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Although Dr. Francine Shapiro’s now-famous walk in the park took place in 1987, the first EMDR study was published 2 years later in 1989. The EMDR community is celebrating its 20th anniversary at this year’s EMDRIA Conference in Atlanta, Georgia. Twenty years later, there are EMDR therapists trained around the world. The efficacy of EMDR has been proven repeatedly, and it is included as the treatment of choice by mental health groups in the United States (American Psychiatric Association, 2004; Department of Veteran Affairs and the Department of Defense, 2004) and abroad (Australian Centre for Posttraumatic Mental Health, 2007; Bleich, Kotler, Kutz, & Shaley, 2002; Clinical Resource Efficiency Support Team [CREST], 2003; and United Kingdom Department of Health, 2007). We have come a long way!

Back History

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

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

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

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

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

It has been my pleasure and honor to be on the editing team for this book. I believe that Dr. Hensley has written a book that is simple, basic, and can mentor therapists who are EMDR trained and yet intimidated. It is the perfect complement to Dr. Shapiro’s text (Shapiro, 2001). Learning EMDR can be likened to learning a language. Having a strong foundation in grammar helps many years down the line.

Ever since my Catholic grammar school education stressed diagramming sentences and studying Latin, I have appreciated the necessity for laying a strong foundation in the understanding, maintenance, and facile
utilization of learned information. The importance of going back to basics cannot be overemphasized. Beyond the therapeutic relationship, a thorough understanding and meticulous use of the EMDR methodology will nurture the best EMDR treatment and therefore the greatest therapeutic effects when applied appropriately. This book brings us back to the basics.

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

—Jennifer Lendl, PhD

REFERENCES


Tuning Into the Creative Force

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

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

Francine Shapiro belongs to a select group of big-C creators in our world. Small-c creativity involves personal creativity while big-C requires the type of ingenuity that “leaves a trace in the cultural matrix” (Csikszentmihalyi, 1997), something that changes some aspect of how we view or treat something in a big way. Anyone who has conducted a successful EMDR session or has experienced its results firsthand can attest to the expanding ripples that Dr. Shapiro began and that continue to grow as we progress further into the future.

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

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

Who Could Benefit From Reading This Primer?

EMDR is a powerful therapeutic approach. However, without the proper training and consultation, an untrained therapist (and this includes very experienced clinicians) could put their clients at risk. A goal of this Primer is to target those clinicians who have attended what is now called Weekends 1 and 2 EMDR Training and have read Dr. Shapiro’s basic text (2001; i.e., *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols and Procedures, Second Edition*) but still want additional information on using it skillfully. They may have experienced fear or apprehension about trying something so new and different or they may simply want to maximize their preparation and skills as they begin using EMDR.

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

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

What Is Included

Much of the information contained in the following pages has already been described by Dr. Shapiro and others in the rapidly growing body of EMDR literature and research. The primary intention of this Primer is to supplement Dr. Shapiro’s explanation of EMDR. It is not meant to be a substitute for her training or previous writings. The reader is urged to read and study them all. This Primer attempts to augment what she has presented in a different way, adding case histories and extensive examples of successful EMDR sessions. The cases represent composite or conglomerate portraits of the many clients with whom I have performed EMDR over the past 15 years.

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

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

The Primer is laid out in the following manner:

- **EMDR Overview**—A straightforward explanation of the Adaptive Information Processing model, the three-pronged approach, the types of targets accessed during the EMDR process, and other relevant information to assist in distinguishing EMDR from other theoretical orientations are provided.

- **Eight Phases of EMDR**—The eight phases of EMDR are summarized.

- **Stepping Stones to Adaptive Resolution**—The components of the standard EMDR protocol used during the Assessment Phase are explained and actual cases are included to demonstrate how the procedural setup is possible with various clients.

- **Building Blocks of EMDR**—The foundation of EMDR—past, present, and future—is assessed in terms of appropriate targeting and successful outcomes.

