR Therapy ................................................ 185
Appendix D: EMDR Therapy Research Articles ....................................................................................... 189
DAY 4:
Advanced Work with the Standard Protocol—
Interweaves and Ethics

“Whenever a doctor cannot do good he must keep from doing harm.”

—Hippocrates
OBJECTIVES: DAY 4

• To discuss, in general, what it means to be an ethical EMDR Therapist and list three safeguards for ensuring safe and ethical practice

• To define interweaves and describe at least three situations where using interweaves are useful in EMDR Therapy

• To list examples of situations within EMDR Therapy where making modifications may be necessary (according to the EMDRIA Definition of EMDR)

• To describe the types of modifications that might be necessary and appropriate with the “special populations” that individual attendees treat in clinical settings

• To execute the EMDR 8-Phase protocol under supervised practice and receive necessary instruction about interweaves and modifications (implementing accordingly)
EMDR International Association Code of Conduct (EMDRIA, n.d.)

Introduction
EMDR International Association (EMDRIA) has adopted a Professional Code of Conduct in order to assure the highest standards of excellence and integrity in EMDR. By adopting this Code, EMDRIA creates guidelines to establish and uphold standards of practice, training, certification, and research. All members of EMDRIA, as a condition of membership, subscribe to the Code of Conduct.

Code of Conduct
1. Members of EMDRIA shall observe the professional and ethical standards of their respective clinical professions. If members are not licensed or accountable to a particular discipline’s code of ethics, or if their Code of Ethics does not address the concern at hand, then the American Psychological Association (APA) Code of Ethics (APA Code of Ethics, June 1, 2003) shall apply.

2. Members shall continue to be in good standing with the professional organization with which they are affiliated and regulatory board (e.g., state or provincial licensure board or Ministry of Health) in their jurisdiction and have no confirmed findings of illegal, unprofessional or unethical conduct. Members shall report within 30 days to EMDRIA any problems and authorize EMDRIA to contact the appropriate licensing boards.

3. Members shall adhere to the code of ethics of their respective clinical profession with regard to the advertising of services or EMDR training programs. If members are not licensed or accountable to a particular discipline’s code of ethics, then the APA Code of Ethics (APA Code of Ethics, January 1, 2017) regarding ethics in advertising and public statements shall apply.

4. Members or Non-Members serving in an EMDRIA-sanctioned position will follow all policies and guidelines related to that position.
In both her 2001/2018 text and her 1997 popular book on Eye Movement Desensitization and Reprocessing, founder Francine Shapiro contended that it is not wise to do EMDR Therapy with a client you would normally not feel comfortable treating anyway. In the view of The Institute for Creative Mindfulness and our team of practitioners and trainers, adhering to this simple logic and the concept of working within your personal scope of practice is one of the best ethical safeguards. Seeking consultation when you are stuck as you develop as an EMDR Therapist and continuing to stay current on professional continuing education specific to EMDR Therapy and/or the Adaptive Information Processing model are two other excellent safeguards. Although the team members are not advocates of using special “release forms” for EMDR Therapy, they are advocates of providing clients with a thorough informed consent about psychotherapy and its benefits and risks upon coming into service. Informed consent is an ongoing process, and the best way to practice this with EMDR Therapy is to be willing and able to answer any questions that the client has about EMDR model, method, and mechanism at any time and to document accordingly.
• Review from Part I: Interweaves are open-ended questions or statements that the clinician can utilize in the flow of EMDR Therapy in any phase to assist clients through blocks in processing. Originally called “cognitive interweaves” by Shapiro in her 2001/2018 text. Remember that although the ideal is to “stay out of the way” as much as possible and not reduce EMDR Therapy to a talk therapy session with bilateral stimulation, interweaves are often essential with complex clients and as closure strategies.

• What experience did you have with using interweaves since your Part I training?
Implementing Interweaves

• Generally best to use when a client is stuck or not showing much forward movement after three sets.

• The best interweaves are typically questions (see following worksheet, “Common Scenarios for Using Interweaves”). However, other varieties (e.g., coaching, encouragement, psychoeducation, breath or movement strategies) can be implemented if appropriate.

• In using an interweave you have the option to: (a) ask the question and then “go with that” as the client contemplates the question, or (b) “Go with” the immediate answer a client gives you to a question. You will learn how to use clinical judgment and feel this out contextually.

• Although working with complex trauma and dissociation generally requires more use of interweaves, you are still advised to stay out of the way as much as possible and not use interweaves just because you have something to say. Remember that the purpose of interweaves is to help clients continue with their own natural processing flow.
**COMMON SCENARIOS FOR USING INTERWEAVES**

**Client:** “I’m just not feeling anything right now.”

- *What’s happening in your body right now?*
- *If you can’t feel, what are you thinking about right now?*
- *What does that mean to you that you’re not getting anything?*
- *What was the last thing that you noticed before the feeling stopped?*
- *How is it serving you not to feel?*

**Client:** “I don’t think that this EMDR thing is working.”

- *How does the body feel when something doesn’t seem to work for you?*
- *What makes you think/say it’s not working?*
- *What does that mean to you when something isn’t working?*
- *What was the last thing that you noticed before the EMDR seemed to stop working?*
- *Could it be that you’re trying to make sense of it all instead of letting the feelings come up on their own?*

**Client:** “I start to feel something then I just shut down or get distracted.”

- *How do you experience distraction in your body?*
- *What does it feel like to be “shut down” (or distracted)?*
- *What was distressing about the last thing that you felt before you shut down?*
- *Thinking over the course of your whole life, when did you seem to develop this shutting down response?*
**COMMON SCENARIOS FOR USING INTERWEAVES (CON’T)**

**Client:** “I just want to make sense of it all.” (or other cognitive-only statements)

- What’s happening in your body right now as you try to make sense of it?
- How does it feel that you can’t make sense of it all?
- What does that mean to you that you can’t make sense of it all?
- How has that worked for you so far just trying to think it through?

**Client:** “I just wish I could go back and change the past.”

- What’s happening in your body right now as you notice that wish?
- What feelings seem to go along with that wish?
- What does that mean to you that you can’t change the past?
- If you could wave a magic wand and change the past, what would you do?

**Client:** “I got nothing.” or “Nothing is happening.”

- Nothing as in numb, or nothing as in all clear?
- What does nothing feel like in your body?
- What does nothing mean to you?
- Would you consider that “nothing” is a protective response?
- What is the last thing you remember noticing before you went into “nothing”?

**Client:** “I just feel so guilty about the whole thing.”

*(Looping: same thing comes up for several consecutive sets or keeps coming up after initial forward movement)*

- Where do you seem to experience/feel that guilt the strongest in your body?
- What does guilt mean to you?
- What does being guilty say about you?
- How might the guilt be serving you presently?
- Does the guilt about this incident we’re working on remind you of how you felt at an earlier time in your life? *(If the guilt or looped report is present-focused)*
Case Conceptualization Treatment Plan: EMDR Therapy Approach

*Use as many of these pages as you need throughout your engagement with the client. Part of Phase 8 Reevaluation is to be continuously evaluating the treatment plan, writing new goals and objectives, and developing targets and future templates accordingly.

Presenting Issue:

relapse triggers—sober for 6 months and afraid of relapse

Goal & Desired Objectives:

to remain abstinent from alcohol and all mood-altering drugs—continued negative screens with monitoring program and moving forward with working on steps with sponsor

EMDR Preparation Resources, Targets or Future Templates to Address:

- Review and reinforce existing coping skills/recovery capital (sober support system, breath work, exercise)
- Develop an expanded set of resources (e.g., guided visualization, grounding, other body-based coping that resonate as effective with client)
- Target identified negative belief “I cannot cope with my feelings without alcohol” connected to memory from first drinking binge at 14 in response to having feelings continually negated at home, experiencing relief from alcohol
- Future template: visualizing activities of daily living as a sober person with more adaptive cognition (e.g., I can cope with my feelings without alcohol)

Presenting Issue:

performance anxiety, especially in the work setting

Goal & Desired Objectives:

To experience a greater sense of confidence in work performance—decrease mild panic that arises when reviewing performance evaluations, increased satisfaction with job

EMDR Preparation Resources, Targets or Future Templates to Address:

- Review and reinforce existing coping skills/recovery capital (sober support system, breath work, exercise)
- Develop an expanded set of resources (e.g., guided visualization, grounding, other body-based coping that resonate as effective with client)
- Target negative belief of “I’m a failure” connected to several early memories
Presenting Issue:

Post-Traumatic Stress Disorder diagnosis—symptoms of trauma with hypervigilence and hyperarousal symptom proving most problematic in activities of daily living

Goal & Desired Objectives:

To decrease symptoms of hypervigilence from daily occurrence to less than 1-2x/week; to improve sleep quality by sleeping through the night for at least 6 hours on most nights out of the week. To decrease incidents of lashing out co-workers and other people generally identified as triggers to one time a week or less, with eventual goal of total elimination of such responses.

EMDR Preparation Resources, Targets or Future Templates to Address:

- Review and reinforce existing coping skills/recovery capital (sober support system, breath work, exercise)
- Develop an expanded set of resources (e.g., guided visualization, grounding, other body-based coping that resonate as effective with client)
- Target identified negative belief of “I am not safe,” connected to several identified earlier memories; “I cannot protect/defend myself” may be another area to explore related to similar memories

Presenting Issue:

Choking/vomiting phobia

Goal & Desired Objectives:

To eliminate irrational fears choking/vomiting; able to eat foods that usually are a concern (e.g., peanuts)

EMDR Preparation Resources, Targets or Future Templates to Address:

- Review and reinforce existing coping skills/recovery capital (sober support system, breath work, exercise)
- Develop an expanded set of resources (e.g., guided visualization, grounding, other body-based coping that resonate as effective with client)
- Target antecedent events, first time fear was experienced, most disturbing experiences of the fear, most recent experiences of the fear, associated present stimuli, the physical sensations of other manifestations of the fear as recommended by Shapiro’s EMDR phobia protocol
- Future template: target future scenarios like eating peanuts, getting sick and handling without excess panic

(Use additional copies of this worksheet if needed)
ISSUES FOR THE ADVANCED EMDR PRACTITIONER

Working with Abreactions & Dissociation

Corresponding Reading in Shapiro Text: Chapters 9-11; Appendix E

• What experience have you had with handling and/or managing abreactions and dissociation since the Part I training?

Abreaction Defined (REVIEW)

• The therapeutic process of bringing forgotten or inhibited material (i.e., experiences, memories) from the unconscious into consciousness, with concurrent emotional release and discharge of tension and anxiety (VandenBos, American Psychological Association Dictionary, 2007).

• “An abreaction is considered a normal potential part of the integrative and emotional cognitive processing of any given target. Clinicians should not view abreaction as either mandatory or unnecessary but should accept it, if present, as an integral part of the client’s subjective response during the processing of the dysfunctional information” (Shapiro, 2018; p. 163).
Abreactions do not have to be all tears and screaming. Sometimes, excessive yawning/tiredness or shutting down can be abreactive.

AN OUNCE OF PREVENTION IS WORTH A POUND OF CURE: In preparation, discuss the possibility of abreactions and have a plan in place. Remind the client at the beginning of reprocessing sessions that this plan is in place and that you will remind the client of their options if you notice this distress. Establish some type of stop/pause sign or other similar signal.

Assure the client that it is their choice to turn back at any time and come back to one of their preparation resources (e.g., Calm Safe Place/Space, container, a mindfulness approach covered in preparation).

It is worth reminding in orientation that turning back (although it is the client’s right) means the issue will likely need to be visited again. Any line on the variation of “the easiest way out is through” may work for this orientation.

You can use the question, “Are you okay to keep going with that?,” if you are uncertain about a client’s willingness to continue when an abreaction happens. You also have the discretion to bring the client back to resource/safety material if it seems they are outside of affective window of tolerance.

If a client chooses to stop or pause processing with bilateral stimulation/dual attention stimulus, you have options:

1. Invite a breath or a check in with an established grounding resource (this can be done without disrupting the flow much)
2. Simply talk within the container of the therapeutic relationship
3. Come back to a resource
4. Do a combination. If enough time remains and they are grounded, ask if they would like to go back into the reprocessing with the bilateral.

There are many options for reactivating the target if the stop or pause is lengthy. Checking back in with target as instructed in the script is the most efficient.
Like with abreaction preparation, AN OUNCE OF PREVENTION IS WORTH A POUND OF CURE. Take preparation seriously using the modification suggestions offered in the exercises in this manual (see Day 2 and Appendix B).

With dissociative responses, you may need to take an active role in inviting the client back into the moment, especially if time is running out. Don’t let dissociation startle you—it can be a natural part of the work and doesn’t have to be scary if you’ve gone slowly in preparation and there is a grounding plan in place.

Keeping the eyes open during reprocessing, regardless of the stimulation choice, is generally wise.

In choosing the form of stimulation during orientation/Phase 2, determine which modality of stimulation is most grounding or anchoring (e.g., makes the client feel “here and now”).

A copy of the Dissociative Experiences Scale (DES) appears in Appendix B. Begin to familiarize yourself with using this tool for screening and inquiry.

If you are feeling ready to interweave parts work into your EMDR therapy practice and treat clients with clinically significant dissociative disorders, we recommend receiving proper consultation as your main learning aid.

Having a general understanding of the theory of structural dissociation is vital for going farther and learning the finesse of working with parts in client history, preparation, target sequencing, and treatment planning. Two critical reads for this learning are:

◊ Dr. Jamie Marich’s (2018) article about her personal experiences with dissociative disorder and recovery, available on the Institute for Creative Mindfulness blog (“Fighting Dissociation Phobia and Coming Out as a Professional with Dissociative Disorder”)

◊ The Haunted Self: Structural Dissociation and the Treatment of Chronic Traumatization (van der Hart, Nijenhuis, & Steele, 2006).
D A Y  5:
Special Populations and Situations in EMDR

“Traumatized people suffer damage to the self. They lose trust in themselves, in other people, in God... The identity they have formed before the trauma is irrevocably destroyed.”

—Judith Herman (Trauma and Recovery)
OBJECTIVES DAY 5

• To list the specific protocols/targeting sequences that Shapiro overviews in her seminal text and be able to set them up (e.g., recent events, anxiety and phobia, illnesses and somatic disorders, grief, self-use)

• To discuss the best practices for conducting EMDR Therapy with the following groups of people/clinical situations: children, couples, addictions, survivors of sexual abuse, complex PTSD & developmental trauma, dissociation, military, and public safety

• To discuss, in greater detail and clinical competence, best practices for the specific groups of people/clinical situations that participants are likely to see in their clinical settings

• To access resources for obtaining specialty resources and “protocols” for these variously noted populations

• To complete, under supervised practice, one of the specialty targeting sequences presented by Shapiro, or a targeting sequence and delivery of EMDR Therapy. Phases 1-8 with a situation identified as a “special population”/situation
“Protocol” is a word that you hear used a great deal in EMDR Therapy circles and written resources. You’ve already seen the word protocol used to describe the 3-pronged protocol and the 8-Phase Standard Protocol. It seems that every month, people are publishing new “protocols” for special populations and situations in EMDR Therapy. We know that this flurry can feel overwhelming!

The general position of the Institute for Creative Mindfulness training team is that if you understand the basic targeting sequences covered to this point in the course, you can point the target at any prong of the three-pronged protocol and tackle any issue. There are a few specialty situations where Shapiro herself made modifications to her standard set-up and we will cover those in this section of the course.

Then we will overview some best practices on work with special populations/clinical scenarios and how you may need to modify the standard targeting sequences in accordance with the EMDR Definition. If you are still intrigued by having more of a script for these modifications, we will provide you with some resource ideas for accessing those in this part of the course and manual.
3-Pronged Protocol: refers to Past-Present-Future orientation in conceptualizing cases

8-Phase Protocol: refers to the flow one follows in leading a client through EMDR (Phase 1: Client History; Phase 2: Preparation; Phase 3: Assessment; Phase 4: Desensitization; Phase 5: Installation; Phase 6: Body Scan; Phase 7: Closure; Phase 8: Re-Evaluation)

Targeting Sequence Protocol: refers to the steps one follows in setting up a reprocessing targeting sequence following preparation (i.e., the Phases 3-7 worksheet). This is sometimes called the 11-Step targeting sequence in Shapiro’s books

Specialty Protocols: suggested modifications for how to conceptualize the case and, in some instances, set-up the target for optimal effect with special populations
Case Conceptualization Treatment Plan: EMDR Therapy Approach

*Use as many of these pages as you need throughout your engagement with the client. Part of Phase 8 Reevaluation is to be continuously evaluating the treatment plan, writing new goals and objectives, and developing targets and future templates accordingly.

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To decrease symptoms of hypervigilence from daily occurrence to less than 1-2x/week; to improve sleep quality by sleeping through the night for at least 6 hours on most nights out of the week. To decrease incidents of lashing out co-workers and other people generally identified as triggers to one time a week or less, with eventual goal of total elimination of such responses.

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- Future template: target future scenarios like eating peanuts, getting sick and handling without excess panic

(Use additional copies of this worksheet if needed)
Modifications will be needed when working with “special populations” or groups that may not respond well to the standard protocol that you learned in Part I. Deviating too far from the Shapiro standard protocol is an issue of contention in many EMDR Therapy circles and it may even be something you’ve read about in your study to this point. Therefore, we feel it is valuable to look at the official EMDRIA Definition of EMDR and pay special attention to where the language of modification or tailoring to special populations (e.g., complex trauma) is used:

**EMDRIA Definition of EMDR (2012)**

1.1.0A. **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.

2.1.0B. **Definition** - EMDR is an evidence-based psychotherapy for Posttraumatic Stress Disorder (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, Adaptive Information Processing (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.

**B1. Foundational Sources and Principles for Evolution** - Shapiro’s (2018) Adaptive Information Processing 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 adaptive information processing and integration. The following are some of the AIP tenets which guide the application of EMDR, i.e., planning treatment and achieving outcomes:
Billia. 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 Posttraumatic Stress Disorder (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.

Billib. 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 adaptive information processing 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 8-phase, 3-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 8 phases (Shapiro, 2018) 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 a 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.

**BIVaii. 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 7 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.

**BIVaiv. During the Desensitization Phase (Phase 4)** the memory is activated and the clinician asks the client to notice their experiences while the clinician provides alternating bilateral stimulation. 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 them 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 bilateral stimulation 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 bilateral stimulation 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.

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 3-8 are repeated.
1. **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.

2. **BVb.** 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.
EMDR & CHILDREN: SUGGESTIONS FROM THE TRAINING TEAM

- Generally best done by clinicians who already have experience with the intricacies of working with children.
- Modify language for developmental appropriateness.
- Incorporate play therapy dynamics wherever appropriate.
- Pictures instead of words (and other creative measures) may offer the optimal approach, especially with retailoring the VoC or SUDs scales.
- Let them talk while they’re processing or playing—although we tend to discourage talking in adults, it may be useful for children.
- Don’t force “I” statements…. especially if they are processing through a play fixture (e.g., an armadillo). It may be more natural for them to transfer their belief states onto the play fixture (e.g., the armadillo is stupid, etc.).
- Be advised that if they’re not in a safe environment you may not get anywhere, although these situations largely need to be handled case-by-case.

Further Reading


EMDR & COUPLES: SUGGESTIONS FROM THE TRAINING TEAM

• Generally best done by clinicians who already have experience working with the intricacies of couples counseling.

• Resourcing with the couple is a possibility; consider how teaching them the art of “tapping in” or strengthening connections to positive qualities about themselves or positive qualities about the relationship may enhance the overall couples counseling experience whether or not EMDR Phases 3-8 ever get used.

• Possible use #1—having a partner sit in to witness the others’ processing work if clinician and partner doing the processing agree that it can be a safe experience

• Possible use #2—having each party attend a separate clinician for EMDR Therapy to process targets that are keeping the couple’s work from moving forward, with full release/communication with primary couple’s therapist

• Possible use #3—having the couple’s therapist integrate use of EMDR Therapy and targeting into the couple’s or family work

Further Reading

ADDICTIONS & COMPULSIVE BEHAVIORS: SUGGESTIONS FROM TRAINING TEAM

• Generally best done by clinicians who already have experience working with the intricacies of addiction counseling.

• More resourcing/preparation work focused on distress tolerance skills and cultivating/working with support networks needed.

• Opinion is split in EMDR Therapy circles on whether or not reprocessing phases (3-6) can be done with people who are still actively using drugs/alcohol or engaging in compulsive behaviors—the Institute for Creative Mindfulness teams takes a more conservative approach and advocates for a modicum of abstinence and commitment to recovery as a goal of phase 2. Specialty protocols (e.g., DeTUR, LOU, FSAP) recommended if you disagree or can be studied further after basic training.

• See “The Greatest Hits List of Addiction Specific Beliefs” on opposite side; very helpful for working with recovery using the standard protocol.

• MET(T)A Protocol currently under development and investigation for systemic integration of EMDR therapy into treatment settings by Institute for Creative Mindfulness senior faculty member Dr. Stephen Dansiger.