- **Abreactions, Blocked Processing, and Cognitive Interweaves**—Strategies and techniques for dealing with challenging clients, high levels of abreaction, and blocked processing is the focus.

- **Past, Present, Future**—Actual cases demonstrate various strategies to assist the client in reaching adaptive resolution of trauma.

The definitions of EMDR provided by the EMDR Institute and EMDRIA are also included in the Appendices. These definitions, particularly the one developed by EMDRIA for clinicians, are the
yardsticks used to assure that the explanation and rationale for EMDR remain consistent from session to session, client to client. In order for clinicians to experience more comfort and familiarity with EMDR, it is suggested that they keep these definitions close at hand and refer to them frequently until an adequate understanding of the methodology is attained.

A sacred space exercise has been added in the Appendices which can be used side by side with the traditional calm (or safe) place exercise. Simple exercises to give clients on grounding, diaphragmatic breathing, and anchoring in the present can also be found in the Appendices. In addition, scripted use of calm (or safe) place, spiral technique, future template, and breathing shift are also included.

The purpose in writing this book is to offer a Primer that can further facilitate mental health professionals in becoming more confident and experienced EMDR clinicians. The process has been simplified as much as possible with diagrams, tables, and other illustrations.

Dr. Shapiro’s basic text, *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols and Procedures, Second Edition*, is a masterpiece in itself and contains a wealth of information on EMDR. One needs to read her text over and over again to savor all the kernels of significant information. These kernels have been separated out by providing explanations, as well as anecdotal and illustrative examples throughout. EMDR is a significant contribution to psychology in the 20th and 21st centuries, and this Primer is offered as a further learning tool.

What is covered in this Primer is but the tip of the iceberg when it comes to all the possibilities in terms of using EMDR with clients that present from different populations, such as children, combat veterans, and couples, and those who present with more complex issues, such as dissociation, phobias, obsessive–compulsive disorder, and substance abuse. Regardless of the client populations or the types of issues that the client brings, the basics in this Primer are essential to the overall outcome and success of EMDR.
My thanks to Dr. Francine Shapiro for providing me with an opportunity to be part of the ripple she created after taking her famous walk in the park. From that memorable walk, I was motivated to create my own small ripples in writing this Primer and in creating the Francine Shapiro Library. Dr. Shapiro has had an enormous impact on my life both personally and professionally as a result of her revolutionary work. My hope is that my efforts on behalf of EMDR will feed her spirit as hers have fed mine.

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

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

Special thanks to Irene Giessl for her relentless pursuit of perfection and clarity. Her support, inspiration, faith in my ability to write this Primer, and sharp eye for the flaw, moved me when courage wavered.
Thanks to Marilyn Schleyer who urged me to “keep it simple” and to provide tables and diagrams to nurture the reader’s learning process. Her mentoring and constant assurance that the Primer could be an important contribution to EMDR literature spurred me on.

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

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

Thanks to Dana Braun, a retired school teacher, friend, and non-clinician, and Deborah Smith-Blackmer, colleague, office mate, friend, and nontrained EMDR clinician, for offering their constructive eyes by reading the Primer for simplicity and ease of understanding. They both provided a view from the outside without the bias and complication of being EMDR trained.

As can be seen, all these women made special and unique contributions to the editing of this Primer. I know they made sacrifices and encountered personal challenges along the way. I owe all of these amazing women a deep debt of gratitude for their time, talents, and expertise.
These women are dear friends and colleagues. They are all ripple creators extraordinaire! From my grateful heart, I offer my sincere thanks.

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

I have always believed in the spirit of generosity, giving freely without strings attached. This philosophy includes making financial contributions, offering pro bono therapy services, and sharing personal and professional resources to support those who might need a step up. I am so rewarded in life for taking this stance. For me, EMDR is a work of the heart, spurred on by my belief in the power of EMDR’s healing properties. I chose to write to assist those beginning to study EMDR as a way of continuing to “pay forward.” In offering this Primer to the EMDR community, it is my hope that many clinicians and their clients will reap the benefits of my efforts.
REINTRODUCTION TO EMDR

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

Although the EMDR principles, protocols, and procedures have been simplified with tables and figures in this Primer, it is not a mechanistic or cookie-cutter approach. EMDR is a fluid process, and the results will vary from client to client. Formal EMDR training allows clinicians to initiate understanding the mechanism, model, and methodology of EMDR. This knowledge, combined with their own clinical intuition, allows them to begin practicing this therapeutic approach. No one should read this book thinking that it is a substitute for formal training. EMDR seems simple on its face; however, in reality, its competent execution is fairly complicated.
Extensive familiarity with Dr. Shapiro’s primary text is a prerequisite for the reading of this Primer, which is intended to supplement, not replace, Dr. Shapiro’s required pretraining readings. No clinician who intends to utilize EMDR with clients can afford to be without *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures, Second Edition* (Shapiro, 2001). In the early days of implementation, you may need to refer to Dr. Shapiro’s book on a daily basis. Read it often and use it as your primary EMDR reference guide. Every time you read it, you will probably notice something that you did not quite understand or retain the first few times around. Read it thoroughly and refer to it often. It is not necessary that you memorize the book; just remember that it is there for you as an ongoing guide to your clinical work.

EMDR is a psychotherapeutic treatment approach that has eight distinct phases. It is not just dual attention stimulation. For it to be called EMDR, we must incorporate all eight of these phases. They include taking a thorough client history, preparing the client for the EMDR process, setting up the protocol, desensitizing and reprocessing the trauma, installing a positive cognition, doing a body scan to check for residual trauma, closing down the session, and reevaluating the status of the trauma. All of these eight phases must be in place in the order described above. Chapter 2 contains an in-depth discussion of these phases. There have been many offshoots of EMDR since its inception. These techniques have their supporters and many successes may have been reported, but these treatments to date have not been validated in the research literature. The efficacy of these models has not been tested within a scientific, empirical setting. EMDR’s validity has been proven over and over again.

**TRAUMA**

*What is Trauma?*

The diagnostic criteria for posttraumatic stress disorder (PTSD; 309.81) cited in the *Diagnostic and Statistical Manual of Mental Disorders, text revision (DSM–IV–TR)* is the definition used most frequently to describe acute trauma in adults. In essence, this definition describes trauma as an event experienced, witnessed, or confronted by a person that: (a) “involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others” and the person’s response to that event; or (b) “involved intense fear, helplessness, or horror,” or, in children, is displayed “by disorganized or agitated behavior” (American
Psychiatric Association (APA), 2000). Flannery describes trauma as “the state of severe fright that we experience when we are confronted with a sudden, unexpected, potentially life-threatening event, over which we have no control, and to which we are unable to respond effectively no matter how hard we try” (1995).

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

Types of Trauma

Dr. Shapiro distinguishes between large “T” and small “t” traumas (2001; see Figure 1.1). When a person hears the word “trauma,” he usually thinks of man-made events, such as fires, explosions, automobile accidents, or natural disasters, which include hurricanes, floods, and tornados. Sexual abuse, a massive heart attack, death of a loved one, Hurricane Katrina, and the 9/11 attacks on the World Trade Center by international terrorists are graphic examples of large “T” traumas. Among other descriptors, these types of traumas can be defined as dangerous and life-threatening and fit the criteria in the DSM–IV–TR (APA, 2000).

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

To illustrate the difference between a small “t” and a large “T” trauma, let’s consider the case of Rebecca who grew up as “the minister’s daughter.” As the offspring of a local pastor, Rebecca grew up, figuratively speaking, in a glass house. She believed that her father’s job rested on her behavior inside and outside of her home. In her world, everyone was watching. She was always in the spotlight, and no one seemed to want to share their life with her. She went through childhood with few friends. “I remember before and after church, the groups of kids forming. I was the outsider. No one invited me in.” All the kids were afraid that every move they made would be reported to her daddy. She never would. She never did.