Further Reading


Marich, J. (2010). EMDR in addiction continuing care: A phenomenological study of women in early recovery. *Psychology of Addictive Behaviors,* 24(3), 498-507. (Content of this article largely contained in EMDR Made Simple—one of the suggested reading items for this course)

The “Greatest Hits” List of Addiction-Specific Beliefs
Developed by Jamie Marich, Ph.D. (May be duplicated for use in clinical settings)

Potential Floatbacks*
(first, worst, most recent connected memories)

I cannot cope without alcohol.
I cannot cope without drugs.
I cannot cope without cigarettes.
I cannot cope without sex.
I cannot cope without acting out violently.
I cannot cope without victimizing others.
I cannot cope with emotions without eating.
I cannot cope without gambling.
I cannot cope without hurting myself.
My addiction is my security.
My addiction is my identity.
I have no identity if I can’t act out.
I am nothing without my addiction.
I am not capable of dealing with my feelings.
I am not capable of dealing with my life.
I cannot accept/deal with reality.
I am not capable of dealing with my past.
I must drink alcohol to be in control.
I must use drugs to be in control.
I must smoke cigarettes to be in control.
I must gamble to be in control.
I must be in a relationship to be in control.
I must have sex to be in control.
I must eat to be in control.
I must injure myself to be in control.
I must act out violently to be in control.
I must victimize others to be in control.
I am incapable of being social without drugs.
I am incapable of being social without cigarettes.
I can’t be social without alcohol.
SEXUAL ABUSE SURVIVORS: SUGGESTIONS FROM THE TRAINING TEAM

• Generally best done by clinicians who already have experience working with the intricacies of sexual abuse and sexual trauma

• Issues connected to body numbing, body dysmorphia may be higher than usual—this is where gently based body-focused preparation exercises are critical in Phase 2

• Trust dynamics may be especially fragile and issues connected to gender of the therapist may be a factor—important to address these in relationship building in Phases 1 & 2

• Delivering a chronological history of the trauma(s) will likely be impractical in Phase 1—more important to work with theme

• The reprocessing Phases 3-6 may have a tendency to go all over the place and not follow a neat flow—use of interweave critical in these situations.

Further Reading


• Not likely to get a neat chronological history in Phase 1 History Taking, nor is that of utmost importance—focus on theme and rapport building.

• More time will likely need to be spent in Phase 2 preparation, including contingencies for safety planning in between sessions.

• Trust dynamics may be especially fragile and issues connected to gender of the therapist may be a factor—important to address these in relationship building in Phases 1 & 2.

• The reprocessing Phases 3-6 may have a tendency to go all over the place and not follow a neat flow—use of interweave critical in these situations.

• High likelihood of abreaction—having a plan in place to address, including the therapist’s self-care plan for keeping calm are critical.

• May be wise to begin in the present or future components of the three-pronged protocol until the client is more comfortable with EMDR procedures and intensity of emotion—may be too much too soon to start with earliest, past memories.

Further Reading


• A therapist addressing their personal discomfort or uncertainty with dissociation is another major area that can improve EMDR efficacy.

• Many of the same suggestions/best practices for Complex PTSD apply.

• Review the preparation exercises in the Part I manual (Day 2) that offer notes about effectiveness with dissociation (e.g., grounding, work with hard textures).

• Keeping eyes closed during processing, at least until the client is more comfortable with the process of EMDR Therapy is generally not advised.

Further Reading


• Generally best done by clinicians who already have experience working with the intricacies of one or both of these populations: if you’re going to freak out at what you hear and you don’t understand the military or public safety culture, especially combat, don’t work with military. The processing will be far more intense.

• Consider receiving consultation and taking general courses on military culture (available online) about the cultural elements in addition to the clinical ones.

• More time will likely need to be spent in Phase 2 Preparation developing exercises for stabilization and distress tolerance.

• The processing may be all over the place in terms of missing links and chronology out of place; important to be able to go with the flow and use interweave where needed.

• Be mindful that these may be in a position where they perceive harm, either intrapersonally or systemically.

• Similar dynamics with public safety and trauma, especially if the public safety client experienced a PTSD-level trauma.

• Be mindful of the delayed expression (especially with Vietnam Veterans); i.e., presenting for reasons other than combat trauma, yet processing reveals unhealed material from combat or service.

Further Reading


• Obtain a narrative history of the event.

• Target the most disturbing aspect of the memory (if necessary) through as much of a standard targeting sequence as possible.

• Target the remainder of the narrative in chronological order (if the standard targeting sequence does not take it there organically).

• Have the client visualize the entire sequence of the event and reprocess as disturbance arises. Repeat until the entire event can be visualized from start to finish without distress.

• Conclude with body scan.

• Process present stimuli if necessary.

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Shapiro began working with this recent events model following the San Francisco earthquake in 1989. She observed that clients had a difficult time generalizing as one might when targeting in the standard set-up. Thus, this model represents processing the event in more of a piece-by-piece approach.

For many clients, having a solid generalization to other targets might not occur. This phenomenon often happens in clients with thought disorders or who can simply be described as more concrete thinkers. In these cases, this recent events or piece-by-piece approach may be beneficial.
CURRENT ANXIETIES/BEHAVIORS TARGETING SEQUENCE MODIFICATIONS

(Shapiro, 2018; pp. 219-220)

- The clinician asks the client to specify: (a) the anxiety to be treated, (b) the initial cause of that anxiety and root memory (if available), and (c) the desired response.

- The following are targeted and reprocessed in this exact order:
  - Initial or earliest memory
  - Most recent or most representative example of present situation that causes anxiety
  - Future projection of desired emotional and behavioral response
• Review self-soothing/preparation exercises to manage fear

• Target and reprocess the following:
  o Antecedent/ancillary events
  o The first time the fear was experienced
  o The most disturbing experiences of the fear
  o The most recent experience of the fear
  o Any associated present stimuli
  o The physical sensations of other manifestations of the fear, including hyperventilation

• Incorporate a positive template for fear-free future action

• Arrange contract for action

• Run mental videotape of full sequence and reprocess disturbance

• Complete reprocessing of targets revealed between sections

There may be some generalization effects that make it unnecessary for you to set up six specific targets, although in Shapiro’s instructions, this generalization may not happen. These instructions are here for the separate sequences if this recommended modification seems like the best fit for a given client.
• Create an action plan to address organic needs
• Identify and reprocess relevant memories, present situations, and fears of the future dealing with:
  o personal or physical constraints
  o social issues
  o medical experiences
• Run “videotape” of the next 1-5 years
• Use guided visualization resources* with appropriate cognitive groundwork
• Identify suitable positive cognition
• Link image and positive cognition
• Assign homework with self-use procedures
• Use log and self-care procedures
The five stages—denial, anger, bargaining, depression, and acceptance—are a part of the framework that makes up our learning to live with the one we lost. They are tools to help us frame and identify what we may be feeling. But they are not stops on some linear timeline in grief.

-Elisabeth Kübler-Ross

GRIEF & BEREAVEMENT TARGETING SEQUENCE MODIFICATIONS

(Shapiro, 2018; pp. 232-234)

- Actual events, including loved one's suffering or death
- Intrusive images
- Nightmare images
- Present triggers
- Issues of personal responsibility, morality, or previous unresolved losses
Self-Use Suggestions

(Shapiro, 2018; pp. 243-245)

The discretion of the clinician is required to determine whether or not clients are able to handle self-exercises with stimulation on their own outside of sessions. Use of self-use should generally be avoided if there is a high potential for abreaction. All of the exercises covered on Day 2 might be appropriate for pairing with eye movements or other bilateral stimulation, with Shapiro especially advocating for Calm Safe Place/Space and Light Stream.

Here are some options recommended by Shapiro for self-use with eye movements

1. Hold the head straight, look forward, and then move the eyes to the extreme right and observe a distant object. The same movement is made to the extreme left. Continue back-and-forth.

2. Look alternately at one side of the room (or a point on the wall) and then another.

3. Sit with one hand, palm down, on each thigh (with legs parted) and raise one index finger at a time while the eyes move back and forth between them.


5. Use of a pendulum, Neurotek or similar light bar, traditional metronome

Revisit Day 2 of your Part I training manual for suggestions made on how to create tactile stimulation for self-use with exercises such as Monkey Tap, Energetic Massage, Alternating Clench and Release.
**SPECIALIZED SCRIPTED PROTOCOL BOOKS**


**USEFUL EMDR CASEBOOKS**


Conceptualizing Cases & Linking Sessions

Case Conceptualization Exercise, Part I
(Receive Instructions from Practicum Leader or Instructor)
Starting a New Session in EMDR Therapy

- At the start of each session after reprocessing begins in EMDR therapy (Phases 3-7), the client reviews any new sensations, insights, awareness or experiences they have noticed (as it relates to the work being done in therapy) since the previous session.

- The clinician checks the level of disturbance from the experiences targeted in the previous session, evaluates the continuation of positive results, identifies any new areas needing targeted as part of treatment, and continues reprocessing of additional targets with the client.

- When checking back in, it is not necessary that you have the client bring up the worst part of the memory since hopefully this changed or shifted somewhat; rather, you are checking, in a general sense, if the progress has held.

- Encourage the negative cognition (NC) to stay the same as the previous session although the wording can shift slightly. Drastically different negative cognitions generally warrant a new targeting sequence set-up.

- A fully processed memory needs to have processed the past memory, present triggers, and future template.

- Shapiro (2018) offers several general examples of how to do a future template in her text (pp. 203-204; Appendix B). A more scripted version is used in this manual in the practicum sections that your faculty members or small group leaders will go over with you.

- When past memories and present triggers have been reprocessed, a future template may be set up to assure maximum crystallization of that target. In cases where the target for reprocessing (Phases 3-7) was future-oriented (which is acceptable), future template would be unnecessary.

- Client and therapist then collaboratively decide what other targets will need to be reprocessed as part of the larger treatment plan. Due to generalization effects during reprocessing, keep in mind that some or all of the floatback memories derived in the initial Phase 1 Client History may have organically resolved on their own.
CHECKING BACK IN ON A COMPLETE TARGET

Completed Target from previous session (SUDs = 0, VoC = 7, clear body scan)

Bring up the target memory, If SUDs = 0, VoC = 7 & clear body scan, move to future template or next target to address

Bring up target memory and check SUDs and VoC:
If SUDs ≠ 0 or VoC ≠ 7 or body scan not clear

Return to Phase 3 – Assessment, continue reprocessing of target memory (be mindful image/worst part may have changed)
Use new Phase 3-7 worksheet

CHECKING BACK IN ON AN INCOMPLETE TARGET

Incomplete Target from previous session where Phase 5 installation did not occur

Return to Phase 3 – Assessment, continue reprocessing of target memory.
Bring up target memory, check SUDs and VoC
SUDs and/or VoC levels may have shifted from last session

If SUDs ≠ 0, Return to Phase 3 – Assessment, continue reprocessing of target memory (be mindful image/worst part may have changed)
Use new Phase 3-7 worksheet

If SUDs = 0, check VoC

If VoC = 7
- go to Phase 5 Installation
- follow instructions on Phase 3-7 worksheet
- Use new Phase 3-7 worksheet

If VoC ≠ 7
- go to Phase 5 Installation
- follow instructions on Phase 3-7 worksheet
- Use new Phase 3-7 worksheet

*There is a worksheet in the practicum sections that takes you through this process.*
• The Re-Evaluation Phase (Phase 8) guides the clinician through the treatment plans that are needed to optimally address the client’s presenting issues. As with any form of good therapy, the Re-Evaluation Phase is vital in order to determine the success of the treatment over time. Although clients may feel relief almost immediately with EMDR therapy, it is as important to complete the eight phases of treatment, as it is to complete an entire course of treatment with antibiotics.

• A major facet of Phase 8 work is evaluating the initial Phase 1 Client History and determining if any other memories initially explored will need reprocessed, or if other issues may have now surfaced, either in the client’s life, or in the course of reprocessing other targets. The Simple Targeting Sequence List For Clinical Tracking and/or the Simple Conceptualization Sheet For Clinical Tracking & Re-Evaluation can assist you in this process.

• Even if your plan was to set up a series of targeting sequences and the client did not respond as anticipated (e.g., the client was not yet ready to do the work in that target; no real movement was observed in that target), you may then decide to regroup and set up another targeting sequence (Phases 3-7 worksheet) or re-evaluate your approach to the case.

• A Re-Evaluation of all targets occurs at the conclusion of therapy. The Simple Targeting Sequence List For Clinical Tracking and/or the Simple Conceptualization Sheet For Clinical Tracking & Re-Evaluation can assist you in this process.
### Simple Targeting Sequence List For Clinical Tracking

#### Target Set Up (Phases 3-7 Worksheet)

<table>
<thead>
<tr>
<th>Target</th>
<th>Outcome/Plan</th>
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<tbody>
<tr>
<td>1. I have to be perfect/please everyone: Memory of failing at early piano recital</td>
<td>Completed 2/2/16</td>
</tr>
<tr>
<td>2. I can succeed on my own terms: Future template about new job</td>
<td>Completed 2/9/16</td>
</tr>
<tr>
<td>3. I cannot let it out: Age 3 sexual abuse experience from neighbor</td>
<td>Started 2/16/16</td>
</tr>
<tr>
<td></td>
<td>Client chose to return to container and wait to target this until more stable overall in new job</td>
</tr>
<tr>
<td>4. I am not safe: Related to a memory that emerged during processing of initial target about not believing client was safe with her 3rd grade teacher; noticing its impact working with new boss.</td>
<td>Completed 3/1/16</td>
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</tbody>
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### Present Triggers

<table>
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<tr>
<th>Theme/Event</th>
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<th>Negative Cognition (rank ordered)</th>
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<th>Memory/Event</th>
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### Future Template

Future Template

__________________________
Installed Positive Cognition (PC):

Target: Can you bring up a situation that is likely to happen in the near future where the positive cognition will serve you? (NOTE: Related to original target is best)

Age or worst part: What image represents the worst part of this future scenario? 
NOTE: If no image available or image doesn’t carry much charge, simply have client notice the target or use another sensory channel like sound if that carries more charge

Positive cognition: When you bring up the image (or worst part) of the future scenario with the positive belief of ___________ what is your gut-level feeling of how true that feels to you right now with 1 being completely false and 7 being completely true?

If the VoC is 7:
Place that positive belief of together with the image (or worst part) of the future scenario.
Continue with at least two sets of FAST bilateral BLS/DAS, checking in between each set. When the client reports on what they are noticing now, continue with the next set of stimulation. Use the statements “Go with that,” or “Just notice that” to begin the next set of stimulation. After at least two sets of FAST bilateral DAS and material continues to be adaptive move to Body Scan (back side of the page)

If the VoC is lower than a 7:
Emotion: What emotions do you feel when you bring up the image (or worst part) of the future scenario?

Subjective Units of Disturbance (SUDs): What is your level of disturbance as you bring up the image (or worst part), with 0 being no disturbance or neutral and 10 being the worst you can imagine?

Location of Body Sensation: What are you noticing in your body in this moment as you bring up the image (or worst part), and the emotions all together?

Go with FAST BLS/DAS after getting body sensation: Go with that... (Go to back side of page)
• Stay out of the way as much as possible, checking in after approximately 24-36 passes of bilateral DAS. After each set, invite a breath, and ask the client, “What are you getting?” or “What are you noticing now?” The broadness of this open-ended question invites free association.
• When the client reports on what they are noticing now, continue with the next set of stimulation. Use the statements “Go with that,” or “Just notice that” to begin the next set of stimulation.
• You can then also ask for a SUDs rating at any time to check in on progress when responses become more adaptive. Take care not to do this excessively. Use a statement such as, “When you return to the future scenario where we began, what is your level of distress in this moment with 0 being no disturbance or neutral and 10 being the worst you can imagine?” If SUDs is anything but 0, ask: “What keeps it from being a 0?” and then continue with “go with that.”
• Proceed with sets of BLS/DAS until SUDs of future target image or worst part is as close to 0 as possible.
• Now check the VoC of the Positive Cognition: When you bring up the image (or worst part) of the future scenario with the positive belief of ____________________ (arrived upon positive belief from just completed related target memory) what is your gut-level feeling of how true that feels to you right now with 1 being completely false and 7 being completely true?
• If VoC is anything but 7, ask “What keeps it from being a 7 (completely true)?” and keep “going with that” until VoC is 7 or as close as reasonable.

Installation Statement (Once VoC returns to 7 or as close as reasonable)

Place that positive belief of ____________________ together with the image (or worst part) of the future scenario. (Apply at least two sets of bilateral DAS)

Body Scan

Now that the positive belief has been further installed, scan your body from head to toe: What are you noticing?

• If the body scan is clear/adaptive, do another set of FAST BLS/DAS, saying,
  • “Hold that clear body scan together with the future scenario and the positive belief of ____________________.”
• If there are residual disturbances, have the client notice and continue with fast sets until body scan is clear, then pair the statement above with at least one set of fast BLS/DAS.

Closure

In closure you can utilize the resources built and strengthened in Phase 2 to quell any residual distress and ensure a safe departure with or without SLOW bilateral DAS. You may also engage in a general debriefing about the session or the future template itself, being mindful to address any client concerns. Apprise what could happen following the session (i.e., processing may continue after session ends), and review a plan for safety, stabilization, and contacting support if needed.
D A Y  6:
The Art of EMDR Therapy & Case Conceptualization

“Therapy should be Relationship-driven, not Theory-driven”

—Irvin Yalom
OBJECTIVES: DAY 6

• To discuss the neurobiology of trauma covered on Day 1 of the course in the context of EMDR Therapy and working hypotheses about mechanisms of action

• To present a clinical case study for the participant’s clinical practice through the EMDR Therapy/AIP framework

• To complete, under supervised practice, any remaining practice elements that a participant may need to attend to using EMDR Therapy

• To discuss the characteristics of strong EMDR therapists

• To evaluate any issues that a participant may need to address to better capture these qualities of strong EMDR therapists

• To develop a plan for continued consultation and formation as an EMDR therapist after the completion of the training course
The neurobiological answer as to “why” EMDR Therapy works is still largely regarded as a series of theoretical hypotheses. As Bessel van der Kolk (2014) notes in The Body Keeps the Score, such a statement does not devalue EMDR Therapy; after all, it took 40 years for scientists to confirm and explain exactly how penicillin works in the human body even though it was actively being used. We are on the road towards new frontiers in neurobiology. The research and writing of the last two decades alone have given a great deal of confirmation to the relevance of mind-body interventions that go beyond talk therapy.

In the following pages, we review the material covered on the neurobiology of trauma on Day 1 of the course and expand on its application. It is likely that your appreciation of the material will now be enriched after practicing EMDR Therapy in many practicum sessions and hopefully clinical practice. If you are the type of person who learns well by studying the science of neurobiology, please consult the research Appendix (D) on mechanism of action and the role of eye movements in your Part I training manual.

Reading Recommendation

“The Hand Model” of the Human Brain by Dr. Dan Siegel, as cited in Marich, J. (2014)
**Triune Brain Basics—Review**

**(MacLean, 1990, Grey, 2010)**

**Brainstem (Reptilian Brain/R-Complex Brain/Lizard Brain)**

- This area is equated with animal instincts, essentially everything human beings generally have in common with reptiles: the basic functions of animal life.
- These functions originate in this lowest part of the brain: reflex behaviors, muscle control, balance, breathing, heartbeat, feeding/digestion, and reproduction.
- Very reactive to direct stimulation.

**Limbic Brain (Paleomammalian Complex/Midbrain)**

- This center of emotion and learning developed very early in mammalian evolution to regulate the motivations and emotions we now associate with feeding, reproduction, and attachment behaviors.
- Everything in the limbic system is either agreeable (pleasure) or disagreeable (pain/distress) and survival is based on the avoidance of pain and the reoccurrence of pleasure.
- The amygdala and hypothalamus are part of the limbic brain and they do not operate on the same rational sense of time we know as human beings.
- The amygdala determines if incoming input is dangerous or not. If the amygdala classifies the information as not a threat, it can process through to the neocortex and is integrated with other useful or useless data that have been acquired over the years. In essence, the information integrates into our existing experience without fallout.
- For many people who go through experiences where threat or danger is signaled, receiving help, support, or validation in as timely a manner as possible assists a person with the process of integration, thus decreasing the chances of long-term consequences associated with PTSD and related problems associated with trauma.
- If the amygdala signals danger, then other parts of the limbic brain activate, specifically the survival-driven thalamus. This illumination can trigger one of three reactions, fueled by the lower reptilian brain: the fight response, the flight response, or the freeze response.
- When these responses are activated and re-activated, the body will do whatever these parts of the brain tell it to do, regardless of what rational thought might be saying.
- Even after the danger has passed, the thalamus remains on high alert, signaling the same responses if anything reminiscent of the original danger passes through again.
- Together, the thalamus and the reptilian brain work on overdrive to prevent against a similar response the next time.

(MacLean, 1990, Grey, 2010)
• These behaviors, such as drinking too much, eating too much, engaging in other pleasurable behaviors that may become problematic are designed to numb the system and prevent against further danger responses happening again.