Being at home was not much better. Her father was never home. He was always out “tending to his flock” and had little time left for his own family. Her mother was not much comfort either because she spent much of her time trying to be perfect as well. Living in a glass house was not easy for any of them, especially Rebecca, the oldest of three.

By the time Rebecca entered therapy, she was a wife and mother. She thought she had to be perfect in motherhood and in her marriage as
well. She became frustrated, angry, and lonely. She felt misunderstood and neglected by her husband. He was never there. He never listened. She thought she could do nothing right, as hard as she tried.

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

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

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

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

**ADAPTIVE INFORMATION PROCESSING**

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

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

Dr. Shapiro posits that inherent in the AIP model is a psychological self-healing construct similar to the body’s healing response to physical injury (2001). For example, if you get a splinter stuck in your
Chapter 1  EMDR Overview

finger, your body’s automatic response is to heal the area of injury. However, because the area is blocked by the splinter, healing cannot easily occur until the sliver is removed. In terms of mental processes, it is the inherent tendency of the information processing system to also move toward a state of health. So, when something mildly disturbing happens, you may think about it, talk about it, and process it. You usually find that, within a day or so, you are no longer thinking so intensely about the event and, when you do, you have come to a resolution. For instance, if you are angry at your spouse, you may start to remember that your spouse has some good qualities as well as these very annoying ones. It is a case of the mind adaptively processing the disturbing material and connecting that disturbance into the larger picture of the experience.

On the other hand, when a trauma occurs that is too large for your system to adequately process, it can become “stuck” (i.e., dysfunctionally stored) in the central nervous system. Maladaptive responses, such as flashbacks or dreams, can be triggered by present stimuli, and there may be attempts of the information processing system to resolve the trauma (Shapiro, 2001). When the system becomes overloaded as just described, EMDR is proving to be the treatment of choice for many to help restart this mental healing process and allow the traumas to be reprocessed. See Figure 1.4 for a graphical representation of the AIP model.

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

Figure 1.3  Adaptive vs. maladaptive resolution.

<table>
<thead>
<tr>
<th>Erica’s possible responses to recovering from an automobile accident:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adaptive Resolution</strong></td>
</tr>
<tr>
<td>I survived.</td>
</tr>
<tr>
<td>or</td>
</tr>
<tr>
<td>I can learn from this.</td>
</tr>
<tr>
<td><strong>Maladaptive Resolution</strong></td>
</tr>
<tr>
<td>Driving phobia</td>
</tr>
<tr>
<td>Intense anxiety while driving</td>
</tr>
</tbody>
</table>
At the time of disturbing or traumatic events, information can be stored in the central nervous system in state-specific form (i.e., the negative cognitive belief and emotional and physical sensations the client experienced at the time of the traumatic event remain stored in the central nervous system just as if the trauma is happening in the now). Over time, a client may develop repeated negative patterns of feeling, sensing, thinking, believing, and behaving as a result of the dysfunctionally stored material. These patterns are stimulated, activated, or triggered by stimuli in the present that cause a client to react in the same or similar ways as in the past. Dr. Shapiro (2001) states in many ways throughout her basic text that the “past is present.” Negative beliefs and affect from past events spill into the present. By processing earlier traumatic memories, EMDR enables the client to generalize positive affect and cognitions to associated memories found throughout the “neuro” networks (i.e., memory networks), thus allowing more appropriate behaviors in the present. Figure 1.5 demonstrates a more simplified version of how EMDR works (Shapiro, 2008).

Cognitive behavioral techniques, such as systematic desensitization, imaginal exposure, or flooding, have the client focus on anxiety-
provoking behaviors and irrational thoughts or relive the traumatic experiences with which he presents. More inclusively, EMDR targets the experiences that caused the negative cognition, affect, and physical sensations to become “stuck” in a client’s nervous system. Once the memories have been processed utilizing EMDR, a physiological shift can occur that causes the disturbing picture to fade appropriately with the associated negative self-belief, feelings, and physical sensations. The “block” (i.e., dysfunctionally stored information) in the client’s nervous system has been shifted, and the disturbance has been brought to an adaptive resolution as the natural healing process is activated. The primary byproduct of reprocessing is a decrease or elimination of the negative charge associated with the trauma.

Changes in perception and attitude, experiencing moments of insight, and subtle differences in the way a person thinks, feels, behaves, and believes are byproducts as well. The changes can be immediate. Take, for instance, a session with a young woman who had been brutally raped by her ex-boyfriend. During the assessment phase, Andrea’s terror appeared raggedly etched in her face and slumped demeanor. After many successive sets of bilateral stimulation, her pale facial features began to redden, her posture to straighten, and her breath to gain strength and resolve as she spontaneously stated, “He took my power that night. No more! I am taking my power back. He no longer has the power to terrorize me.” Figure 1.6 demonstrates in action the inherent

![Figure 1.5 Activation components of EMDR.](image)
information processing mechanism as it highlights the changes that occurred as a result of Andrea’s dynamic drive toward mental health with the use of EMDR.

Because the heart of EMDR is the AIP model, it is critical that the clinician have a clear understanding of it before proceeding with EMDR. An adequate conceptual understanding helps the clinician determine a client’s appropriateness for EMDR, as well as explain the process to the client during the preparation phase, so he has some understanding of the potential treatment effects. Table 1.1 highlights the before and after changes of EMDR in terms of the AIP model.

THREE-PRONGED APPROACH

Past, Present, Future

EMDR is a three-pronged treatment approach that focuses on past events, current stimuli, and future situations (see Figure 1.7). This may seem to be a simple idea, but it is often a concept that escapes many newly trained EMDR clinicians because their first exposure to EMDR can be overwhelming, even to the most seasoned clinical professional.
Regardless of what you as a participant were taught in the earlier didactic trainings, what you most likely will remember is what was on the instructional sheet that sat on your lap. The first question that you asked the client was, “What old issue or old memory would you like to focus on today?” It is important to note that this question was only used in the training exercises and not in daily clinical practice. Fortunately, this teaching method has changed as the training focus now is to establish a more formalized plan (e.g., a targeting sequence plan; Shapiro, 2009) that attempts to identify past events (and a touchstone event, if available), present triggers, a future template, and to encourage the participant to process in this order.

To completely resolve a client’s issue and achieve adaptive resolution, EMDR is designed to: (a) address a client’s past events; (b) clean out related current stimuli that might trigger distress in the client; and (c) prepare the client for future situations involving the same kind of circumstance (or reaction). The concept of the three-pronged approach is so important that an entire chapter in this Primer has been devoted to it (see chapter 4).

Three-Pronged Targets

The order of the processing is important. First, it is necessary to strive to adaptively resolve past traumas, then process current stimuli that trigger distress, and continue on to any future situations that have the potential or likelihood to do the same. See Figure 1.8 for a breakdown of what is identified and processed under each prong of the EMDR approach.
What this means is that the clinician may want to consider targeting the memories that lay the groundwork for any present problems and/or issues first. It may be a single traumatic event or what is called a touchstone event, a primary and self-defining event in the client’s life. In AIP language, Dr. Shapiro refers to the touchstone memory as a node to which similar events will attach in the continuous formation of a “neuro” or memory network that is critical to the client’s sense of self (2001; see Figure 1.9).

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

During recent EMDR trainings, the order of processing the three prongs (i.e., past, present, future) and strategically identifying the touchstone event, if any, have been emphasized more dramatically. If you have not been trained in EMDR in the past year or so, pay particular attention to chapter 3 and chapter 4 of this Primer.