Neocortex (Cerebral Cortex)

• More efficient in long-term storage; the goal of successful trauma processing in any modality is to move the primary place of storage from the limbic brain to the neocortex.

• Unique to primates; contains the prefrontal lobes or cortices.

• The neocortex regulates processes that are unique to humans: executive functioning, higher-order thinking skills, reason, speech, meaning making, willpower, and wisdom.

• Cognitive or any reason-based interventions primarily target the prefrontal cortices of the brain. Yet the limbic region of the brain activated during the original trauma to help the person survive (through flight, fight, or freeze to submission) is where the unprocessed material remains stuck.

• Because the left frontal lobe turned off (there is no blood flow) and the right frontal lobe was abandoned (there is awareness but lack of ability to process), the individual was never able to link up that limbic activation with frontal lobe functions during the experience. For a person in crisis or intense emotional distress, this process is playing out in real time, and/or triggers from earlier, unprocessed experiences fuel the distress.

Talk therapy and straight cognitive approaches work primarily with the neocortex. Interventions that involve action (any type of bilateral or dual attention engagement qualifies), use of all sensory channels, somatic awareness, and use of breath are more likely to work with the whole brain, promoting the connections needed for healing and shifts in how memories are stored.
The bilateral processes involved with EMDR Therapy, whether they are eye movements, audio tones, or tactile motions, all use movement or action and thus stimulate all three brains. Pagani, Hogberg, Fernandez, & Siracusano (2014) published a comprehensive summary on all the imaging and other biological monitoring studies conducted on EMDR to date. EMDR-related neurobiological changes were monitored by EEG during the therapy sessions themselves and showed a shift of the maximal activation from emotional limbic to cortical cognitive brain regions—the first documented finding of its kind. Neuroimaging investigations of the effects of psychotherapies treating posttraumatic stress disorder (PTSD), including eye movement desensitization and reprocessing (EMDR), have reported findings consistent with modifications in cerebral blood flow (CBF; single photon emission computed tomography [SPECT]), in neuronal volume and density (magnetic resonance imaging [MRI]), and more recently in brain electric signal (electroencephalography [EEG])
“For real change to take place, the body needs to learn that the danger has passed and to live in the reality of the present.” (p.21)

Ways for helping survivors feel alive in the present and move on with their lives:

Top down methods: talking, connecting with others, self-knowledge

Technology: medications to shut down inappropriate alarm reactions; other therapies/technologies that change the way the brain organizes information

Bottom up methods: allowing the body to have experiences that deeply and viscerally contradict the helplessness, rage, and collapse that result from the trauma
The adaptive information processing model (AIP) is the model that EMDR Therapy founder Dr. Francine Shapiro created to explain how unhealed traumatic memories are stored in the brain and ultimately lead to maladaptive responses. Until these unhealed memories are processed, maladaptive responses are likely to continue. Originally published as the accelerated information processing model in the first edition of her EMDR textbook in 1995, Shapiro renamed and retooled the model in the 2001 second edition of the text. Dr. Shapiro continues to present her updated model, the AIP model, as the theoretical underpinning of EMDR Therapy, although some of the wording currently published by the EMDR International Association and later versions of her writing have changed to correspond with updates made due to research and changes in the field.

Shapiro cites the work of Peter Lang (1977, 1979, 2000), Stanley Rachman (2000), Gordon Bower (2000), and Edna Foa & Michael Kozak (1986) as forerunners to the AIP model. The behaviorist work of Gagnè from the 1960’s (for a good review, see Gagnè & Medsker, 1996) also bears many similarities to the AIP model. If you are interested in deepening your study in this area, these citations are provided in the References section.

The following page offers the updated (as of 2014) working tenets of the adaptive information processing model.
The Adaptive Information Processing Model

- The neurobiological information processing system is intrinsic, physical, and adaptive
- This system is geared to integrate internal and external experiences
- Memories are stored in associative memory networks and are the basis of perception, attitude, and behavior
- Experiences are translated into physically stored memories
- Stored memory experiences are contributors to pathology and to health

- Trauma causes a disruption of normal adaptive information processing, which results in unprocessed information being dysfunctions held in memory networks
- Trauma can include DSM-5© Criterion A events and/or the experience of neglect or abuse that undermines an individual’s sense of self-worth, safety, ability to assume appropriate responsibility for self or other, or limits one’s sense of control or choices
- New experiences link into previously stored memories which are the basis of interpretations, feelings, and behaviors
- If high levels of disturbance accompany experiences, they may be stored in the implicit/non-declarative memory system.
- These memory networks contain the perspectives, affects, and sensations of the disturbing event and are stored in a way that does not allow them to connect with adaptive information networks
- When similar experiences occur (internally or externally), they link into the unprocessed memory networks and the negative perspective, affect, and/or sensations arise
- This expanding network reinforces the previous experiences
- Adaptive (positive) information, resources, and memories are also stored in memory networks

- Direct processing of the unprocessed information facilitates linkage to the adaptive memory networks and a transformation of all aspects of the memory
- Non-adaptive perceptions, affects, and sensations are discarded
- As processing occurs, there is a posited shift from implicit/non-declarative memory to explicit/declarative memory and from episodic to semantic memory systems (Stickgold, 2002)
- Processing of the memory causes an adaptive shift in all components of the memory, including sense of time and age, symptoms, reactive behaviors, and sense of self
• Clinical complaints that are not organically based or are caused by insufficient information are viewed as stemming from maladaptively stored and unprocessed information which has been unable to link with more adaptive information.

• Earlier memories which are maladaptively stored increase vulnerability to pathology including anxiety, depression, PTSD, and physical symptoms of stress and may interfere with healthy development of an individual’s sense of self-worth, safety, ability to assume appropriate responsibility for self or other, or limits one's sense of control or choices.

• The information processing system and stored associative memories are a primary focus of treatment.

• Procedures are geared to access and process dysfunctional memories and incorporate adaptive information.

• The intrinsic information processing system and the client’s own associative memory networks are the most effective and efficient means to achieve optimal clinical effects.

• Targeted memories must be accessed as currently stored so the appropriate associative connections are made throughout the relevant networks.

• Unimpeded processing allows the full range of associations to be made throughout the targeted memory and the larger integrated networks (i.e., generalizability).

• Interventions to assist blocked processing should mimic spontaneous processing (i.e., interweaves).

• All interventions change the natural course of processing and potentially close some associated pathways.

• Following any intervention, the target needs to be re-accessed and fully processed in the original form (i.e., reintegration).

• Processing shifts all elements of a memory to adaptive resolution.
Here are some tips based on clinical practice that seem to resonate with most clients. Of course, you may need to adjust your language depending on variables such as the client’s cognitive/educational abilities and stage of change.

• Explain the story of how Shapiro created EMDR therapy—most people can connect with a story.

• Get into some basics of the triune brain. Explain that sometimes the part of our brain that is rational (the pre-frontal cortex) goes offline when we are triggered by traumatic experiences and that there is a good reason for this: The emotionally driven part of our brain (the limbic brain) and/or the survival instincts (the reptilian brain) take over. Explain that the back-and-forth bilateral stimulation of EMDR helps the various parts of the brain communicate with each other.

• If a client has had talk therapy in the past and it hasn’t helped, some of these triune brain basics can be especially helpful, because you can explain that whereas talk therapy is designed to activate only the rational part of the brain, many traumatic memories are locked inside the other two parts of the brain that can’t be accessed easily through just talking. Bilateral stimulation can help access and process those memories.

• Let a client know that the bilateral stimulation itself won’t produce effects; rather, bringing up the material (either adaptive or maladaptive) together with the bilateral stimulation points the brain in the direction it needs to go.

• Using a pamphlet that is made available from sources like the EMDR International Association (EMDRIA) or pointing clients to YouTube videos (your faculty member will point you to some of their favorite) is an option. Be prepared to answer any questions and engage in discussion.
• With some clients, it’s appropriate not to even mention EMDR therapy as you get to know them. Let them know that you have a trauma focus in your approach and begin working with EMDR-style questioning, case conceptualization, and resourcing strategies as soon as possible. If the client is feeling a connection to this approach, especially if you’ve used some bilateral strategies in teaching skills, explaining EMDR therapy and explaining the benefits of taking the approach further will be much easier for you.

Be sure to review Jamie & Amber’s video, Explaining Bilateral/Dual Attention Stimulus to a Client on the Institute for Creative Mindfulness’ EMDR Video Resources Page.
Common “Blocking Beliefs”: Implications for Targeting Sequences & Treatment Planning

• I cannot show my emotions/ It’s not safe to show my emotions.

• have to be perfect/ I have to please everyone.

• I cannot handle it/ I cannot stand it.

• My (trauma/addiction/depression/anxiety) is my identity.

• What other “blocking beliefs” may speak directly to secondary gains or other issues?

• Are there any other blocking beliefs you’ve encountered in your practice of EMDR therapy thus far?
• Refer to the case study that you wrote up yesterday on p. 49.

• Now it is your turn to build a treatment plan using the language of EMDR therapy case conceptualization on the pages that follow.

• The sample Case Conceptualization Treatment Plan is included for your review, followed by a blank one for you to fill in using your case.
Case Conceptualization Treatment Plan: EMDR Therapy Approach

*Use as many of these pages as you need throughout your engagement with the client. Part of Phase 8 Reevaluation is to be continuously evaluating the treatment plan, writing new goals and objectives, and developing targets and future templates accordingly.

Presenting Issue:

relapse triggers—sober for 6 months and afraid of relapse

Goal & Desired Objectives:

to remain abstinent from alcohol and all mood-altering drugs—continued negative screens with monitoring program and moving forward with working on steps with sponsor

EMDR Preparation Resources, Targets or Future Templates to Address:

- Review and reinforce existing coping skills/recovery capital (sober support system, breath work, exercise)
- Develop an expanded set of resources (e.g., guided visualization, grounding, other body-based coping that resonate as effective with client)
- Target identified negative belief “I cannot cope with my feelings without alcohol” connected to memory from first drinking binge at 14 in response to having feelings continually negated at home, experiencing relief from alcohol
- Future template: visualizing activities of daily living as a sober person with more adaptive cognition (e.g., I can cope with my feelings without alcohol)

Presenting Issue:

performance anxiety, especially in the work setting

Goal & Desired Objectives:

To experience a greater sense of confidence in work performance--decrease mild panic that arises when reviewing performance evaluations, increased satisfaction with job

EMDR Preparation Resources, Targets or Future Templates to Address:

- Review and reinforce existing coping skills/recovery capital (sober support system, breathwork, exercise)
- Develop an expanded set of resources (e.g., guided visualization, grounding, other body-based coping that resonate as effective with client)
- Target negative belief of “I’m a failure” connected to several early memories
Presenting Issue:

Post-Traumatic Stress Disorder diagnosis—symptoms of trauma with hypervigilence and hyperarousal symptom proving most problematic in activities of daily living

Goal & Desired Objectives:

To decrease symptoms of hypervigilence from daily occurrence to less than 1-2x/week; to improve sleep quality by sleeping through the night for at least 6 hours on most nights out of the week. To decrease incidents of lashing out co-workers and other people generally identified as triggers to one time a week or less, with eventual goal of total elimination of such responses.

EMDR Preparation Resources, Targets or Future Templates to Address:

- Review and reinforce existing coping skills/recovery capital (sober support system, breathwork, exercise)
- Develop an expanded set of resources (e.g., guided visualization, grounding, other body-based coping that resonate as effective with client)
- Target identified negative belief of "I am not safe," connected to several identified earlier memories; "I cannot protect/defend myself" may be another area to explore related to similar memories

Presenting Issue:

Choking/vomiting phobia

Goal & Desired Objectives:

To eliminate irrational fears choking/vomiting; able to eat foods that usually are a concern (e.g., peanuts)

EMDR Preparation Resources, Targets or Future Templates to Address:

- Review and reinforce existing coping skills/recovery capital (sober support system, breathwork, exercise)
- Develop an expanded set of resources (e.g., guided visualization, grounding, other body-based coping that resonate as effective with client)
- Target antecedent events, first time fear was experienced, most disturbing experiences of the fear, most recent experiences of the fear, associated present stimuli, the physical sensations of other manifestations of the fear as recommended by Shapiro’s EMDR phobia protocol
- Future template: target future scenarios like eating peanuts, getting sick and handling without excess panic

(Use additional copies of this worksheet if needed)
Case Conceptualization Treatment Plan: EMDR Therapy Approach

*Use as many of these pages as you need throughout your engagement with the client. Part of Phase 8 Reevaluation is to be continuously evaluating the treatment plan, writing new goals and objectives, and developing targets and future templates accordingly.

Presenting Issue:

Goal & Desired Objectives:

EMDR Preparation Resources, Targets or Future Templates to Address:

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Presenting Issue:

Goal & Desired Objectives:

EMDR Preparation Resources, Targets or Future Templates to Address:

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Presenting Issue:

Goal & Desired Objectives:

EMDR Preparation Resources, Targets or Future Templates to Address:

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(Use additional copies of this worksheet if needed)
Qualities of a Good EMDR Therapist

(List by Parnell, 2007; Evaluation Questions by Marich, 2011)

1. Good clinical skills

   • How comfortable am I with implementing the most basic clinical strategies for safety (e.g., risk assessment, contracting for safety, seeking outside help when necessary)?

   • If an EMDR session did not go as planned, what other clinical skills do I have to work with so that I will not harm my client?

2. Ability to develop rapport with clients

   • What strategies have worked for me so far in establishing rapport at the first meeting with a client?

   • What are my struggles with forging a solid therapeutic relationship?

   • Are there certain populations with which I find it especially difficult to connect?

   • If it becomes clear that the client and I are not connecting after several sessions, am I willing to explore the potential problems and solutions? Would I be willing to make a referral?

3. Comfort with trauma and intense affect

   • How do I feel when a client enters a state of extreme emotional catharsis in my office (which can include, but is not limited to, intense crying, screaming, lashing out at a figure from the past, who is not in the office, such as a past abuser)?

   • What issues of my own do clients seem to provoke the most?

   • What aspects of trauma and its sequelae might I still find hard to grasp clinically or personally?
Qualities of a Good EMDR Therapist (con’t)

4. Spacious

- Have I ever forced a client to work on an area that they might not be ready to handle?
- Am I aware of the impact of presence in sessions and during moments of crisis and intense affect?
- What might my motives be for pushing a client to work on traumatic material that they are not yet ready to address?

5. Well-grounded

- Have I worked on my own issues when it comes to trauma, addiction, and mental health?
- What were my motives for getting trained in EMDR?
- Do I let the client lead the session, or is it the other way around most times?

6. Attuned to clients

- What issues may keep me from staying present with my client during sessions?
- At what times might I find myself drifting off or distracted during sessions?
- Am I able to read my clients’ non-verbal and para-verbal cues?
• You will be expected to complete the remainder of your individual or group consultation hours and send verification of these hours to the Institute for Creative Mindfulness before your final Certificate of Basic Training will be issued. As a reminder, you are required to work with an Institute of Creative Mindfulness consultant or consultants-in-training for these hours. Refer to our website for a current listing.

• Following the receipt of your Certificate of Basic Training, you will be able to refer to yourself as an EMDR trained Therapist.

• To formally use the title “Certified EMDR Therapist,” you are required to go through additional training and consultation as prescribed by the current standards of the EMDR International Association (EMDRIA). Please refer to www.emdria.org for the latest information on requirements.

• Whether or not you choose to pursue EMDRIA Certification, you are encouraged to continue with taking periodic continuing education courses specific to EMDR or consultation if you plan to continue practicing EMDR Therapy.

Wherever your journey with EMDR Therapy takes you next, your training team wishes you well and thanks you for the privilege of having you in our course!

Please stay in touch and let us know about your progress.
**Approved Consultant**

- *At least 3 years post EMDR Therapy Training*
- *Additional 20 hours of consultation* (learning the skills of being a consultant)
  - Additional 12 hours of EMDRIA-Approved education
  - At least 300 EMDR sessions with 75 clients
  - 3 letters of recommendation (one from primary consultant)
  - Fees to EMDRIA (see www.emdria.org)

**Certified EMDR Therapist (EMDRIA)**

- Successful completion of an approved Training Program
- 20 hours of consultation with any EMDRIA-Approved Consultant

☞ Although you may use a combination of consultants, one primary consultant must complete approximately 10 of the hours to write you a letter of recommendation upon completion of your hours; simple signature verification suffices on rest of the hours.
☞ Only 10 of these hours can be completed in the group format
☞ Up to 15 of these hours can be completed with a consultant-in-training as long as they are working with an Approved Consultant

- 12 hours of EMDRIA-Approved special topics courses or other approved continuing education (e.g., Annual Conference, ICM or other provider)
- Two years of professional licensure in your field (or be on post-Masters licensure track) and completion of at least 50 EMDR sessions with 25 clients; both requirements must be attested to via a notarized statement
- Additional 2 letters of recommendation from a colleague (does not have to be EMDR-specific)
- Fee to EMDRIA (see www.emdria.org); Renewal period every 2 years (additional 12 hours of EMDRIA-approved continuing education plus fee)

**Certificate of EMDR Therapy Training**

- Part 1 & Part 2 EMDR Therapy Training Courses (6 days)
- 10 hours of supplementary consultation (any combination of group or individual hours can be completed)
Consultation Documentation Form
EMDR Therapy Training Program
(The Institute for Creative Mindfulness)

Trainee’s Name: ___________________________________________

* At the Training level, you may complete your 10 hours in any combination: all group, all individual, or a combination.

** If consultation is completed over the phone or Skype, please have the consultant verify your completion of these hours via email or letter.

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SPECIAL SECTION

Practicum Worksheets
• In this latest edition of the training manual, we have all of your practicum worksheets assembled in one section so that you do not have to constantly be flipping back and forth to consult your notes.

• There is a set of worksheets to use when you are the therapist over the course of two practicum sessions, and there is a set of worksheets to use when you are the observer.

• When you are the client, please put your books down and let yourself be the client!
Worksheet Set 1

My Role (Circle One):

Therapist
Observer
Phase 1 History Taking (For Practicum & Initial Learning)

Ask partner for some general information about themselves to allow for rapport building in the practicum experience (5 minutes):

What are some of your strengths, assets, and resources?
*An alternate way to ask is “What are the things you have going for you, both internal and external?”

What do you want to work on during this practicum?
*Specific memories or general themes are both workable for practicum

What would you like to get out of doing this work? (e.g, goals and outcomes)
Target Selection

It is not important that we go through a detailed, chronological history. For many people, recounting a detailed history may be impossible until you’ve processed certain memories or you may not feel ready for it right now. Are there any themes you can identify related to your presenting issue(s) that seem to be keeping you stuck right now?

I. Presenting Issue:

A. Theme:
   1. *Negative Cognition:*
      a. First floatback memory:
      b. Worst floatback memory:
      c. Most recent floatback memory:

   2. *Negative Cognition:*
      a. First floatback memory:
      d. Worst floatback memory:
      e. Most recent floatback memory:

   3. *Negative Cognition:*
      a. First floatback memory:
      b. Worst floatback memory:
      c. Most recent floatback memory:

➢ In practicum we only expect you to work on one presenting issue.
   In clinical practice you may use as many of these worksheets as needed to work on other presenting issues.
➢ Use the negative cognitions list on the opposite page to help you
The “Greatest Hits” List of Negative Cognitions for Target Selection
Developed by Jamie Marich, Ph.D. (May be duplicated for use in clinical settings)

Responsibility
I should have known better.
I should have done something.
I did something wrong.
I am to blame.
I cannot be trusted.

Safety
I cannot trust myself.
I cannot trust anyone.
I am in danger.
I am not safe.
I cannot show my emotions.

Choice
I am not in control.
I have to be perfect/please everyone.
I am weak.
I am trapped.
I have no options.

Power
I cannot get what I want.
I cannot handle it/stand it.
I cannot succeed.
I cannot stand up for myself.
I cannot let it out.
I am powerless/helpless.

Value
I am a bad person./ I am terrible.
I am permanently damaged.
I am defective.
I am worthless/inadequate.
I am insignificant.
I am not important.
I deserve to die.
I deserve only bad things.
I am stupid.
I do not belong.
I am different.
I am a failure.
I am ugly.
My body is ugly.
I am alone.

How to Use:

➢ Have your client check off any negative beliefs that they may still hold in the present, especially those that go along with the presenting issue they have chosen.

➢ If more than 3 are checked, have them go over the list again and see if they can rank (1, 2, 3) the “hottest” or “most charged” beliefs.

➢ Once identified, ask them three floatback questions and document on facing page (use this wording):

a. Looking back over the course of your life, when is the first time you believed… (e.g., I am…; I cannot…; I do not…)

b. Looking back over the course of your life, when is the worst time you believed…

c. Looking back over the course of your life, when is the most recent time you believed…
Phase 2 Preparation: Resourcing (For Practicum & Initial Learning)

List of existing adaptive coping skills and resources (internal and/or external):

- 
- 
- 
- 
- 

Briefly review skills/resources and their use and allow client to demonstrate if applicable.