**Why Is the Concept of Past, Present, Future so Important?**

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

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

**TARGETING POSSIBILITIES**

**Targets May Arise in Any Part of the EMDR Process**

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

Throughout Dr. Shapiro’s clinical books, she refers to several different targets that may arise in certain parts of the process. The past, present, and future targets referred to above are the primary focus in the EMDR training. Her text also introduces the reader to other associated words, such as node, channel, cluster, and progression. Figure 1.10 attempts to provide a better understanding of the relationship between these types of targets from a more visual perspective.
Types of EMDR Targets

As you think about your client sessions, do you recognize any of the types of targets, including the ancillary targets (i.e., other factors that may be contributing to a client’s disturbance) listed in Figure 1.10? Are you aware under which prong of the EMDR protocol these types of targets might fall? The following definitions are provided as a refresher:

**Targets From the Past**

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

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

**Targets From the Present**

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

Example: Getting summoned to the principal’s office caused Jerry to flush with anxiety, even though he had been Teacher of the Year three times running and was a 25-year veteran in the public school system as a high school teacher.

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

Examples: Sights, sounds, or smells may be triggers. A client reports becoming triggered by driving on or near a section of roadway where he was involved in a fatal crash in which his best friend was killed. Or a client becomes anxious and ashamed when being innocently questioned by a police officer, even though he has not done anything wrong.

**Targets From the Future**

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

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

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

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

*Other Potential Targets*

*Node.* In terms of the AIP model, a node is an associated system of information (Shapiro, 2001). It is “the biologically stored experience central to the memory network designated for therapeutic targeting” (Shapiro, 2008). A node could represent a cluster, a progression, or a feeder memory.
Example: Jeremy initially entered therapy because he had difficulty interacting professionally with his supervisor. Whenever his boss called or e-mailed asking him to come to his office, Jeremy felt like a small child being summoned to the principal’s office. “What did I do now?” he thought. After a thorough investigation of his past and present, Jeremy related how he felt and reacted around his father. “I always felt as though I had done something wrong.” Jeremy’s father worked and traveled extensively and was not home very much. When he was, Jeremy could find his father in his office working steadily and mostly unaware of the rest of the family activities in their home. His father was gruff and matter-of-fact and never paid much attention to Jeremy. When he wanted something from Jeremy or would reprimand him for something he did, he would call Jeremy to his office. It was one of those memories that became the target for Jeremy’s presenting issue.

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

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

Progression. A progression is a potential node. It generally arises in the course of the reprocessing of an identified target during or between sets (Shapiro, 2001). It is a more serious issue that cannot be pursued when it arises in the middle of an EMDR session.

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

**Feeder Memory.** This type of memory has been described by Dr. Shapiro as an inaccessible, earlier memory that contributes to a client’s current dysfunction and that subsequently blocks the reprocessing of it (2001). Unlike progressions, which typically arise spontaneously, feeder memories usually are discovered more by direct inquiry and are touchstone memories that have yet to be identified. If a client becomes stuck during reprocessing, this is a clue that there may be a feeder memory stalling the processing. Note: A feeder memory also differs from a progression in that the feeder memory is an untapped memory related to the current memory being processed. The feeder memory is treated before the current memory (i.e., EMDR within EMDR). This is unlike a progression, which is a new target (i.e., memory) that pops up during the processing of another traumatic incident (see above, under Progression). The progression is acknowledged and processed at a later time.

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

**Blocking Belief.** A blocking belief is a belief that stops the processing of an initial target. Blocking beliefs typically show themselves when the clinician is evaluating the Subjective Units of Disturbance (SUD) or Validity of Cognition (VoC). In the desensitization phase, the SUD level will not move below a “1” and, in the installation
phase, the VoC remains below a “7.” Typically, when the clinician asks the client in the desensitization phase, “What prevents it (i.e., SUD) from being a ‘0’?” or, if the client is in the installation phase, “What prevents it (i.e., VoC) from being a ‘7’?” the client is able to respond with a negative belief and an appropriate, associative early memory. At this point, the processing on the initial target is stopped until the blocking belief memory has been targeted and reprocessed. Then, and only then, is the original memory retargeted and reprocessing continued.