Teach the options for bilateral Dual Attention Stimulus (DAS) at the SLOW, SHORT rate and have client make their initial choice. Remember that slow varies from client-to-client.

Teach 1 (preferably 2 if time allows) of the three major choices covered in the course:

- ________ Light Stream
- ________ Calm Safe Place/Space
- ________ Container

Using the bilateral DAS of the client’s choosing (i.e., eye movements, tactile tapping, audio tones), therapist strengthens Calm Safe Place/Space, Light Stream, or container with SLOW, SHORT sets (at least 6-8 passes per set). Follow the scripts in your manual for guidance on how to apply while you are first learning.
Phase 2 Preparation: Stabilization and Resourcing (For Clinical Settings)

Exercises/coping skills that will likely work best in session (e.g., for closure):

Exercises/coping skills that will likely work best outside of session:

Nature of client’s support network & who knows that client is in EMDR Therapy:

Safety risks to note/Evaluation of protective factors:

Client’s understanding of EMDR/Questions or areas of concern to bear in mind:

Chosen form of bilateral DAS/Review speed differences and stop/pause sign technique:
• In general, slower, shorter sets are used for preparation and coming back to stabilization exercises or ending a session. Think of the gas pedal metaphor…slower, shorter sets will slow things down.

• Generally, reprocessing speed is faster and the sets are longer. Your live instructors will demonstrate the differences in speed as it is difficult to capture in writing.

• The traditional number suggested in most EMDR Therapy texts and instructional manuals suggest 24-36 passes with the bilateral stimulation as a long set for reprocessing.

• It is important to recognize that what is “slow” and what is “fast,” what is “long” and what is “short” vary from person to person.

• Thus, working out these logistical issues with speed will be part of the EMDR Therapy orientation processed in Phase 2 and being open to feedback from the client’s experience in Phases 4-6.

Check the Flight Plan: Before Beginning Phases 3-7 Targeting Sequence

________ Review at least one of the already strengthened resources from Phase 2 Preparation (e.g., Calm Safe Place, Light Stream, Container); it is not necessary to use any bilateral DAS at this point.

________ Establish which skill or resource is best to use as a return to safety, grounding or stabilization if client chooses to stop/pause reprocessing or if session is incomplete. Remind client that they are in control of the process and have the right to stop/pause. Review a stop/pause sign (preferably a physical gesture) for use if needed.

________ Test out speed of bilateral DAS (**fast and long, i.e., 24-36 passes**) for reprocessing in the client’s chosen modality to make sure they can comfortably track or tolerate the faster stimulation.

Proceed to targeting sequence (Phases 3-7) on next page →
Targeting Sequence Based on Shapiro’s 8-Phase Protocol
Phases 3-7

Phase 3: Assessment

TARGET (Memory or incident): __________________________________________

Image or worst part: Looking back on it now, what image represents the worst part of the target? (NOTE: If no image available or image doesn't carry much charge, simply have client think about the target or use another sensory channel like sound if that carries more charge)

Negative cognition: When you bring up that image (or worst part) now, what is the negative belief about yourself that goes along with it? (NOTE: Generally an “I am”/“I am not” statement)

Positive cognition: When you bring up the image (or worst part) of the target, what would you like to believe about yourself now? (NOTE: Encourage positive “I am” language instead of an “I am not” statement)

Validity of Cognition (VoC): As you look back on the image (or worst part) now, what is your gut-level feeling of how true that positive belief is right now with 1 being completely false and 7 being completely true?

Emotion: What emotions do you feel when you link the image (or worst part) with the negative belief of _________________________________?

Subjective Units of Disturbance (SUDs): What is your level of disturbance as you bring up the image (or worst part), the negative belief, and the emotions all together, with 0 being no disturbance or neutral and 10 being the worst you can imagine?

Location of Body Sensation: What are you noticing in your body in this moment as you bring up the image (or worst part), the negative belief, and the emotions all together?

Phase 4: Desensitization

Bring up the body sensation(s) together with the negative belief of _________________________________ and the image (or worst part) of the target memory. Notice whatever you notice as I begin the stimulation (e.g., FAST eye movements, tones, tactile stimulation)…. (turn page)
• Stay out of the way as much as possible, checking in after approximately 24-36 passes of bilateral DAS. After each set, invite a breath, and ask the client, “What are you getting? or “What are you noticing now?” The breadth of this open-ended question invites free association.

• When the client reports on what they are noticing now, continue with the next set of stimulation. Use the statements “Go with that,” or “Just notice that” to begin the next set of stimulation.

• You can have the client bring up the image (or worst part) and ask for a SUDs rating at any time to check in on progress when responses become more adaptive. Take care not to do this excessively. Use a statement such as, “When you return to the target image (or worst part) where we began, what is your level of distress in this moment with 0 being no disturbance or neutral and 10 being the worst you can imagine?” If SUDs is anything but 0, ask: “What keeps it from being a 0?” continue to “go with that.”

• If SUDs is not a 0 or as close as reasonable in this session: Go to Phase 7, Closure (skip Phases 5 & 6). If SUDs is 0 or as close as reasonable, move on to Phase 5 if time allows.

Phase 5: Installation

• Check the Positive Cognition: “When you bring up the image (or worst part), does the original positive belief of fit, or is there another positive belief that fits better now?”

• Now check the VoC of the arrived upon Positive Cognition: “What is your gut-level feeling of how true that positive belief is right now as you look back on the image (or worst part), with 1 being completely false and 7 being completely true.” If VoC is anything but 7, ask “What keeps it from being a 7 (completely true)” and keeping “going with that” until VoC is 7 or as close as reasonable.

• If VoC is not a 7 or as close as reasonable in this session, go to Phase 7-Closure (Skip Phase 6).

Phase 6: Body Scan

Now that the positive belief has been installed, what are you noticing as you scan your body?

• If there are residual disturbances, have the client notice and continue with fast sets until body scan is neutralized, then pair the statement above with at least one set of fast bilateral DAS.

• When body scan becomes adaptive/clear, do another set of FAST bilateral DAS, saying, “Hold that body scan together with the original target and the positive belief of .”

Phase 7: Closure. In the case of incomplete sessions, you may have jumped from Phase 4 or Phase 5 to Phase 7 and this is permissible. In closure you can utilize the resources built and strengthened in Phase 2 to quell any residual distress and ensure a safe departure with or without SLOW bilateral DAS. You may also engage in a general debriefing about the session, being mindful to address any client concerns. Apprise what could happen following the session (i.e., processing may continue after session ends), and review a plan for safety, stabilization, and contacting support if needed.
### "Greatest Hits List" of Negative & Positive Cognitions

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**Scripted Future Template Based on Shapiro’s 8-Phase Protocol**

**Detailed Positive Cognition (PC):**

**Target:** Can you bring up a situation that is likely to happen in the near future where the positive cognition will serve you? (NOTE: Related to original target is best)

**Image or worst part:** What image represents the worst part of this future scenario? (NOTE: If no image available or image doesn’t carry much charge, simply have client notice the target or use another sensory channel like sound if that carries more charge)

**Positive cognition:** When you bring up the image (or worst part) of the future scenario with the positive belief of [ ] what is your gut-level feeling of how true that feels to you right now with 1 being completely false and 7 being completely true?

---

**If the VoC is 7:**

Place that positive belief of [ ] together with the image (or worst part) of the future scenario.

Continue with at least two sets of **FAST** bilateral BLS/DAS, checking in between each set. When the client reports on what they are noticing now, continue with the next set of stimulation. Use the statements “Go with that,” or “Just notice that” to begin the next set of stimulation. After at least two sets of **FAST** bilateral DAS and material continues to be adaptive move to **Body Scan (back side of the page)**

**If the VoC is lower than a 7:**

**Emotion:** What emotions do you feel when you bring up the image (or worst part) of the future scenario?

**Subjective Units of Disturbance (SUDs):** What is your level of disturbance as you bring up the image (or worst part), with 0 being no disturbance or neutral and 10 being the worst you can imagine?

**Location of Body Sensation:** What are you noticing in your body in this moment as you bring up the image (or worst part), and the emotions all together?

Give FAST BLS/DAS after getting body sensation: **Go with that...** (Go to back side of page)
Stay out of the way as much as possible, checking in after approximately 24-36 passes of bilateral DAS. After each set, invite a breath, and ask the client, “What are you getting?” or “What are you noticing now?” The broadness of this open-ended question invites free association.

When the client reports on what they are noticing now, continue with the next set of stimulation. Use the statements “Go with that,” or “Just notice that” to begin the next set of stimulation.

You can then also ask for a SUDs rating at any time to check in on progress when responses become more adaptive. Take care not to do this excessively. Use a statement such as, “When you return to the future scenario where we began, what is your level of distress in this moment with 0 being no disturbance or neutral and 10 being the worst you can imagine?” If SUDs is anything but 0, ask: “What keeps it from being a 0?” and then continue with “go with that.”

Proceed with sets of BLS/DAS until SUDs of future target image or worst part is as close to 0 as possible.

Now check the VoC of the Positive Cognition: When you bring up the image (or worst part) of the future scenario with the positive belief of ____________________ (arrived upon positive belief from just completed related target memory) what is your gut-level feeling of how true that feels to you right now with 1 being completely false and 7 being completely true?

If VoC is anything but 7, ask “What keeps it from being a 7 (completely true)?” and keeping “going with that” until VoC is 7 or as close as reasonable.

Installation Statement (Once VoC returns to 7 or as close as reasonable)

Place that positive belief of ____________________ together with the image (or worst part) of the future scenario. (Apply at least two sets of bilateral DAS)

Body Scan

Now that the positive belief has been further installed, scan your body from head to toe: What are you noticing?

- If the body scan is clear/adaptive, do another set of FAST BLS/DAS, saying,
- “Hold that clear body scan together with the future scenario and the positive belief of ____________________.”
- If there are residual disturbances, have the client notice and continue with fast sets until body scan is clear, then pair the statement above with at least one set of fast BLS/DAS.

Closure

In closure you can utilize the resources built and strengthened in Phase 2 to quell any residual distress and ensure a safe departure with or without SLOW bilateral DAS. You may also engage in a general debriefing about the session or the future template itself, being mindful to address any client concerns. Apprise what could happen following the session (i.e., processing may continue after session ends), and review a plan for safety, stabilization, and contacting support if needed.
Starting a New Session in EMDR Therapy After Phases 3-6 Begin
(Part of Phase 8 Work)

General Check In
Hello there. So, what have you noticed since our last session? Any new insights, experiences, sensations? (You can alter specific wording to the client’s needs)

☑ In Case of Completed Target (SUDs=0/ VoC= 7/ Adaptive Body Scan)
When you bring up the target memory from last session, where would you rate the level of distress in this moment on a scale of 0-10 with 0 being no distress or neutral and 10 being the worst you can imagine? (NOTE: Do not mention the image or worst part and try to only mention the target memory itself if the client needs reminded. This is a general check in.)

- If SUDs > 0, determine if it is ecological/valid. If not, get out a clean worksheet and return to Phase 3
- If SUDs is 0 or an ecologically low number, check the VoC

How true does the Positive Cognition of __________________________ feel at your gut level in this moment when you bring up the target memory on a scale of 1-7 with 1 being completely false and 7 being completely true?

- If VoC < 7, determine if it is ecological/valid. If not, get out a clean worksheet and return to Phase 5
- If VoC is 7 or otherwise ecological, re-evaluate the Body Scan

What are you noticing in your body?
- If Body Scan is not adaptive, get out a clean worksheet and return to Phase 6
- If Body Scan is adaptive, the progress on the target is maintained. You may now:
  - Go directly to a Future Template if appropriate
  - Return to Phase 1 Client History and evaluate if other memories obtained in the same theme still carry a charge. If so, move on to reprocessing those or setting up a target for any feeder memories that emerged in reprocessing of original target that are related to treatment goals. Appropriate Future Templates can be visited at any time.
  - Treatment plan can be reviewed to determine new goals, directions, and related targets
- Get out a clean worksheet and begin with Phase 3
- Be mindful that the image or worst part may have changed although encourage the client to keep the Negative Cognition (NC) the same
- Continue with reprocessing until the target completes (if SUDs should go down to 0 naturally between sessions, be sure to check the VoC, install a positive cognition and do a body scan)
- If no forward movement is noted after three sessions, you may consider the following options:
  - Change the modality of bilateral DAS or experiment with set length
  - Consider if there are any other interweave strategies you haven’t tried
  - Evaluate if a blocking belief is interfering with forward movement and if client history needs to be completed around that blocking belief. Consider putting current target on pause and targeting a memory connected to the blocking belief.
  - Treatment plan can be reviewed to determine new goals, directions, and related targets
Phase 3: Assessment

TARGET (Memory or incident): ________________________________

**Image or worst part:** Looking back on it now, what image represents the worst part of the target? (NOTE: If no image available or image doesn't carry much charge, simply have client think about the target or use another sensory channel like sound if that carries more charge)

**Negative cognition:** When you bring up that image (or worst part) now, what is the negative belief about yourself that goes along with it? (NOTE: Generally an “I am”/“I am not” statement)

**Positive cognition:** When you bring up the image (or worst part) of the target, what would you like to believe about yourself now? (NOTE: Encourage positive “I am” language instead of an “I am not” statement)

**Validity of Cognition (VoC):** As you look back on the image (or worst part) now, what is your gut-level feeling of how true that positive belief is right now with 1 being completely false and 7 being completely true?

**Emotion:** What emotions do you feel when you link the image (or worst part) with the negative belief of ________________________________?

**Subjective Units of Disturbance (SUDs):** What is your level of disturbance as you bring up the image (or worst part), the negative belief, and the emotions all together, with 0 being no disturbance or neutral and 10 being the worst you can imagine?

**Location of Body Sensation:** What are you noticing in your body in this moment as you bring up the image (or worst part), the negative belief, and the emotions all together?

Phase 4: Desensitization

Bring up the body sensation(s) together with the negative belief of ________________________________ and the image (or worst part) of the target memory. Notice whatever you notice as I begin the stimulation (e.g., FAST eye movements, tones, tactile stimulation)…. (turn page)
• Stay out of the way as much as possible, checking in after approximately 24-36 passes of bilateral DAS. After each set, invite a breath, and ask the client, “What are you getting? or “What are you noticing now?” The broadness of this open-ended question invites free association.

• When the client reports on what they are noticing now, continue with the next set of stimulation. Use the statements “Go with that,” or “Just notice that” to begin the next set of stimulation.

• You can have the client bring up the image (or worst part) and ask for a SUDs rating at any time to check in on progress when responses become more adaptive. Take care not to do this excessively. Use a statement such as, “When you return to the target image (or worst part) where we began, what is your level of distress in this moment with 0 being no disturbance or neutral and 10 being the worst you can imagine?” If SUDs is anything but 0, ask: “What keeps it from being a 0?;” continue to “go with that.”

• If SUDs is not a 0 or as close as reasonable in this session: Go to Phase 7, Closure (skip Phases 5 & 6). If SUDs is 0 or as close as reasonable, move on to Phase 5 if time allows.

Phase 5: Installation

• Check the Positive Cognition: “When you bring up the image (or worst part), does the original positive belief of fit, or is there another positive belief that fits better now?”

• Now check the VoC of the arrived upon Positive Cognition: “What is your gut-level feeling of how true that positive belief is right now as you look back on the image (or worst part), with 1 being completely false and 7 being completely true.” If VoC is anything but 7, ask “What keeps it from being a 7 (completely true)?” and keeping “going with that” until VoC is 7 or as close as reasonable.

• If VoC is not a 7 or as close as reasonable in this session, go to Phase 7-Closure (Skip Phase 6). If VoC is 7 or as close as reasonable, proceed to installation statement and sets:

Place that positive belief of together with the original image (or worst part).

(NOTE: Continue with at least two sets of FAST bilateral DAS; check in between the sets as usual)

Phase 6: Body Scan

Now that the positive belief has been installed, what are you noticing as you scan your body?

• If there are residual disturbances, have the client notice and continue with fast sets until body scan is neutralized, then pair the statement above with at least one set of fast bilateral DAS.

• When body scan becomes adaptive/clear, do another set of FAST bilateral DAS, saying, “Hold that body scan together with the original target and the positive belief of “.

Phase 7: Closure. In the case of incomplete sessions, you may have jumped from Phase 4 or Phase 5 to Phase 7 and this is permissible. In closure you can utilize the resources built and strengthened in Phase 2 to quell any residual distress and ensure a safe departure with or without SLOW bilateral DAS. You may also engage in a general debriefing about the session, being mindful to address any client concerns. Apprise what could happen following the session (i.e., processing may continue after session ends), and review a plan for safety, stabilization, and contacting support if needed.
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Scripted Future Template Based on Shapiro’s 8-Phase Protocol

Called Positive Cognition (PC):

**get**: Can you bring up a situation that is likely to happen in the near future where the positive cognition will serve you? (NOTE: Related to original target is best)

**ge or worst part**: What image represents the worst part of this future scenario?

*NOTE: If no image available or image doesn't carry much charge, simply have client notice the target use another sensory channel like sound if that carries more charge*

**positive cognition**: When you bring up the image (or worst part) of the future scenario with the positive belief of what is your gut-level feeling of how true that feels to you right now with 1 being completely false and 7 being completely true?

---

If the VoC is 7:

- If the positive belief of together with the image (or worst part) of the future scenario.

Continue with at least two sets of **FAST** bilateral BLS/DAS, checking in between each set. When the client reports on what they are noticing now, continue with the next set of stimulation. Use the statements “Go with that,” or “Just notice that” to begin the next set of stimulation. After at least two sets of **FAST** bilateral DAS and material continues to be adaptive move to Body Scan (back side of the page)

If the VoC is lower than a 7:

**emotion**: What emotions do you feel when you bring up the image (or worst part) of the future scenario?

**Subjective Units of Disturbance (SUDs)**: What is your level of disturbance as you bring up the image (or worst part), with 0 being no disturbance or neutral and 10 being the worst you can imagine?

**Location of Body Sensation**: What are you noticing in your body in this moment as you bring up the image (or worst part), and the emotions all together?

In **FAST** BLS/DAS after getting body sensation: Go with that... (Go to back side of page)
• Stay out of the way as much as possible, checking in after approximately 24-36 passes of bilateral DAS. After each set, invite a breath, and ask the client, “What are you getting? or “What are you noticing now?” The broadness of this open-ended question invites free association.

• When the client reports on what they are noticing now, continue with the next set of stimulation. Use the statements “Go with that,” or “Just notice that” to begin the next set of stimulation.

• You can then also ask for a SUDs rating at any time to check in on progress when responses become more adaptive. Take care not to do this excessively. Use a statement such as, “When you return to the future scenario where we began, what is your level of distress in this moment with 0 being no disturbance or neutral and 10 being the worst you can imagine?” If SUDs is anything but 0, ask: “What keeps it from being a 0?” and then continue with “go with that.”

• Proceed with sets of BLS/DAS until SUDs of future target image or worst part is as close to 0 as possible.

• Now check the VoC of the Positive Cognition: When you bring up the image (or worst part) of the future scenario with the positive belief of ____________________(arrived upon positive belief from just completed related target memory) what is your gut-level feeling of how true that feels to you right now with 1 being completely false and 7 being completely true?

• If VoC is anything but 7, ask “What keeps it from being a 7 (completely true)?” and keeping “going with that” until VoC is 7 or as close as reasonable.

Installation Statement (Once VoC returns to 7 or as close as reasonable)

Place that positive belief of ___________________________ together with the image (or worst part) of the future scenario. (Apply at least two sets of bilateral DAS)

Body Scan

Now that the positive belief has been further installed, scan your body from head to toe: What are you noticing?

• If the body scan is clear/adaptive, do another set of FAST BLS/DAS, saying,
• “Hold that clear body scan together with the future scenario and the positive belief of ___________________________. “

• If there are residual disturbances, have the client notice and continue with fast sets until body scan is clear, then pair the statement above with at least one set of fast BLS/DAS.

Closure

In closure you can utilize the resources built and strengthened in Phase 2 to quell any residual distress and ensure a safe departure with or without SLOW bilateral DAS. You may also engage in a general debriefing about the session or the future template itself, being mindful to address any client concerns. Apprise what could happen following the session (i.e., processing may continue after session ends), and review a plan for safety, stabilization, and contacting support if needed.
Worksheet Set 2

My role (Circle one):
Therapist
Observer
Phase 1 History Taking (For Practicum & Initial Learning)

Ask partner for some general information about themselves to allow for rapport building in the practicum experience (5 minutes):

What are some of your strengths, assets, and resources?
*An alternate way to ask is “What are the things you have going for you, both internal and external?”

What do you want to work on during this practicum?
*Specific memories or general themes are both workable for practicum

What would you like to get out of doing this work? (e.g, goals and outcomes)
Target Selection

It is not important that we go through a detailed, chronological history. For many people, recounting a detailed history may be impossible until you’ve processed certain memories or you may not feel ready for it right now. Are there any themes you can identify related to your presenting issue(s) that seem to be keeping you stuck right now?