Example: Heather, a sergeant in the military, returned home after sustaining injuries during a rocket attack while on a routine field mission in Iraq. Two of her fellow soldiers died from the blast. Heather was hit by flying shrapnel that literally left a hole in her leg. She required two subsequent surgeries, both of which were unable to remove all of the rocket shrapnel from her leg. During recuperation, Heather reported disturbing recurring dreams, flashbacks, and thoughts of the rocket attack, which were frequently accompanied by high levels of anxiety or a panic attack. While targeting the event utilizing EMDR, the sergeant’s negative cognition was “I’m unsafe” and her positive cognition was “I can be safe.” When assessing the sergeant’s positive cognition during the installation phase, she reported a VoC of “6.” After attempting to shift her response by changing the direction and speed of the bilateral stimulation with no success, Heather was asked by the clinician, “What prevents it (i.e., VoC) from being a 7?” Heather immediately responded with the blocking belief, “I can never be safe.” Further questioning by the clinician revealed that, when Heather was 5, she had been digitally penetrated by an older cousin who had said to her, “If you tell anyone what happened, you will never be safe. I will find you. And I will kill you.” This is also a feeder memory in that it contributes to the current dysfunction and blocked processing. This feeder memory is represented by the blocking belief, “I can never be safe.”

Peelback Memory. A peelback memory usually occurs when a touchstone has not been identified and, during reprocessing, other associations begin to “peel back” to expose prior disturbing memories.

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

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

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

**Wellsprings of Disturbance.** This phenomenon is indicative of “the presence of a large number of blocked emotions that can be resistant to full EMDR processing” (Shapiro, 2001) and is often caused by the existence of an extensive negative belief system. A wellspring is similar to a feeder memory in that both are feeding the emerging emotions. Clients who are resistant to therapy or who seek therapy involuntarily at the urging of someone else (e.g., therapy is court-ordered or requested by a persistent and threatening spouse) are most susceptible to this phenomenon. They are in therapy because of someone else and possess no desire to report or deal with any feelings (Shapiro, 2001).

*Example:* A man who is forced into therapy at the urging of a disgruntled spouse may possess the belief that “real men don’t cry.” This
belief may be associated with an earlier traumatic memory and result in the client suppressing any high level of disturbance that might otherwise naturally occur under a current circumstance (e.g., dealing with his wife’s raging episodes). The true level of affective disturbance is never reached by the client, and it is this same level that contributes to the client’s present dysfunction. Earlier experiences taught him that men (or boys) are not allowed to express themselves emotionally. If there is no change in the client’s imagery, body sensations, or insight but he continues to report a low level of disturbance, the wellspring phenomenon is probably in effect. When present, the clinician may need to provide additional EMDR strategies in order to access the blockage. See the formulas in Figure 1.11.

**Blocking Belief =** A negative belief about oneself that stalls EMDR processing

**Wellsprings of Disturbance =** Negative Beliefs + Unresolved (Early Memories) + Blocked Emotions

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

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

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

Now that you have a clearer picture of what these targets are and how they are related, can you think of examples for each? Recollect targets from some of your EMDR sessions with clients to help you identify
examples of each. Targets . . . past, present, and future . . . especially ancillary targets can emerge in any of the three prongs in the EMDR protocol. Refer to Figure 1.12 for assistance. It is important to be on the lookout for them through the entire process in order to ensure adaptive resolution of every aspect of the client’s traumatic history.