I. Presenting Issue:

A. Theme:
   1. *Negative Cognition*:
      a. First floatback memory:
      b. Worst floatback memory:
      c. Most recent floatback memory:

   2. *Negative Cognition*:
      a. First floatback memory:
      d. Worst floatback memory:
      e. Most recent floatback memory:

   3. *Negative Cognition*:
      a. First floatback memory:
      b. Worst floatback memory:
      c. Most recent floatback memory:

➢ In practicum we only expect you to work on one presenting issue.
   In clinical practice you may use as many of these worksheets as needed to work on other presenting issues.
➢ Use the negative cognitions list on the opposite page to help you
The “Greatest Hits” List of Negative Cognitions for Target Selection
Developed by Jamie Marich, Ph.D. (May be duplicated for use in clinical settings)

Responsibility
I should have known better.
I should have done something.
I did something wrong.
I am to blame.
I cannot be trusted.

Safety
I cannot trust myself.
I cannot trust anyone.
I am in danger.
I am not safe.
I cannot show my emotions.

Choice
I am not in control.
I have to be perfect/please everyone.
I am weak.
I am trapped.
I have no options.

Power
I cannot get what I want.
I cannot handle it/stand it.
I cannot succeed.
I cannot stand up for myself.
I cannot let it out.
I am powerless/helpless.

Value
I am a bad person./ I am terrible.
I am permanently damaged.
I am defective.
I am worthless/inadequate.
I am insignificant.
I am not important.
I deserve to die.
I deserve only bad things.
I am stupid.
I do not belong.
I am different.
I am a failure.
I am ugly.
My body is ugly.
I am alone.

How to Use:

- Have your client check off any negative beliefs that they may still hold in the present, especially those that go along with the presenting issue they have chosen.
- If more than 3 are checked, have them go over the list again and see if they can rank (1, 2, 3) the “hottest” or “most charged” beliefs.
- Once identified, ask them three floatback questions and document on facing page (use this wording):

  a. Looking back over the course of your life, when is the first time you believed… (e.g., I am…; I cannot…; I do not…)
  b. Looking back over the course of your life, when is the worst time you believed…
  c. Looking back over the course of your life, when is the most recent time you believed…
List of existing adaptive coping skills and resources (internal and/or external):

- 
- 
- 
- 
- 

Briefly review skills/resources and their use and allow client to demonstrate if applicable.

Teach the options for bilateral Dual Attention Stimulus (DAS) at the SLOW, SHORT rate and have client make their initial choice. Remember that slow varies from client-to-client.

Teach 1 (preferably 2 if time allows) of the three major choices covered in the course:

_______ Light Stream

_______ Calm Safe Place/Space

_______ Container

Using the bilateral DAS of the client’s choosing (i.e., eye movements, tactile tapping, audio tones), therapist strengthens Calm Safe Place/Space, Light Stream, or container with SLOW, SHORT sets (at least 6-8 passes per set). Follow the scripts in your manual for guidance on how to apply while you are first learning.
Phase 2 Preparation: Stabilization and Resourcing (For Clinical Settings)

Exercises/coping skills that will likely work best in session (e.g., for closure):

Exercises/coping skills that will likely work best outside of session:

Nature of client’s support network & who knows that client is in EMDR Therapy:

Safety risks to note/Evaluation of protective factors:

Client’s understanding of EMDR/Questions or areas of concern to bear in mind:

Chosen form of bilateral DAS/Review speed differences and stop/pause sign technique:
• In general, slower, shorter sets are used for preparation and coming back to stabilization exercises or ending a session. Think of the gas pedal metaphor…slower, shorter sets will slow things down.

• Generally, reprocessing speed is faster and the sets are longer. Your live instructors will demonstrate the differences in speed as it is difficult to capture in writing.

• The traditional number suggested in most EMDR Therapy texts and instructional manuals suggest 24-36 passes with the bilateral stimulation as a long set for reprocessing.

• It is important to recognize that what is “slow” and what is “fast,” what is “long” and what is “short” vary from person to person.

• Thus, working out these logistical issues with speed will be part of the EMDR Therapy orientation processed in Phase 2 and being open to feedback from the client’s experience in Phases 4-6.

Check the Flight Plan: Before Beginning Phases 3-7 Targeting Sequence

________ Review at least one of the already strengthened resources from Phase 2 Preparation (e.g., Calm Safe Place, Light Stream, Container); it is not necessary to use any bilateral DAS at this point.

________ Establish which skill or resource is best to use as a return to safety, grounding or stabilization if client chooses to stop/pause reprocessing or if session is incomplete. Remind client that they are in control of the process and have the right to stop/pause. Review a stop/pause sign (preferably a physical gesture) for use if needed.

________ Test out speed of bilateral DAS (fast and long, i.e., **24-36 passes**) for reprocessing in the client’s chosen modality to make sure they can comfortably track or tolerate the faster stimulation.

Proceed to targeting sequence (Phases 3-7) on next page ➔
Targeting Sequence Based on Shapiro’s 8-Phase Protocol
Phases 3-7

Phase 3: Assessment

TARGET (Memory or incident): ____________________________________________

**Image or worst part:** Looking back on it now, what image represents the worst part of the target?
*(NOTE: If no image available or image doesn't carry much charge, simply have client think about the target or use another sensory channel like sound if that carries more charge)*

**Negative cognition:** When you bring up that image (or worst part) now, what is the negative belief about yourself that goes along with it? *(NOTE: Generally an “I am”/”I am not” statement)*

**Positive cognition:** When you bring up the image (or worst part) of the target, what would you like to believe about yourself now? *(NOTE: Encourage positive “I am” language instead of an “I am not” statement)*

**Validity of Cognition (VoC):** As you look back on the image (or worst part) now, what is your gut-level feeling of how true that positive belief is right now with 1 being completely false and 7 being completely true?

**Emotion:** What emotions do you feel when you link the image (or worst part) with the negative belief of______________________________?

**Subjective Units of Disturbance (SUDs):** What is your level of disturbance as you bring up the image (or worst part), the negative belief, and the emotions all together, with 0 being no disturbance or neutral and 10 being the worst you can imagine?

**Location of Body Sensation:** What are you noticing in your body in this moment as you bring up the image (or worst part), the negative belief, and the emotions all together?

Phase 4: Desensitization

Bring up the body sensation(s) together with the negative belief of______________________________ and the image (or worst part) of the target memory. Notice whatever you notice as I begin the stimulation (e.g., FAST eye movements, tones, tactile stimulation).... (turn page)
• Stay out of the way as much as possible, checking in after approximately 24-36 passes of bilateral DAS. After each set, invite a breath, and ask the client, “What are you getting? or “What are you noticing now?” The broadness of this open-ended question invites free association.

• When the client reports on what they are noticing now, continue with the next set of stimulation. Use the statements “Go with that,” or “Just notice that” to begin the next set of stimulation.

• You can have the client bring up the image (or worst part) and ask for a SUDs rating at any time to check in on progress when responses become more adaptive. Take care not to do this excessively. Use a statement such as, “When you return to the target image (or worst part) where we began, what is your level of distress in this moment with 0 being no disturbance or neutral and 10 being the worst you can imagine?” If SUDs is anything but 0, ask: “What keeps it from being a 0?;” continue to “go with that.”

• If SUDs is not a 0 or as close as reasonable in this session: Go to Phase 7, Closure (skip Phases 5 & 6). If SUDs is 0 or as close as reasonable, move on to Phase 5 if time allows.

Phase 5: Installation

• Check the Positive Cognition: “When you bring up the image (or worst part), does the original positive belief of fit, or is there another positive belief that fits better now?”

• Now check the VoC of the arrived upon Positive Cognition: “What is your gut-level feeling of how true that positive belief is right now as you look back on the image (or worst part), with 1 being completely false and 7 being completely true.” If VoC is anything but 7, ask “What keeps it from being a 7 (completely true)?“ and keeping “going with that” until VoC is 7 or as close as reasonable.

• If VoC is not a 7 or as close as reasonable in this session, go to Phase 7-Closure (Skip Phase 6).

If VoC is 7 or as close as reasonable, proceed to installation statement and sets:

Place that positive belief of together with the original image (or worst part).

(Note: Continue with at least two sets of FAST bilateral DAS; check in between the sets as usual)

Phase 6: Body Scan

Now that the positive belief has been installed, what are you noticing as you scan your body?

• If there are residual disturbances, have the client notice and continue with fast sets until body scan is neutralized, then pair the statement above with at least one set of fast bilateral DAS.

• When body scan becomes adaptive/clear, do another set of FAST bilateral DAS, saying, “Hold that body scan together with the original target and the positive belief of “.

Phase 7: Closure. In the case of incomplete sessions, you may have jumped from Phase 4 or Phase 5 to Phase 7 and this is permissible. In closure you can utilize the resources built and strengthened in Phase 2 to quell any residual distress and ensure a safe departure with or without SLOW bilateral DAS. You may also engage in a general debriefing about the session, being mindful to address any client concerns. Apprise what could happen following the session (i.e., processing may continue after session ends), and review a plan for safety, stabilization, and contacting support if needed.
## “Greatest Hits List” of Negative & Positive Cognitions

<table>
<thead>
<tr>
<th>NEGANIVE COGNITIONS</th>
<th>POSITIVE COGNITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Responsibility</strong></td>
<td><strong>Responsibility</strong></td>
</tr>
<tr>
<td>I should have known better</td>
<td>I did the best I could</td>
</tr>
<tr>
<td>I should have done something</td>
<td>I do the best I can with what I have</td>
</tr>
<tr>
<td>I did something wrong</td>
<td>I did/do my best</td>
</tr>
<tr>
<td>I am to blame</td>
<td>I am blameless/I am not at fault</td>
</tr>
<tr>
<td>I cannot be trusted</td>
<td>I can be trusted</td>
</tr>
<tr>
<td>My best is not good enough</td>
<td>I am okay/I do my best</td>
</tr>
<tr>
<td><strong>Safety</strong></td>
<td><strong>Safety</strong></td>
</tr>
<tr>
<td>I cannot trust myself</td>
<td>I can trust myself</td>
</tr>
<tr>
<td>I cannot trust anyone</td>
<td>I can choose who to trust</td>
</tr>
<tr>
<td>I am in danger</td>
<td>I am safe now</td>
</tr>
<tr>
<td>I am not safe</td>
<td>I can create my sense of safety</td>
</tr>
<tr>
<td>I cannot show my emotions</td>
<td>I can show my emotions</td>
</tr>
<tr>
<td><strong>Choice</strong></td>
<td><strong>Choice</strong></td>
</tr>
<tr>
<td>I am not in control</td>
<td>I am in control</td>
</tr>
<tr>
<td>I have to be perfect/please everyone</td>
<td>I have power now</td>
</tr>
<tr>
<td>I am weak</td>
<td>I can help myself</td>
</tr>
<tr>
<td>I am trapped</td>
<td>I have a way out</td>
</tr>
<tr>
<td>I have no options</td>
<td>I have options</td>
</tr>
<tr>
<td><strong>Power</strong></td>
<td><strong>Power</strong></td>
</tr>
<tr>
<td>I cannot get what I want</td>
<td>I can get what I want</td>
</tr>
<tr>
<td>I cannot handle it/stand it</td>
<td>I can handle it</td>
</tr>
<tr>
<td>I cannot succeed</td>
<td>I can succeed</td>
</tr>
<tr>
<td>I cannot stand up for myself</td>
<td>I can stand up for myself</td>
</tr>
<tr>
<td>I cannot let it out</td>
<td>I can let it out</td>
</tr>
<tr>
<td>I am powerless/helpless</td>
<td>I am powerful</td>
</tr>
<tr>
<td><strong>Value</strong></td>
<td><strong>Value</strong></td>
</tr>
<tr>
<td>I am not good enough</td>
<td>I am good enough</td>
</tr>
<tr>
<td>I am a bad person./I am terrible</td>
<td>I am a good person</td>
</tr>
<tr>
<td>I am permanently damaged</td>
<td>I am restored/I am sacred</td>
</tr>
<tr>
<td>I am defective</td>
<td>I am whole</td>
</tr>
<tr>
<td>I am worthless/inadequate</td>
<td>I am worthy</td>
</tr>
<tr>
<td>I am insignificant/I am not important</td>
<td>I am significant/I am important</td>
</tr>
<tr>
<td>I deserve to die</td>
<td>I deserve to live</td>
</tr>
<tr>
<td>I deserve only bad things</td>
<td>I deserve only good things</td>
</tr>
<tr>
<td>I am stupid</td>
<td>I am smart</td>
</tr>
<tr>
<td>I do not belong</td>
<td>I can belong</td>
</tr>
<tr>
<td>I am different</td>
<td>I am special</td>
</tr>
<tr>
<td>I am a failure</td>
<td>I am a success</td>
</tr>
<tr>
<td>I am ugly/My body is ugly</td>
<td>I am beautiful/My body is sacred</td>
</tr>
<tr>
<td>I am alone</td>
<td>I am support</td>
</tr>
</tbody>
</table>
Scripted Future Template Based on Shapiro’s 8-Phase Protocol

**Target:** Can you bring up a situation that is likely to happen in the near future where the positive cognition will serve you? (NOTE: Related to original target is best)

**Image or worst part:** What image represents the worst part of this future scenario?

NOTE: If no image available or image doesn't carry much charge, simply have client notice the target use another sensory channel like sound if that carries more charge)

**Positive cognition:** When you bring up the image (or worst part) of the future scenario with the positive belief of __________________________ what is your gut-level feeling of how true that feels to you right now with 1 being completely false and 7 being completely true?

---

**If the VoC is 7:**

Place that positive belief of __________________________ together with the image (or worst part) of the future scenario.

Continue with at least two sets of FAST bilateral BLS/DAS, checking in between each set.

When the client reports on what they are noticing now, continue with the next set of stimulation. Use the statements “Go with that,” or “Just notice that” to begin the next set of stimulation.

After at least two sets of FAST bilateral DAS and material continues to be adaptive move to Body Scan (back side of the page)

**If the VoC is lower than a 7:**

**Emotion:** What emotions do you feel when you bring up the image (or worst part) of the future scenario?

**Subjective Units of Disturbance (SUDs):** What is your level of disturbance as you bring up the image (or worst part), with 0 being no disturbance or neutral and 10 being the worst you can imagine?

**Location of Body Sensation:** What are you noticing in your body in this moment as you bring up the image (or worst part), and the emotions all together?

**Finish FAST BLS/DAS after getting body sensation:** Go with that… (Go to back side of page)
• Stay out of the way as much as possible, checking in after approximately 24-36 passes of bilateral DAS. After each set, invite a breath, and ask the client, “What are you getting?” or “What are you noticing now?” The broadness of this open-ended question invites free association.

• When the client reports on what they are noticing now, continue with the next set of stimulation. Use the statements “Go with that,” or “Just notice that” to begin the next set of stimulation.

• You can then also ask for a SUDs rating at any time to check in on progress when responses become more adaptive. Take care not to do this excessively. Use a statement such as, “When you return to the future scenario where we began, what is your level of distress in this moment with 0 being no disturbance or neutral and 10 being the worst you can imagine?” If SUDs is anything but 0, ask: “What keeps it from being a 0?” and then continue with “go with that.”

• Proceed with sets of BLS/DAS until SUDs of future target image or worst part is as close to 0 as possible.

• Now check the VoC of the Positive Cognition: When you bring up the image (or worst part) of the future scenario with the positive belief of ____________________ (arrived upon positive belief from just completed related target memory) what is your gut-level feeling of how true that feels to you right now with 1 being completely false and 7 being completely true?

• If VoC is anything but 7, ask “What keeps it from being a 7 (completely true)?” and keeping “going with that” until VoC is 7 or as close as reasonable.

Installation Statement (Once VoC returns to 7 or as close as reasonable)

Place that positive belief of __________________ together with the image (or worst part) of the future scenario. (Apply at least two sets of bilateral DAS)

Body Scan

Now that the positive belief has been further installed, scan your body from head to toe: What are you noticing?

• If the body scan is clear/adaptive, do another set of FAST BLS/DAS, saying,

• “Hold that clear body scan together with the future scenario and the positive belief of __________________.”

• If there are residual disturbances, have the client notice and continue with fast sets until body scan is clear, then pair the statement above with at least one set of fast BLS/DAS.

Closure

In closure you can utilize the resources built and strengthened in Phase 2 to quell any residual distress and ensure a safe departure with or without SLOW bilateral DAS. You may also engage in a general debriefing about the session or the future template itself, being mindful to address any client concerns. Apprise what could happen following the session (i.e., processing may continue after session ends), and review a plan for safety, stabilization, and contacting support if needed.
Starting a New Session in EMDR Therapy After Phases 3-6 Begin
(Part of Phase 8 Work)

General Check In
Hello there. So, what have you noticed since our last session? Any new insights, experiences, sensations? (You can alter specific wording to the client’s needs)

➢ In Case of Completed Target (SUDs=0/ VoC= 7/ Adaptive Body Scan)
When you bring up the target memory from last session, where would you rate the level of distress in this moment on a scale of 0-10 with 0 being no distress or neutral and 10 being the worst you can imagine? (NOTE: Do not mention the image or worst part and try to only mention the target memory itself if the client needs reminded. This is a general check in.)

- If SUDs > 0, determine if it is ecological/valid. If not, get out a clean worksheet and return to Phase 3
- If SUDs is 0 or an ecologically low number, check the VoC

How true does the Positive Cognition of __________________________ feel at your gut level in this moment when you bring up the target memory on a scale of 1-7 with 1 being completely false and 7 being completely true?

- If VoC < 7, determine if it is ecological/valid. If not, get out a clean worksheet and return to Phase 5
- If VoC is 7 or otherwise ecological, re-evaluate the Body Scan

What are you noticing in your body?
- If Body Scan is not adaptive, get out a clean worksheet and return to Phase 6
- If Body Scan is adaptive, the progress on the target is maintained. You may now:
  ➢ Go directly to a Future Template if appropriate
  ➢ Return to Phase 1 Client History and evaluate if other memories obtained in the same theme still carry a charge. If so, move on to reprocessing those or setting up a target for any feeder memories that emerged in reprocessing of original target that are related to treatment goals. Appropriate Future Templates can be visited at any time.
  ➢ Treatment plan can be reviewed to determine new goals, directions, and related targets
In Case of Incomplete Target
(Where Phase 5 Installation or Phase 6 Body Scan Did Not Occur)

- Get out a clean worksheet and begin with Phase 3
- Be mindful that the image or worst part may have changed although encourage the client to keep the Negative Cognition (NC) the same
- Continue with reprocessing until the target completes (if SUDs should go down to 0 naturally between sessions, be sure to check the VoC, install a positive cognition and do a body scan)
- If no forward movement is noted after three sessions, you may consider the following options:
  - Change the modality of bilateral DAS or experiment with set length
  - Consider if there are any other interweave strategies you haven’t tried
  - Evaluate if a blocking belief is interfering with forward movement and if client history needs to be completed around that blocking belief. Consider putting current target on pause and targeting a memory connected to the blocking belief.
  - Treatment plan can be reviewed to determine new goals, directions, and related targets
Phase 3: Assessment

TARGET (Memory or incident): ________________________________

Image or worst part: Looking back on it now, what image represents the worst part of the target?
(NOTE: If no image available or image doesn’t carry much charge, simply have client think about the target or use another sensory channel like sound if that carries more charge)

Negative cognition: When you bring up that image (or worst part) now, what is the negative belief about yourself that goes along with it? (NOTE: Generally an “I am”/”I am not” statement)

Positive cognition: When you bring up the image (or worst part) of the target, what would you like to believe about yourself now? (NOTE: Encourage positive “I am” language instead of an “I am not” statement)

Validity of Cognition (VoC): As you look back on the image (or worst part) now, what is your gut-level feeling of how true that positive belief is right now with 1 being completely false and 7 being completely true?

Emotion: What emotions do you feel when you link the image (or worst part) with the negative belief of ____________________________?

Subjective Units of Disturbance (SUDs): What is your level of disturbance as you bring up the image (or worst part), the negative belief, and the emotions all together, with 0 being no disturbance or neutral and 10 being the worst you can imagine?

Location of Body Sensation: What are you noticing in your body in this moment as you bring up the image (or worst part), the negative belief, and the emotions all together?

Phase 4: Desensitization

Bring up the body sensation(s) together with the negative belief of ____________________________ and the image (or worst part) of the target memory. Notice whatever you notice as I begin the stimulation (e.g., FAST eye movements, tones, tactile stimulation).... (turn page)
• Stay out of the way as much as possible, checking in after approximately 24-36 passes of bilateral DAS. After each set, invite a breath, and ask the client, “What are you getting? or “What are you noticing now?” The breadth of this open-ended question invites free association.

• When the client reports on what they are noticing now, continue with the next set of stimulation. Use the statements “Go with that,” or “Just notice that” to begin the next set of stimulation.

• You can have the client bring up the image (or worst part) and ask for a SUDs rating at any time to check in on progress when responses become more adaptive. Take care not to do this excessively. Use a statement such as, “When you return to the target image (or worst part) where we began, what is your level of distress in this moment with 0 being no disturbance or neutral and 10 being the worst you can imagine?” If SUDs is anything but 0, ask: “What keeps it from being a 0?” “What keeps it from being a 0?,” continue to “go with that.”

• If SUDs is not a 0 or as close as reasonable in this session: Go to Phase 7, Closure (skip Phases 5 & 6). If SUDs is 0 or as close as reasonable, move on to Phase 5 if time allows.

Phase 5: Installation

• Check the Positive Cognition: “When you bring up the image (or worst part), does the original positive belief of fit, or is there another positive belief that fits better now?”

• Now check the VoC of the arrived upon Positive Cognition: “What is your gut-level feeling of how true that positive belief is right now as you look back on the image (or worst part), with 1 being completely false and 7 being completely true.” If VoC is anything but 7, ask “What keeps it from being a 7 (completely true)?” and keeping “going with that” until VoC is 7 or as close as reasonable.

• If VoC is not a 7 or as close as reasonable in this session, go to Phase 7-Closure (Skip Phase 6). If VoC is 7 or as close as reasonable, proceed to installation statement and sets:

Place that positive belief of together with the original image (or worst part).

(NOTE: Continue with at least two sets of FAST bilateral DAS; check in between the sets as usual)

Phase 6: Body Scan

Now that the positive belief has been installed, what are you noticing as you scan your body?

• If there are residual disturbances, have the client notice and continue with fast sets until body scan is neutralized, then pair the statement above with at least one set of fast bilateral DAS.

• When body scan becomes adaptive/clear, do another set of FAST bilateral DAS, saying, “Hold that body scan together with the original target and the positive belief of “.

Phase 7: Closure. In the case of incomplete sessions, you may have jumped from Phase 4 or Phase 5 to Phase 7 and this is permissible. In closure you can utilize the resources built and strengthened in Phase 2 to quell any residual distress and ensure a safe departure with or without SLOW bilateral DAS. You may also engage in a general debriefing about the session, being mindful to address any client concerns. Apprise what could happen following the session (i.e., processing may continue after session ends), and review a plan for safety, stabilization, and contacting support if needed.
SCRATCH NOTES:
### “Greatest Hits List” of Negative & Positive Cognitions

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Scripted *Future Template* Based on Shapiro’s 8-Phase Protocol

**called Positive Cognition (PC):**

**get:** Can you bring up a situation that is likely to happen in the near future where the positive cognition will serve you? *(NOTE: Related to original target is best)*

**ge or worst part:** What image represents the worst part of this future scenario?

*OTE: If no image available or image doesn't carry much charge, simply have client notice the target (see another sensory channel like sound if that carries more charge)*

**itive cognition:** When you bring up the image (or worst part) of the future scenario with the positive belief of ___________________________ what is your gut-level feeling of how true that feels to you right now with 1 being completely false and 7 being completely true?

**If the VoC is 7:**

Place that positive belief of ___________________________ together with the image (or worst part) of the future scenario.

*Continue with at least two sets of FAST bilateral BLS/DAS, checking in between each set When the client reports on what they are noticing now, continue with the next set of stimulation. Use the statements “Go with that,” or “Just notice that” to begin the next set of stimulation. After at least two sets of FAST bilateral DAS and material continues to be adaptive move to Body Scan (back side of the page)*

**If the VoC is lower than a 7:**

**otion:** What emotions do you feel when you bring up the image (or worst part) of the future scenario?

**jective Units of Disturbance (SUDs):** What is your level of disturbance as you bring up the image (or worst part), with 0 being no disturbance or neutral and 10 being the worst you can imagine?

**ation of Body Sensation:** What are you noticing in your body in this moment as you bring up the image (or worst part), and the emotions all together?

*in FAST BLS/DAS after getting body sensation: Go with that... (Go to back side of page)*
• Stay out of the way as much as possible, checking in after approximately 24-36 passes of bilateral DAS. After each set, invite a breath, and ask the client, “What are you getting?” or “What are you noticing now?” The broadness of this open-ended question invites free association.
• When the client reports on what they are noticing now, continue with the next set of stimulation. Use the statements “Go with that,” or “Just notice that” to begin the next set of stimulation.
• You can then also ask for a SUDs rating at any time to check in on progress when responses become more adaptive. Take care not to do this excessively. Use a statement such as, “When you return to the future scenario where we began, what is your level of distress in this moment with 0 being no disturbance or neutral and 10 being the worst you can imagine?” If SUDs is anything but 0, ask: “What keeps it from being a 0?” and then continue with “go with that.”
• Proceed with sets of BLS/DAS until SUDs of future target image or worst part is as close to 0 as possible.
• Now check the VoC of the Positive Cognition: When you bring up the image (or worst part) of the future scenario with the positive belief of _______________________(arrived upon positive belief from just completed related target memory) what is your gut-level feeling of how true that feels to you right now with 1 being completely false and 7 being completely true?
• If VoC is anything but 7, ask “What keeps it from being a 7 (completely true)?” and keeping “going with that” until VoC is 7 or as close as reasonable.

Installation Statement (Once VoC returns to 7 or as close as reasonable)

Place that positive belief of ______________________ together with the image (or worst part) of the future scenario. (Apply at least two sets of bilateral DAS)

Body Scan
Now that the positive belief has been further installed, scan your body from head to toe: What are you noticing?

• If the body scan is clear/adaptive, do another set of FAST BLS/DAS, saying,
• “Hold that clear body scan together with the future scenario and the positive belief of ______________________.”
• If there are residual disturbances, have the client notice and continue with fast sets until body scan is clear, then pair the statement above with at least one set of fast BLS/DAS.

Closure
In closure you can utilize the resources built and strengthened in Phase 2 to quell any residual distress and ensure a safe departure with or without SLOW bilateral DAS. You may also engage in a general debriefing about the session or the future template itself, being mindful to address any client concerns. Apprise what could happen following the session (i.e., processing may continue after session ends), and review a plan for safety, stabilization, and contacting support if needed.
APPENDIX A:

Clean Copies of Worksheets & DES

Your faculty member will also provide you with a link at your training or in a follow-up email on how to access .pdf versions online.
Phase 1 History Taking (For Clinical Use)

Background: Intake information already used in your clinical setting, initial rapport building, obtaining client’s understanding of trauma and basic psychoeducation on trauma:

What are some of your strengths, assets, and resources?
*An alternate way to ask is “What are the things you have going for you, both internal and external?”

What do you want to work on during this practicum?
*Specific memories or general themes are both workable for practicum

What would you like to get out of doing this work? (e.g, goals and outcomes)
Target Selection

It is not important that we go through a detailed, chronological history. For many people, recounting a detailed history may be impossible until you’ve processed certain memories or you may not feel ready for it right now. Are there any themes you can identify related to your presenting issue(s) that seem to be keeping you stuck right now?

Presenting Issue:

A. Theme:
   1. Negative Cognition:
      o First floatback memory:
      o Worst floatback memory:
      o Most recent floatback memory:

   2. Negative Cognition:
      a. First floatback memory:
      o Worst floatback memory:
      o Most recent floatback memory:

   3. Negative Cognition:
      a. First floatback memory:
      b. Worst floatback memory:
      c. Most recent floatback memory:
B. Theme:

1. *Negative Cognition*:
   a. First floatback memory:
   b. Worst floatback memory:
   c. Most recent floatback memory:

2. *Negative Cognition*:
   a. First floatback memory:
   b. Worst floatback memory:
   c. Most recent floatback memory:

3. *Negative Cognition*:
   a. First floatback memory:
   d. Worst floatback memory:
   e. Most recent floatback memory:

- Use the .docx file provided in the supplementary electronic handouts to add as many themes as you need under a particular presenting issue (C, D, E, etc.)
- You may also use the worksheet to correspond with each new presenting issue
The “Greatest Hits” List of Problematic Beliefs (Negative Cognitions)
Developed by Jamie Marich, Ph.D. (May be duplicated for use in clinical settings)

Responsibility
I should have known better.
I should have done something.
I did something wrong.
I am to blame.
I cannot be trusted.

Safety
I cannot trust myself.
I cannot trust anyone.
I am in danger.
I am not safe.
I cannot show my emotions.

Choice
I am not in control.
I have to be perfect/please everyone.
I am weak.
I am trapped.
I have no options.

Power
I cannot get what I want.
I cannot handle it/stand it.
I cannot succeed.
I cannot stand up for myself.
I cannot let it out.
I am powerless/helpless.

Value
I am a bad person./ I am terrible.
I am permanently damaged.
I am defective.
I am worthless/inadequate.
I am insignificant.
I am not important.
I deserve to die.
I deserve only bad things.
I am stupid.
I do not belong.
I am different.
I am a failure.
I am ugly.
My body is ugly.
I am alone.

How to Use:

- Have your client check off any negative beliefs that they may still hold in the present, especially those that go along with the presenting issue they have chosen.
- If more than 3 are checked, have them go over the list again and see if they can rank (1, 2, 3) the “hottest” or “most charged” beliefs.
- Once identified, ask them three floatback questions and document on facing page (use this wording):

  a. Looking back over the course of your life, when is the first time you believed…
     (e.g., I am…; I cannot…; I do not…)

  b. Looking back over the course of your life, when is the worst time you believed…

  c. Looking back over the course of your life, when is the most recent time you believed…
Phase 2 Preparation: Resourcing (For Practicum & Initial Learning)

List of existing adaptive coping skills and resources (internal and/or external):

- 
- 
- 
- 
- 

Briefly review skills/resources and their use and allow client to demonstrate if applicable.

Teach the options for bilateral Dual Attention Stimulus (DAS) at the SLOW, SHORT rate and have client make their initial choice. Remember that slow varies from client-to-client.

Teach 1 (preferably 2 if time allows) of the three major choices covered in the course:

_______  Light Stream

_______  Calm Safe Place/Space

_______  Container

Using the bilateral DAS of the client’s choosing (i.e., eye movements, tactile tapping, audio tones), therapist strengthens Calm Safe Place/Space, Light Stream, or container with SLOW, SHORT sets (at least 6-8 passes per set). Follow the scripts in your manual for guidance on how to apply while you are first learning.
Phase 2 Preparation: Stabilization and Resourcing (For Clinical Settings)

Exercises/coping skills that will likely work best in session (e.g., for closure):

Exercises/coping skills that will likely work best outside of session:

Nature of client’s support network & who knows that client is in EMDR Therapy:

Safety risks to note/Evaluation of protective factors:

Client's understanding of EMDR/Questions or areas of concern to bear in mind:

Chosen form of bilateral DAS/Review speed differences and stop/pause sign technique:
Phase 3: Assessment

TARGET (Memory or incident): ________________________________

Image or worst part: Looking back on it now, what image represents the worst part of the target? (NOTE: If no image available or image doesn't carry much charge, simply have client think about the target or use another sensory channel like sound if that carries more charge)

Negative cognition: When you bring up that image (or worst part) now, what is the negative belief about yourself that goes along with it? (NOTE: Generally an “I am”/”I am not” statement)

Positive cognition: When you bring up the image (or worst part) of the target, what would you like to believe about yourself now? (NOTE: Encourage positive “I am” language instead of an “I am not” statement)

Validity of Cognition (VoC): As you look back on the image (or worst part) now, what is your gut-level feeling of how true that positive belief is right now with 1 being completely false and 7 being completely true?

Emotion: What emotions do you feel when you link the image (or worst part) with the negative belief of ________________________________?

Subjective Units of Disturbance (SUDs): What is your level of disturbance as you bring up the image (or worst part), the negative belief, and the emotions all together, with 0 being no disturbance or neutral and 10 being the worst you can imagine?

Location of Body Sensation: What are you noticing in your body in this moment as you bring up the image (or worst part), the negative belief, and the emotions all together?

Phase 4: Desensitization

Bring up the body sensation(s) together with the negative belief of ________________________________ and the image (or worst part) of the target memory. Notice whatever you notice as I begin the stimulation (e.g., FAST eye movements, tones, tactile stimulation)…. (turn page)
Stay out of the way as much as possible, checking in after approximately 24-36 passes of bilateral DAS. After each set, invite a breath, and ask the client, “What are you getting? or “What are you noticing now?” The breadth of this open-ended question invites free association.

When the client reports on what they are noticing now, continue with the next set of stimulation. Use the statements “Go with that,” or “Just notice that” to begin the next set of stimulation.

You can have the client bring up the image (or worst part) and ask for a SUDs rating at any time to check in on progress when responses become more adaptive. Take care not to do this excessively. Use a statement such as, “When you return to the target image (or worst part) where we began, what is your level of distress in this moment with 0 being no disturbance or neutral and 10 being the worst you can imagine?” If SUDs is anything but 0, ask: “What keeps it from being a 0?” continue to “go with that.”

If SUDs is not a 0 or as close as reasonable in this session: Go to Phase 7, Closure (skip Phases 5 & 6). If SUDs is 0 or as close as reasonable, move on to Phase 5 if time allows.

Phase 5: Installation

Check the Positive Cognition: “When you bring up the image (or worst part), does the original positive belief of ___________ fit, or is there another positive belief that fits better now?”

Now check the VoC of the arrived upon Positive Cognition: “What is your gut-level feeling of how true that positive belief is right now as you look back on the image (or worst part), with 1 being completely false and 7 being completely true.” If VoC is anything but 7, ask “What keeps it from being a 7 (completely true)?” and keeping “going with that” until VoC is 7 or as close as reasonable.

If VoC is not a 7 or as close as reasonable in this session, go to Phase 7-Closure (Skip Phase 6). If VoC is 7 or as close as reasonable, proceed to installation statement and sets:

Place that positive belief of ___________ together with the original image (or worst part).

(NOTE: Continue with at least two sets of FAST bilateral DAS; check in between the sets as usual)

Phase 6: Body Scan

Now that the positive belief has been installed, what are you noticing as you scan your body?

If there are residual disturbances, have the client notice and continue with fast sets until body scan is neutralized, then pair the statement above with at least one set of fast bilateral DAS.

When body scan becomes adaptive/clear, do another set of FAST bilateral DAS, saying, “Hold that body scan together with the original target and the positive belief of ___________ “.

Phase 7: Closure. In the case of incomplete sessions, you may have jumped from Phase 4 or Phase 5 to Phase 7 and this is permissible. In closure you can utilize the resources built and strengthened in Phase 2 to quell any residual distress and ensure a safe departure with or without SLOW bilateral DAS. You may also engage in a general debriefing about the session, being mindful to address any client concerns. Apprise what could happen following the session (i.e., processing may continue after session ends), and review a plan for safety, stabilization, and contacting support if needed.
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The “Greatest Hits” List of Addiction-Specific Beliefs
Developed by Jamie Marich, Ph.D. (May be duplicated for use in clinical settings)

Potential Floatbacks*
(first, worst, most recent connected memories)

I cannot cope without alcohol.
I cannot cope without drugs.
I cannot cope without cigarettes.
I cannot cope without sex.
I cannot cope without acting out violently.
I cannot cope without victimizing others.
I cannot cope with emotions without eating.
I cannot cope without gambling.
I cannot cope without hurting myself.
My addiction is my security.
My addiction is my identity.
I have no identity if I can’t act out.
I am nothing without my addiction.
I am not capable of dealing with my feelings.
I am not capable of dealing with my life.
I cannot accept/deal with reality.
I am not capable of dealing with my past.
I must drink alcohol to be in control.
I must use drugs to be in control.
I must smoke cigarettes to be in control.
I must gamble to be in control.
I must be in a relationship to be in control.
I must have sex to be in control.
I must eat to be in control.
I must injure myself to be in control.
I must act out violently to be in control.
I must victimize others to be in control.
I am incapable of being social without drugs.
I am incapable of being social without cigarettes.
I can’t be social without alcohol.
Starting a New Session in EMDR Therapy After Phases 3-6 Begin
(Part of Phase 8 Work)

General Check In
Hello there. So, what have you noticed since our last session? Any new insights, experiences, sensations? (You can alter specific wording to the client’s needs)

➢ In Case of Completed Target (SUDs=0/ VoC= 7/ Adaptive Body Scan)
When you bring up the target memory from last session, where would you rate the level of distress in this moment on a scale of 0-10 with 0 being no distress or neutral and 10 being the worst you can imagine? (NOTE: Do not mention the image or worst part and try to only mention the target memory itself if the client needs reminded. This is a general check in.)

- If SUDs > 0, determine if it is ecological/valid. If not, get out a clean worksheet and return to Phase 3
- If SUDs is 0 or an ecologically low number, check the VoC

How true does the Positive Cognition of __________________________ feel at your gut level in this moment when you bring up the target memory on a scale of 1-7 with 1 being completely false and 7 being completely true?

- If VoC < 7, determine if it is ecological/valid. If not, get out a clean worksheet and return to Phase 5
- If VoC is 7 or otherwise ecological, re-evaluate the Body Scan

What are you noticing in your body?
- If Body Scan is not adaptive, get out a clean worksheet and return to Phase 6
- If Body Scan is adaptive, the progress on the target is maintained. You may now:
  ➢ Go directly to a Future Template if appropriate
  ➢ Return to Phase 1 Client History and evaluate if other memories obtained in the same theme still carry a charge. If so, move on to reprocessing those or setting up a target for any feeder memories that emerged in reprocessing of original target that are related to treatment goals. Appropriate Future Templates can be visited at any time.
  ➢ Treatment plan can be reviewed to determine new goals, directions, and related targets
In Case of Incomplete Target
(Where Phase 5 Installation or Phase 6 Body Scan Did Not Occur)

- Get out a clean worksheet and begin with Phase 3
- Be mindful that the image or worst part may have changed although encourage the client to keep the Negative Cognition (NC) the same
- Continue with reprocessing until the target completes (if SUDs should go down to 0 naturally between sessions, be sure to check the VoC, install a positive cognition and do a body scan)
- If no forward movement is noted after three sessions, you may consider the following options:
  - Change the modality of bilateral DAS or experiment with set length
  - Consider if there are any other interweave strategies you haven’t tried
  - Evaluate if a blocking belief is interfering with forward movement and if client history needs to be completed around that blocking belief. Consider putting current target on pause and targeting a memory connected to the blocking belief.
  - Treatment plan can be reviewed to determine new goals, directions, and related targets
Scripted Future Template Based on Shapiro's 8-Phase Protocol

Installed Positive Cognition (PC):

Target: Can you bring up a situation that is likely to happen in the near future where the positive cognition will serve you? (NOTE: Related to original target is best)

Image or worst part: What image represents the worst part of this future scenario? (NOTE: If no image available or image doesn’t carry much charge, simply have client notice the target or use another sensory channel like sound if that carries more charge)

Positive cognition: When you bring up the image (or worst part) of the future scenario with the positive belief of _______________ what is your gut-level feeling of how true that feels to you right now with 1 being completely false and 7 being completely true?

If the VoC is 7:
Place that positive belief together with the image (or worst part) of the future scenario.

• Continue with at least two sets of FAST bilateral BLS/DAS, checking in between each set
• When the client reports on what they are noticing now, continue with the next set of stimulation. Use the statements “Go with that,” or “Just notice that” to begin the next set of stimulation.
• After at least two sets of FAST bilateral DAS and material continues to be adaptive move to Body Scan (back side of the page)

If the VoC is lower than a 7:

Emotion: What emotions do you feel when you bring up the image (or worst part) of the future scenario?

Subjective Units of Disturbance (SUDs): What is your level of disturbance as you bring up the image (or worst part), with 0 being no disturbance or neutral and 10 being the worst you can imagine?

Location of Body Sensation: What are you noticing in your body in this moment as you bring up the image (or worst part), and the emotions all together?

Begin FAST BLS/DAS after getting body sensation: Go with that… (Go to back side of page)
• Stay out of the way as much as possible, checking in after approximately 24-36 passes of bilateral DAS. After each set, invite a breath, and ask the client, “What are you getting? or “What are you noticing now?” The broadness of this open-ended question invites free association.
• When the client reports on what they are noticing now, continue with the next set of stimulation. Use the statements “Go with that,” or “Just notice that” to begin the next set of stimulation.
• You can then also ask for a SUDs rating at any time to check in on progress when responses become more adaptive. Take care not to do this excessively. Use a statement such as, “When you return to the future scenario where we began, what is your level of distress in this moment with 0 being no disturbance or neutral and 10 being the worst you can imagine?” If SUDs is anything but 0, ask: “What keeps it from being a 0?” and then continue with “go with that.”
• Proceed with sets of BLS/DAS until SUDs of future target image or worst part is as close to 0 as possible.
• Now check the VoC of the Positive Cognition: When you bring up the image (or worst part) of the future scenario with the positive belief of ____________________(arrived upon positive belief from just completed related target memory) what is your gut-level feeling of how true that feels to you right now with 1 being completely false and 7 being completely true?
• If VoC is anything but 7, ask “What keeps it from being a 7 (completely true)?” and keeping “going with that” until VoC is 7 or as close as reasonable.

Installation Statement (Once VoC returns to 7 or as close as reasonable)

Place that positive belief of _______________________ together with the image (or worst part) of the future scenario. (Apply at least two sets of bilateral DAS)

Body Scan

Now that the positive belief has been further installed, scan your body from head to toe: What are you noticing?

• If the body scan is clear/adaptive, do another set of FAST BLS/DAS, saying,
• “Hold that clear body scan together with the future scenario and the positive belief of _______________________.”
• If there are residual disturbances, have the client notice and continue with fast sets until body scan is clear, then pair the statement above with at least one set of fast BLS/DAS.

Closure

In closure you can utilize the resources built and strengthened in Phase 2 to quell any residual distress and ensure a safe departure with or without SLOW bilateral DAS. You may also engage in a general debriefing about the session or the future template itself, being mindful to address any client concerns. Apprise what could happen following the session (i.e., processing may continue after session ends), and review a plan for safety, stabilization, and contacting support if needed.
Simple Targeting Sequence List For Clinical Tracking

<table>
<thead>
<tr>
<th>Target Set Up (Phases 3-7 Worksheet)</th>
<th>Outcome/Plan</th>
</tr>
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<tbody>
<tr>
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## Simple Conceptualization Sheet For Clinical Tracking & Re-Evaluation

**Present Triggers**

<table>
<thead>
<tr>
<th>Theme/Event</th>
<th>=&gt; Negative Cognition (rank ordered)</th>
<th>=&gt; Memory/Event</th>
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<tbody>
<tr>
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<td>1.</td>
<td>First</td>
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**Future Template**

Future Template

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Dissociative Experiences Scale (DES)

(Eva Bernstein Carlson & Frank W. Putnam)

Directions: This questionnaire consists of twenty-eight questions about experiences that you may have in your daily life. We are interested in how often you have these experiences. It is important, however, that your answers show how often these experiences happen to you when you are not under the influence of alcohol or drugs. To answer the questions, please determine to what degree the experience described in the question applies to you and circle the number to show what percentage of the time you have the experience.

Example:
(never) 0% 10 20 30 40 50 60 70 80 90 100% (always)

1. Some people have the experience of driving a car and suddenly realizing that they don’t remember what has happened during all or part of the trip.
Circle a number to show what percentage of the time this happens to you.
(never) 0% 10 20 30 40 50 60 70 80 90 100% (always)

2. Some people find that sometimes they are listening to someone talk and they suddenly realize that they did not hear all or part of what was said.
Circle a number to show what percentage of the time this happens to you.
(never) 0% 10 20 30 40 50 60 70 80 90 100% (always)

3. Some people have the experience of finding themselves in a place and having no idea how they got there.
Circle a number to show what percentage of the time this happens to you.
(never) 0% 10 20 30 40 50 60 70 80 90 100% (always)

4. Some people have the experience of finding themselves dressed in clothes that they don’t remember putting on.
Circle a number to show what percentage of the time this happens to you.
(never) 0% 10 20 30 40 50 60 70 80 90 100% (always)

5. Some people have the experience of finding new things among their belongings that they do not remember buying.
Circle a number to show what percentage of the time this happens to you.
(never) 0% 10 20 30 40 50 60 70 80 90 100% (always)
6. Some people sometimes find that they are approached by people that they do not know who call them by another name or insist that they have met them before.

Circle a number to show what percentage of the time this happens to you.
(never)  0%  10  20  30  40  50  60  70  80  90  100%  (always)

7. Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something as if they were looking at another person.

Circle a number to show what percentage of the time this happens to you.
(never)  0%  10  20  30  40  50  60  70  80  90  100%  (always)

8. Some people are told that they sometimes do not recognize friends or family members.

Circle a number to show what percentage of the time this happens to you.
(never)  0%  10  20  30  40  50  60  70  80  90  100%  (always)

9. Some people find that they have no memory for some important events in their lives (for example, a wedding or graduation).

Circle a number to show what percentage of the time this happens to you.
(never)  0%  10  20  30  40  50  60  70  80  90  100%  (always)

10. Some people have the experience of being accused of lying when they do not think that they have lied.

Circle a number to show what percentage of the time this happens to you.
(never)  0%  10  20  30  40  50  60  70  80  90  100%  (always)

11. Some people have the experience of looking in a mirror and not recognizing themselves.

Circle a number to show what percentage of the time this happens to you.
(never)  0%  10  20  30  40  50  60  70  80  90  100%  (always)

12. Some people sometimes have the experience of feeling that other people, objects, and the world around them are not real.

Circle a number to show what percentage of the time this happens to you.
(never)  0%  10  20  30  40  50  60  70  80  90  100%  (always)

13. Some people sometimes have the experience of feeling that their body does not belong to them.

Circle a number to show what percentage of the time this happens to you.
(never)  0%  10  20  30  40  50  60  70  80  90  100%  (always)
14. Some people have the experience of sometimes remembering a past event so vividly that they feel as if they were reliving that event.
Circle a number to show what percentage of the time this happens to you.
(never) 0% 10 20 30 40 50 60 70 80 90 100% (always)

15. Some people have the experience of not being sure whether things that they remember happening really did happen or whether they just dreamed them.
Circle a number to show what percentage of the time this happens to you.
(never) 0% 10 20 30 40 50 60 70 80 90 100% (always)

16. Some people have the experience of being in a familiar place but finding it strange and unfamiliar.
Circle a number to show what percentage of the time this happens to you.
(never) 0% 10 20 30 40 50 60 70 80 90 100% (always)

17. Some people find that when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them.
Circle a number to show what percentage of the time this happens to you.
(never) 0% 10 20 30 40 50 60 70 80 90 100% (always)

18. Some people sometimes find that they become so involved in a fantasy or daydream that it feels as though it were really happening to them.
Circle a number to show what percentage of the time this happens to you.
(never) 0% 10 20 30 40 50 60 70 80 90 100% (always)

19. Some people find that they are sometimes able to ignore pain.
Circle a number to show what percentage of the time this happens to you.
(never) 0% 10 20 30 40 50 60 70 80 90 100% (always)

20. Some people find that they sometimes sit staring off into space, thinking of nothing, and are not aware of the passage of time.
Circle a number to show what percentage of the time this happens to you.
(never) 0% 10 20 30 40 50 60 70 80 90 100% (always)

21. Some people sometimes find that when they are alone they talk out loud to themselves.
Circle a number to show what percentage of the time this happens to you.
(never) 0% 10 20 30 40 50 60 70 80 90 100% (always)
22. Some people find that in one situation they may act so differently compared with another situation that they feel almost as if they were different people.

Circle a number to show what percentage of the time this happens to you.
(never) 0% 10 20 30 40 50 60 70 80 90 100% (always)

23. Some people sometimes find that in certain situations they are able to do things with amazing ease and spontaneity that would usually be difficult for them (for example, sports, work, social situations, etc.).

Circle a number to show what percentage of the time this happens to you.
(never) 0% 10 20 30 40 50 60 70 80 90 100% (always)

24. Some people sometimes find that they cannot remember whether they have done something or have just thought about doing that thing (for example, not knowing whether they have just mailed a letter or have just thought about mailing it).

Circle a number to show what percentage of the time this happens to you.
(never) 0% 10 20 30 40 50 60 70 80 90 100% (always)

25. Some people find evidence that they have done things that they do not remember doing.

Circle a number to show what percentage of the time this happens to you.
(never) 0% 10 20 30 40 50 60 70 80 90 100% (always)

26. Some people sometimes find writings, drawings, or notes among their belongings that they must have done but cannot remember doing.

Circle a number to show what percentage of the time this happens to you.
(never) 0% 10 20 30 40 50 60 70 80 90 100% (always)

27. Some people find that they sometimes hear voices inside their head that tell them to do things or comment on things that they are doing.

Circle a number to show what percentage of the time this happens to you.
(never) 0% 10 20 30 40 50 60 70 80 90 100% (always)

28. Some people sometimes feels as if they are looking at the world through a fog so that people or objects appear far away or unclear.

Circle a number to show what percentage of the time this happens to you.
(never) 0% 10 20 30 40 50 60 70 80 90 100% (always)

For more information on scoring go to- The DES Taxon Calendar:
https://www.isst-d.org/default.asp?contentID=66
APPENDIX B:

Mindfulness-Informed Activities for Preparation, Stabilization, and Resourcing
**MONKEY TAP (I.E., BUTTERFLY HUG)**

In nature, primates cross their arms over their chest and tap their shoulders in an alternating manner to self-soothe. In this exercise, we will duplicate this experience with mindful intent as a way of being gentle with ourselves and practicing self-soothing.

- Cross your arms over your chest.
- Begin tapping your hands against your body in a slow, deliberate, alternating fashion…
- Find a pace that for you is slow, soothing or grounding. Tapping quickly can induce anxiety so you may want to spend a set or two finding this ideal pace.
- Tap for about a minute and then return your hands to your lap or the table and breathe. Repeat as many sets as needed for grounding, rest, or relaxation. Notice what happens when you can embrace this tapping like its own mindful meditation experience, using the taps as your point of focus.

**Modification and Application:**

- Tapping on the knees, tapping the feet, or making “OK” signs with the index finger to thumb are all appropriate alternatives to Monkey/Butterfly tapping.
- Although this exercise can be mindful and calming in and of itself by simply, mindfully focusing on the tapping, pairing the tapping with a calming scent, a pleasant thought, a positive cognition, or any other positive experience can be sensory paradise!
Using the visual power of your imagination can be remarkably healing, especially to clear out some of the body-level distress or discomfort that you may have identified or described. Here is a very simple guided visualization exercise that you can use to work with that distress or discomfort:

- Imagine that a bright and healing light is forming overhead. This light can be whatever color you want it to be: whatever you associate with healing, happiness, goodness, or any other positive quality. If you don’t like the idea of a light, you can think of it simply as a color or an essence… (pause) “Take a breath. What are you noticing now?”

(Apply slow, short sets to reinforce if response is adaptive)

- Now, think about this light beginning to move through your body or over your body like a shield or force field (your choice), from the top of your head, moving inch-by-inch, slowly, until it reaches the bottom of your feet… “Take a breath. What are you noticing now?”

(Apply slow, short sets to reinforce if response is adaptive)

- Spend a few moments just noticing the presence of this light or essence in your body. Notice if you want the light to have any other qualities besides color, like a texture or a sound, a temperature or a smell… “Take a breath. What are you noticing now?”

(Apply slow, short sets to reinforce if response is adaptive)

- Draw your attention back to where you first may have noticed or described distress at the body level… what’s happened to it? If the distress is still there on some level in the body, think about deepening your breath so it makes the light or essence more brilliant and intense… so brilliant and intense that the distress dissolves into it.

(If client reports adaptive experience, apply slow, short sets to reinforce)

- Keep practicing the exercise, in the attitude of patience, if you don’t notice much of a shift the first time.

(Apply slow, short sets to reinforce if responses are adaptive, modifying as you might need to for each client)
Modification and Application:

- If you have a spiritual belief system, you can imagine the light coming from a spiritual source (e.g., heaven, God/Goddess/god/G-D, Jesus, the universe, etc.)

- The light/essence can enter anywhere in the body. For instance, if your chest anxiety is very high, it may feel more appropriate to have the light enter there.

- For clients who struggle with grounding, it may be more appropriate to have the light enter in from the earth through the feet. This modification may also be appropriate for clients with a history of spiritual abuse or trauma who will automatically associate light coming in through the head as spiritual/religious.

- If the light stream image by itself is hard to keep in focus, add another sensory element to enhance the focus (e.g., smell, simple sound or music, tactile sensation).

- Although in many traditional EMDR Therapy trainings this technique is taught as a session closure device, many of us prefer it to the classic “Calm Safe Place” as a Preparation exercise because it promotes here-and-now focus instead of creating a place outside of yourself that may come with triggering potential. Moreover, if you teach it well and the client grasps it in Phase 2 Preparation, it will be more likely that a client can access it well during Phase 7 Closure.
Calm Safe Place/Space Guided Visualization

This exercise and its many variations are classics in guided imagery work. Sometimes called the “Happy Place,” the purpose of this exercise is for you to sense into a place that you’ve been or that you can imagine going. Choose a place where bringing it up and engaging it will likely elicit a pleasant, happy, or safe experience. Try to keep other people out of the visualization—make it just about you and the place. We can talk together to try to come up with a good one before we formally begin.

Allow the place you chose to come into focus. Let’s scan your senses and allow each sense to experience the place. What are you seeing? How would you describe the colors? What are the sounds, if any, in your place? Are there any smells or tastes? If so, notice those. Where are your hands and feet? Notice any sensations they are experiencing..... (pause)

“What are you noticing now?” .................................................................

(Apply slow, short sets to reinforce if response is adaptive)

• Take a moment to notice the details. What is most noticeable you? Take a moment to absorb that detail or those details…. “Take a breath. What are you noticing now?”

(Apply slow, short sets to reinforce if response is adaptive)

• Notice what you are doing in this place of yours. Whether you are in stillness or in motion, pay attention to that.... “Take a breath. What are you noticing now?”

(Apply slow, short sets to reinforce if response is adaptive)

NOTE: From this point, you can use the client’s feedback to continue building a calm safe place that is personal to them; apply slow, short sets of DAS if client desires

• Notice what your body is experiencing in this place. (NOTE: If the body sensation isn’t positive, grounded or adaptive, you can ask what they would need to feel more positive, grounded, or adaptive in the place and modify accordingly; apply slow, short sets of DAS if client desires)

• If you wish, give your place and your experience in it a word or a phrase. This word or phrase will be your cue to access the place whenever you might need it.

(Apply slow, short sets to reinforce the cue word)
Modification and Application:

- Guided visualizations of this nature can promote dissociation. Although the intent is positive/adaptive, clients struggling with dissociation may be triggered or taken further into a dissociative state. Thus, it is generally good practice to make sure you’ve tried some of the other skills first so that there’s a “safety net” for the “Calm Safe Place” if needed.

- Let the client know that this exercise can be done with the eyes open. Much of the overwhelm that guided visualizations cause clients who dissociate or struggle with more complex trauma can be averted by opening the eyes. Our tendency in leading many of these exercises is to invite clients to “close the eyes” yet this can do more harm than good.

- Like with many of the exercises already covered, having the client hold onto a solid object can help with grounding.

- For children and the artistically inclined, drawing or crafting the Safe Place may be a lovely option that promotes a higher degree of engagement. Going this route may also prove to be a viable option for clients who are prone to dissociative tendencies.

- A goal is to help clients focus on responses without talking too much or analyzing the experience excessively. However, while the client is getting used to doing this type of silent inquiry, promoting dialogue during the visualization can help the client feel more connected to you and the process. Staying in silence too long at first can lead to drifting off.
Containers come in various shapes, and they can hold things for us that we are not quite ready to digest and address. What are some examples of containers that you can think of? A Mason jar? A shelf with a drawer? A piece of Tupperware? A tin? A backpack? A box for leftovers? In this exercise, we will help you choose a visual that you can use to “pack away” memories, emotions, body sensations, or anything else that you are not quite ready to deal with, or that we may not have time to address in a specific session.

- Pick a visual representation of a container that works for you. Many containers can work for this purpose. You can choose something that carries great meaning for you or something that is more neutral…(pause) What are you coming up with?

- Picture yourself opening the container. Send in or picture yourself placing whatever you may need to place in the container. Consider that this exercise is not about stuffing it away…it’s simply helping you to manage the negativity until you are ready to deal with it…. “Take a breath. What are you noticing now?”

(Apply slow, short sets to reinforce if response is adaptive)

- Close the container. Notice the experience and any sensations that come up with closing the container. Remember to breath evenly…. “Take a breath. What are you noticing now?”

(Apply slow, short sets to reinforce if response is adaptive)

- If you wish, you can give your container a name or a phrase. You can use this to remind you of the container if you are feeling distressed.

(Apply slow, short sets to reinforce the cue word)

Modification and Application:

- For young children and the creatively inclined, you can have them actually make or craft a container. Ask if it seems better to take the container with them to use during the week or if it feels more organic to leave in your office until next session.

- Even if you are not making an actual container, have the clients use their arms/hands and invite them to “pick up” (in an imaginary sense) what they might need to put into the imaginal container. You can have them use their hands in this play/drama-inspired technique to close off and seal/lock the container.
Too often in life we beat ourselves up with messages like, “I just can’t pay attention.” Rest assured, you are not alone…it takes practice. This exercise is a basic gateway for learning mindfulness and to begin practicing it.

• Shift around in your chair a little bit, or in a seated position on the ground, until you find a position that, for you, embodies paying attention.

• Be careful not to slouch your shoulders, but also be aware not to sit so straight up that it hurts you to be in this sitting posture.

• Spend some time paying attention to your body and make a mental note of what this posture of awareness feels like for you.

• If your mind starts to wander or you feel that you’ve stopped paying attention, that’s okay! It’s a chance to practice the mindfulness principles of non-judgment and beginner’s mind. When you catch yourself, just use this as a chance to bring your attention back to that body posture of awareness.

• Work up to practicing this in three-minute increments. If all you can start with is 30 seconds--1 minute, that is fine. It’s about practicing patience with the process and yourself.

Modification and Application:

• If three minutes simply can’t be done, consider adding in another sensory element and practice paying attention to that element (e.g., a scent, like an oil, spice, or candle; a simple sound, like something from a nature sounds CD; a tactile sensation, like holding a rock, a marble, or a stuffed animal).

• If sitting doesn’t work, this same exercise can also be done standing up or lying down. Remember to keep the emphasis on that word ‘awareness’…you can lie down with awareness!

• The eyes do not have to be closed—for this basic mindfulness exercise, it may work better for them to be open.
Multi-Sensory Grounding Exercise

- Look around the room that we are in right now. Start naming the different things that you see. I encourage you to be as specific as possible, like, “I see the carpet below my feet. The carpet is blue with some bits of brown in the thread…. I see the lamp on the desk. The base of the lamp is brown glass and the shade is beige.” Keep going for as long as you need, until you are secure in the knowing that you are here and now, in this space, in this time.

- Move on to the other senses: What are you hearing (or not hearing) in this moment, in this room? Observe and describe. What are you smelling? What are you tasting? Then, I invite you to use your hands and either touch your clothes or make contact with the chair or the table. Observe and describe touch sensation.

Simple Grounding Exercise

- Take a look around the room that we are in right now. Start naming the different things that you see. I encourage you to be as specific as possible, like, “I see the carpet below my feet. The carpet is blue with some bits of brown in the thread….I see the lamp on the desk. The base of the lamp is brown glass and the shade is beige.” Keep going for as long as you need.

- When you are ready, I encourage you to make contact with my eyes.
**TREE GROUNDING VISUALIZATION**

- Whether you are sitting or standing, notice the connection of your feet to the ground below you. Take a few moments here. Maybe pump your feet back and forth a few times and then let them come to stillness. Really notice the connection.

- If this works for you, imagine that roots are coming out of your feet and shooting into the earth below you, like the roots of a tree.

- Notice the roots moving deep, deep, deep into the earth, through all of the different layers. Take a moment to just be with this experience. Think of yourself being firmly rooted in the earth, in the here-and-now.

**Modifications and Applications:**

- For children or willing adults, have them name what kind of tree they are (e.g., an oak, a banyan, an elm, a pine).

- If you have earth elements around your office, such as essential oils like Cedarwood or Pine, or even a Mason jar full of dirt (try it, it smells like the “good earth”), consider bringing those in—it can add to the grounding experience.

- If you have a personal yoga practice and feel comfortable showing your client tree pose, this can be an excellent way to experience a greater sense of embodied connection to the skill.
Have you ever been so angry or stressed you just want to make fists and hit something? In this exercise, you’ll be able to make those fists…and then practice mindfully letting go!

Make fists.

Feel your fingernails make contact with your skin if possible.

Whenever it feels too uncomfortable for you to keep holding on, know that you can slowly, mindfully let go at any time.

Notice your fingers uncurling, and feel the trickle of letting go all through your arms, up to your shoulders.

Simply observe the sensation of letting go.

**Modifications and Applications:**

- Any muscle group can be clenched and released, especially if clenching the fists is too painful or not possible due to context or physical limitations. Clenching and releasing the stomach and feet are other popular choices.

- You can clench and release bilaterally (e.g., first time on right side, next time on left side); this is also a great way to introduce bilateral stimulation as a concept.

- Add a relaxing sound (e.g., nature sound, music) in the background, or use an aromatherapy diffuser if you are using this exercise for sleep.

- For help with sleep and deeper relaxation, clench and release one muscle group at a time (holding each clench 20-30 seconds and then slowly releasing). The entire exercise should take about 20 minutes.

- If working with dissociation or complex trauma, it is generally wise to teach this exercise first, before breathing or guided visualization exercises. Because this exercise works directly with body sensation, it serves as an excellent anchor should any of those other exercises prove problematic.
Learning to pay attention to the messages that your body gives you is a vital part of wellness. Body cuing modifies the mindfulness practice of body scan. It helps you to pay better attention to your body and listen to what it needs in any given moment.

- Bring to mind something that stresses you out. It doesn't have to be a major trauma, a general stressor will suffice.

- Spend a few moments reflecting on that stressor. What does it look like? Does it have a sound or any other sensory qualities?

- Now, notice what is happening in your body. Does the stress seem to be felt in one part of your body, or maybe in one organ specifically? Or is the stressor all over your body?

- There are no right or wrong answers, just practice acceptance of what is going on in your body right now. Spend a few moments just sitting with the stressor, just noticing the body response, in a spirit of non-judgment.

- If you want, begin describing the presence of that stressor in your body: If it had a color, what color would it be? If it had a shape, what shape would it be? If it had a texture, what would that texture be? Are there any other qualities, like temperature, sound, or smell?

- Now ask yourself, what does my body need the most right now to help the presence of this body stress? Even if your gut-level answer doesn’t seem to be the healthiest response, practice non-judgment, just notice what your body needs.

**Modifications and Applications:**

- Consider drawing the experience of stress in your body; young people may find this approach more appealing or accessible than having to describe it. Colored pencils, crayons, markers, or other crafting elements can be employed.
Mindfulness of Feeling Tone

Buddha suggested that all sensations, emotions and thoughts could be tracked to be within one of three categories: Pleasant, unpleasant or neutral. This meditation allows us to begin that process of simplifying our relationship to our mind’s constant opinions about our experience.

• Settle into your posture. Scan around the points of contact: Your back on the chair if you have chosen that option, your seat, the backs of your legs, feet on the floor, where the hands and arms meet the body. See if any of these points feels more grounded than the others. If you are not feeling particularly grounded at this moment, see if you can just notice that lack of grounded feeling with as little judgment as possible.

• If you feel your grounding to be stronger at one or more contact points, go ahead and lean into that grounding. Let yourself have that ground.

• After a minute or so, turn your attention toward your breath. Find the spot either just outside or just inside the nostrils, or notice the rising and falling of the belly. Any one of these is a great place to note the sensation of the breath going in and out. It’s not important which you choose, though it is wise to choose one for the length of this sitting.

• Begin to more carefully track general body sensations, thoughts and feelings. If you notice a physical sensation, rate it on the scale of pleasant, unpleasant or neutral. As you continue to track physical sensations you might wander toward feelings, thoughts, sounds, and other sensory stimuli. Have a goal of beginning to find the rhythm of pleasant, unpleasant or neutral being the one thought you are having in each moment.

• It is the nature of the mind to think. When (not if) your mind begins to wander, just notice that it is happening. In this meditation, we can notice if this wandering is in fact pleasant, unpleasant or neutral. Then continue to find your way back to the rating system as you begin tracking your experience again.

• Set a timer, and continue this practice for a time scale that feels appropriate and sustainable for your current level of practice. Five minutes a day to start is generally recommended. Five minutes a day is better than 30 minutes on Saturday. One minute is better than no minutes. The development of a practice is key.
This exercise is like the general practicing awareness exercise, only this time the focus will be on paying total attention to our breath.

• Shift around in your chair a little bit, or in a seated position on the ground, until you find a position that, for you, signifies paying attention.

• Be careful not to slouch your shoulders, but also be aware not to sit so straight up that it hurts you to be in this sitting posture.

• Spend some time paying attention to your breath and just notice the experience; notice the natural rise and fall of your chest or stomach. See if you can keep your attention fully on your breath.

• If your mind starts to wander or you feel that you’ve stopped paying attention, that’s okay! Even if your mind wanders 10 times in a minute, you can always bring the attention back to the breath—the exercise is in noticing it wander.

• Work up to practicing this in three-minute increments. If all you can start with is 30 seconds--1 minute, that is fine. It’s about practicing patience with the process and yourself.

Modifications and Applications:

• If three minutes simply can’t be done, consider adding in another sensory element and practice paying attention to that element (e.g., a scent, like an oil, spice, or candle; a simple sound, like something from a nature sounds CD; a tactile sensation, like holding a rock, a marble, or a stuffed animal). Harder textures are recommended for working with dissociative clients.

• If sitting doesn’t work, this same exercise can also be done standing up or lying down. Remember to keep the emphasis on that word ‘awareness’…you can lie down with awareness!

• The eyes do not have to be closed—for these basic mindfulness exercises, it may work better for them to be open.
Have you ever watched an infant breathe? If so, you will notice that babies naturally breathe with their bellies...somewhere along the way we seem to lose this natural tendency and develop rapid, shallow breathing that originates in the chest. Like with all elements of mindfulness, belly breathing takes practice!

- Put one or both hands on the upper area of your stomach so that you can really pay attention to the motions you are engaging with your diaphragm.
- As you inhale with your nose, allow your belly to expand as far as it will go.
- Exhale with your mouth, allowing the belly to pull back in.
- Continue this inhale-exhale pattern at your own pace, giving it at least 6-7 repetitions to find a rhythm and style that work for you...curiosity and non-judgment are key.
- After finding your rhythm, consider puckering your mouth and really exaggerating your exhale, striving to make it somewhat longer than your inhale. This ought to help you relax even more.

**Modifications and Applications:**

- If you feel awkward or in any way out of control with this suggested pattern, consider starting with an exhale instead of the inhale.
- If paying attention to the breath on its own is not working for you, consider adding a count to it (e.g., “In 1, out 1; In 2, out 2; go as high as 10 and then begin again at 1). You can also add a word or a special phrase (e.g., “Satnam;” “Amen,” “Help me”). The possibilities are endless.
- You can really engage children in this practice by having them put something like a Beanie Baby or a flatter type of stuffed animal on their stomach so they have a focus point while they observe the rise and fall of the belly.
- Once again, eyes do not have to be closed. You can also go very slowly. For clients who struggle with dissociation or getting relaxed, one full breath can be a major achievement to start. Consider having dissociation-prone clients hold onto a hard-textured element like a rock, a marble, or a stone for further grounding. Even stuffed animals or other soft textures can work for grounding if that is their established intention.
Complete Breathing (i.e., Three-Part or Dirgha Breath)

Think of a complete breath as a three-part breath, with the diaphragmatic part of the breath being the first step. In essence, complete breath, as the name suggests, is a fuller breath.

• Begin with a diaphragmatic breath but continue the inhale into the ribs and then the chest. You can put a hand on the chest to help with your awareness.

• At the top of the inhale, hold the breath in your awareness for a moment. If it causes you pain or distress to hold the breath like this, even for a moment, you can release right into the exhale.

• Gradually release the breath with your exhale, allowing the chest, the ribs, and the belly to pull back in.

• Continue this inhale-exhale pattern at your own pace, giving it at least 6-7 repetitions to find a rhythm and style that work for you…curiosity and non-judgment are key, like with any other breath.

Modifications and Applications:

• The standard pattern with exhales is to keep them slow and deliberate. However, a very powerful variation is to do a fast, dramatic exhale, like a “sigh of relief.”

• Feel free to get as dramatic as you want on the exhale, perhaps bringing the hand to the forehead like a stereotypical “drama queen.” Think of this breath as a chance to practice letting go of negative energy.

• When you expand your chest on the inhale, you can bring up “superhero” imagery (especially fun to do with kids) to further the empowering motion.

• Once again, eyes do not have to be closed. You can also go very slowly. For clients who struggle with dissociation or getting relaxed, one full breath can be a major achievement to start. Consider having dissociation-prone clients hold onto a hard-textured element like a rock, a marble, or a stone for further grounding. Even stuffed animals or other soft textures can work for grounding if that is their established intention.
Ujjayi Breathing (i.e., Ocean-Sounding Victory Breath or Darth Vader Breath)

So many of the therapeutically beneficial breaths that we learn in mindfulness are in through the nose, out through the mouth. Ocean breath is fundamentally different because it is in through the nose, out through the nose. If you make a certain formation with your mouth and throat, you can create the sound of the ocean, right within yourself! Or, you may like to think of this sound as the infamous character, Darth Vader. This breath is excellent for endurance of stress, physical or mental.

- Pucker your mouth like you’re sucking through a straw or about to kiss someone. Attempt to contract the back of your throat slightly closed.
- Inhale with your nose; allow the belly to expand with this motion.
- Exhale with your nose; although air may flow out of your mouth, think about doing the work with your nose.
- If your mouth is puckered and throat is contracted, you ought to be hearing the sound of the ocean within you.
- Attempt to keep the inhales and exhales even, especially when you’re first learning the breath.
- Do not attempt more than five full repetitions during your first attempt if you are new to this breath.
- It is completely normal if you feel somewhat light headed, but it should be a “good” light-headed. If it does not feel good, chances are you tried too many too soon, or the inhales and exhales were uneven.

**Modifications and Applications:**

- You can envision many different characters with this breath, like Darth Vader, or a charging bull “huffing and puffing.”
- Get a mirror and see the steam of your breath on the surface (young people like this especially), attuning you to the idea of your breath as “the Force.”
- You can visualize, on any breath, that you are breathing in a calming or soothing color and breathing out a color that represents stress.
LION BREATHING

• Although taking on the full character of a lion is optional with this exercise, allowing
  yourself to make the face of a lion with this breath can help you with letting go of
  negative energy.

• Begin with a healthy inhale (what you learned in complete breathing).

• Exhale vigorously, allowing the tongue to hang out as far as it will go. Feel the jaw and
  cheeks loosen. Open the eyes widely to help with this release.

• Try at least 5 full repetitions, although you can continue with this breath as long as is
  physically comfortable for you.

Modifications and Applications:

• This is a wonderful exercise to teach to children (or adults who aren’t too self-conscious
  to try it). You can think of making this face when ugly thoughts about trauma or stress
  come up…think about embodying the strength of a lion in the wake of a painful
  trigger!

• Like with all breaths, eyes do not have to be closed. You can also go very slowly. For
  clients who struggle with dissociation or getting relaxed, one full breath can be a major
  achievement to start. Consider having dissociation-prone clients hold onto a hard-
  textured element like a rock, a marble, or a stone for further grounding.
• If you are willing, this is one of the best breaths we can cover to start teaching you about bilateral stimulation/dual attention stimulus and how it can be used to balance the brain. The Sanskrit name for the breath that yogis use translates as *energy cleansing breath*.

• Use your right thumb to plug off your right nostril at the side. Take a moment to notice this and make sure it’s not too uncomfortable.

• Inhale with the left side of your nostril using a diaphragmatic or complete breath.

• Hold the breath for a moment, then use your right pinky to plug off the left nostril at the side. Many hand positions are possible to help you with this rotation; see the video on www.traumamadesimple.com for other options.

• Exhale through the right nostril.

• Inhale again through the right nostril and repeat this alternating process as long as is comfortable.

**Modifications and Applications:**

• This is an amazing breath for orienting clients to bilateral stimulation if they are willing to follow it.

• Like with all of the breaths, eyes do not have to be closed. You can also go very slowly. For clients who struggle with dissociation or getting relaxed, one full breath can be a major achievement to start. Consider having dissociation-prone clients hold onto a hard-textured element like a rock, a marble, or a stone for further grounding.

• This breath may be too triggering at first for clients with complex trauma or dissociation—any breath that promotes a conscious holding of the breath may be. Just be advised and modify as needed.
Energetic Massage

• Do you ever feel, quite literally like your brain hurts? Wouldn’t it be great if you could give your brain a massage? With a simple mindfulness exercise that harnesses the power of your own tactile energy, you can!

• Rub your hands together for at least thirty seconds (you can go longer if you want). Really work up some heat!

• Pull your hands apart and bring them to your forehead…there are many variations. You can close your eyes and place the base of your palms over your eyes; let the rest of your hands curl over your forehead to the top of the forehead. Or you can rest the base of your palms on your cheeks and go around your eyes.

• Settle in, feel the energy you generated in your hands move into your brain. Let the energy work in you and practice non-striving.

• Hold as long as you like.

Modifications and Applications:

• You can bring the energy from your hands to any part of your body that is feeling tense or anxious. Think about bringing the heat energy from your hands to your chest or stomach if you are noticing any tension or pain.

• The ‘cranial hold’ position is an option after generating the energy. To achieve this, horizontally bring one hand to your forehead and the other hand to the back of your head.

• Consider adding another sense into the process for optimal relaxation, like meditative music, or an aromatherapy oil of your choice.

• Also an excellent exercise for introducing dual attention stimulus since you are using a bilateral motion to generate the energy.
Haven’t you ever envied a cooked noodle? The way it just slithers freely and easily, without stress, is an admirable quality that can teach us how to practice the attitude of letting go. Think of how fun, and potentially beneficial, it could be, to take on the role of a noodle.

- For optimal benefit, come to your feet (although you can also do this sitting or lying down).

- With your next breath, think of taking on the role of a noodle…it’s suggested that you begin in your shoulders and then let the ‘noodling’ move through the rest of your body.

- Keep noodling, in a mindful way, practicing beginner’s mind, non-judgment, and non-striving for at least three minutes.

- When you’ve completed one round, allow yourself to be still for a few moments longer (standing, sitting, or lying down)…notice how it feels!

- Repeat as many times as necessary.

**Modifications and Applications:**

- Although you can do this in silence, it is lots of fun if you put on some music that can bring out your inner noodle! Adding in the music may help anchor in the present if a client tends to dissociate.

- This exercise can be fun with props like scarves or ribbons…excellent for children!

- To further orient the bilateral stimulation/dual attention stimulus idea, invite the person to noodle on the right side, then the left, and keep alternating.
Loving Kindness meditation has become one of the most used meditative practices of the 21st century, thanks to the work of Sharon Salzberg (who brought the practice to the United States from Burma) and other teachers in the Insight Tradition of meditation. What follows is a version of loving kindness meditation based on the work of all these teachers.

- Settle into your posture. Scan around the points of contact… your back on the chair if you have chosen that option, your seat, the backs of your legs, feet on the floor, where the hands and arms meet the body. See if any of these points feels more grounded than the others. If you are not feeling particularly grounded at this moment, see if you can just notice that lack of grounded feeling with as little judgment as possible.

- After a minute or so, turn your attention toward your breath. Find the spot either just outside or just inside the nostrils, or notice the rising and falling of the belly. Any one of these is a great place to note the sensation of the breath going in and out. It’s not important which you choose, though it is wise to choose one for the length of this sitting.

- Begin to silently say the Loving Kindness phrases, first toward yourself. “May I be free from fear, May I be healthy, May I be happy, May I be at ease.” Send the phrases to yourself a few times. Then move on to someone whom it is extremely easy for you to send the phrases to, someone where unconditional love flows in one direction or both. Then send it to a neutral person, someone for whom you have no particular positive or negative charge. Then, send loving kindness to the difficult person, who doesn’t have to be the worst person in the world, just someone difficult to send the phrases to. Then radiate it out in all directions, proceeding as slowly or as quickly as you wish… slowly would be to everyone on my block… my city… my state… my country… my hemisphere… the world… all sentient beings in the world… all sentient beings in all known and unknown universes. Finally, land with one last round toward ourselves.

- It is the nature of the mind to think. When (not if) your mind begins to wander, just notice that it is happening. The return to the phrases, noticing any discomfort or resistance. These become part of our process.

- Set a timer, and continue this practice for a time period that feels appropriate and sustainable for your current level of practice.
Walking meditation represents one of the primary teachings of Buddha regarding mindfulness. This practice helps individuals to have the direct experience that Buddha had, which was that human beings can practice in any posture, not just sitting.

- Find a comfortable standing position. Map out a pathway in front of you from six to eight feet long with no obstructions. You will simply be walking back and forth in this path.

- Begin your stride, which can be in super slow motion, or a regular gait, or something in between. Something in between may mimic the bilateral stimulation speed used in EMDR therapy.

- You may simply notice your walking, or you can use anchoring phrases such as lifting, moving, placing, shifting…. Either way, keep your eyes downcast at a 45 degree angle. The goal is not to look around, which might promote the wandering mind. We are focused on the act of walking, perhaps our breathing and the accompanying body sensations.

- After a minute or so, turn your attention toward your breath. Find the spot either just outside or just inside the nostrils, or notice the rising and falling of the belly. Any one of these is a great place to note the sensation of the breath going in and out. It’s not important which you choose, though it is wise to choose one for this walking meditation.

- Continue to walk back and forth on this path for the time you allot for the meditation.

- It is the nature of the mind to think. When (not if) your mind begins to wander, just notice that it is happening. The return to your body and its practice of walking.

- Set a timer, and continue this practice for a time period that feels appropriate and sustainable for your current level of practice.
In EMDR therapy, anything with a positive or adaptive connection can be strengthened. These resources may include people (real or imagined), spiritual entities, or even fictional characters to whom you have a special attachment can be used. Precautions must be taken, especially if you are using people who are still alive or may qualify as a mixed resource, in that they possess some adaptive and some maladaptive qualities. The exercise is written to go slowly and be adapted to the specific person.

**Single Figure**

- Let’s start by working with just a single figure. You can choose if you want to use an adjective like protector figure, sacred figure, maybe a word like cheerleader, nurturer, works better for the intention that you’re setting today.

- Try to stay away from real people at first. Think of the spiritual realm, or even fictional characters, or an entity that you create using the power of your imagination.

- Sense in, breathe and notice. Does this figure you chose have a name? What do they look like? What are they wearing? If they have a face, what do you observe on their face?

- Notice what this figure is doing, or where they are in relation to you in this meditation. Maybe they’re literally sitting beside you. Maybe you imagine them putting their hands on your shoulders in support. Maybe you’re engaging in an activity with them. Notice whatever you notice.

- And then notice the qualities that this figure you’ve selected brings to you. How do they make you feel about yourself? What are you noticing in your thoughts, your feelings, your experiences when you’re in their presence?

- Is there a certain bodily sensation that you may be noticing, the deeper you engage or notice this figure of yours? Keep breathing.

- To go further: is there a challenging situation that may be coming up in your life the next few days or weeks. What would it look like, or what would it feel like, if you imagined bringing this protector figure with you?
To go further, you can imagine a circle of support, people who are spiritual entities, fictional entities from who we’ve drawn great strength. Historical figures and those who have passed away (from whose tales we draw great inspiration) can also be part of your circle. You can also bring people who are in your life right now into your circle, as long as they feel like a primarily positive resource.

• Imagine who is surrounding you. Who constitutes your circle of support?

• Maybe there’s only one additional figure, maybe there are several. Maybe each figure takes on a different quality. Perhaps you have a protector figure, a sacred figure, a cheerleading figure, a nurturing figure.

• Notice what do you most need in your life today, or in your life in general, and who are some figures that you can ally to present you with those qualities? Take a moment here to see what comes into focus.

• Think of a situation coming up in your life in the next few days, in the next week, that may present a particular challenge. When that’s come into your awareness, notice it. Notice what that would feel like, what that would look like, and notice your response as you imagine your circle of support taking you into this challenge. Keep breathing.
Appendix C:

Resources for Purchasing Equipment for EMDR Therapy
• **Neurotek** ([www.neurotekcorp.com](http://www.neurotekcorp.com)) is the oldest manufacturer of equipment specifically for EMDR Therapy. You can browse their inventory online; they offer combination machines in the various available modalities. If you choose to order, you will need to supply a copy of your certificate from Days 1-3 of this training.

• **EMDR Equipment Europe** ([www.emdrequipmenteurope.com](http://www.emdrequipmenteurope.com)) offers several nice products including a very sleek light bar. While they always run some nice specials, the cost of shipping can be pricey with the equipment coming from the United Kingdom.

• **EMDR Kit- Netherlands** ([www.emdrkit.com](http://www.emdrkit.com)) features the widest range of wireless EMDR therapy products and apps.

• **TheraTapper™** ([www.theratapper.com](http://www.theratapper.com)) produces a basic unit that just offers tactile stimulation at a reasonable price.

*There are a variety of companies in the modern era offering EMDR Therapy bilateral stimulation products, software, and apps. We have not been able to evaluate the quality of all of these, just know they are out there. We also encourage you to look on eBay or Amazon.com Marketplace for used Neurotek products. Many of our former students have found good deals this way.*

*Feel free to consult us if you have any questions about ideas for bilateral stimulation that you may come up with on your own. For example, a former student of ours does most of his work using a good old-fashioned music metronome, which creates both the audio and the visual field for stimulation.*
APPENDIX D:

EMDR Therapy Research Articles with Qualitative Focus
The Francine Shapiro Library

The Francine Shapiro Library is the definitive resource for seeking out articles on EMDR Therapy. Everything published on EMDR—good, bad, or neutral—is catalogued. Although full text articles are rarely available, you will at least be able to access a citation and full abstract after doing a subject or author search.

http://emdria.omeka.net

In Part I of the course, Appendix D provided you with a listing of research articles largely of an empirical, quantitative nature that are often used to uphold EMDR Therapy's clinical status. In this appendix, we are providing you with qualitative articles. Although these research papers are likely to get overlooked in the push to “validate” EMDR Therapy and establish its clinical legitimacy, qualitative research has a unique ability to provide clinicians with insight into best practices for practice implementation and transfer of these ideas into real-world settings. Where empirical research can demonstrate that EMDR Therapy works, qualitative research articles and case studies offer insight into how EMDR works for real people. This list is not exhaustive. If you work with a special population or area of focus, you are encouraged to consult the Shapiro Library to see if there is a paper/case study in your area.