<table>
<thead>
<tr>
<th>PAST</th>
<th>PRESENT</th>
<th>FUTURE</th>
</tr>
</thead>
</table>
| **Touchstone Memory**  
Failed first Spelling test | **Present Circumstances**  
On probation at place of employment  
Can’t get ahead financially | **Future Desired State**  
Being successful  
Future, Imaginal Template  
Imagining successful outcomes  
Role play being successful |
| **Single Event**  
Failed college entrance exam | **Internal/External Triggers**  
Upcoming exams  
Performance reviews  
Being summoned to boss’s office |  |
| **Recent Event**  
Business burned down two weeks ago, 20 employees were killed | **Cluster Memories**  
Failed driver’s license test first time  
Flunked gym in 7th grade  
Was asked to quit church choir by music director |  |
|  | **Progression**  
(For Later Processing)  
Was kicked off the football team because he witnessed sexual misconduct between another player and coach |  |
|  | **ANCILLARY TARGETS**  
(Block Processing) |  |
|  | **Feeder Memory**  
I will fail  
Target earliest memory of having failed |  |
|  | **Blocking Belief**  
In order to succeed, I need to have my father’s approval |  |
|  | **Peelback Memory**  
Rape |  |
|  | **Fear**  
Fear of failure |  |
|  | **Wellsprings of Disturbance**  
Low level of disturbance; Inability to feel emotions  
Target earliest memory of having failed and negative belief that blocks emotions |  |
|  | **Secondary Gain**  
Fear of loss of identity  
Who am I without this fear of failure?  
Who am I if I succeed? |  |

**Figure 1.12** Three-pronged targets: Types of targets with examples.
DUAL ATTENTION STIMULATION

What Does It Do?

When Dr. Shapiro was in the early stages of developing the theory, procedures, and protocol behind EMDR, she thought that it was the saccadic eye movements or eye tracking that helped to activate the information processing system, which processes the dysfunctionally stored material around a traumatic event. It was subsequently found that alternating bilateral hand taps and auditory tones could also be utilized. Some clinicians use alternating bilateral instrumental music. The type of bilateral stimulation utilized is important in terms of what the client can best tolerate. A person with an eye disorder obviously might not be able to track a clinician’s fingers well. Someone who does not like to be touched may not be able to tolerate being tapped by the clinician or the close proximity of the clinician to them. The type of stimulation chosen depends on the client. It is important to be able to offer more than one type of stimulation to accommodate the preferences presented by the client.

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

Preferred Means of Dual Attention Stimulation

Dr. Shapiro’s preferred means of bilateral stimulation is eye movement. All the research involved in establishing the efficacy of EMDR was done utilizing eye movements. This type of stimulation also supports dual attention whereby the client can attend to both internal and external stimuli. The client processes using eye movement with his eyes open so that he remains aware of his present environment. Twenty studies have focused on investigating the role of eye movements in EMDR to date: (a) case studies (Montgomery & Ayllon, 1994; Lohr, Tolin, & Kleinknecht, 1995; Lohr, Tolin, & Kleinknecht, 1996; Acierno, Tremont, Last, & Montgomery, 1994); (b) clinical dismantling studies with
diagnosed participants (Devilly, Spence, & Rapee, 1998; Renfrey & Spates, 1994; Boudewyns & Hyer, 1996; Pitman et al., 1996); (c) clinical dismantling studies with analogue participants (Carrigan & Levis, 1999; Sanderson & Carpenter, 1992; Solomon, Gerrity, & Muff, 1992; Van Etten & Taylor, 1998); and (d) component action studies (Barrowcliff, Gray, MacCulloch, Freeman, & MacCulloch, 2003; Wilson, Silver, Covi, & Foster, 1996, Kuiken, Bears, Miall & Smith, 2001–2002; Christman, Garvey, Propper, & Phaneuf, 2003; Andrade, Kavanagh, & Baddeley, 1997; Kavanagh, Freese, Andrade, & May, 2001; Shapley, Montgomery, & Scalzo, 1996; van den Hout, Muris, Salemink, & Kindt, 2001). See also Maxfield, Melnyk, and Hayman (2008) and Propper and Christman (2008) for further information on this important topic. No research presently exists to support having the client process with his eyes closed or for the other methods of stimulation (i.e., auditory tones, tapping).

Is Dual Attention Stimulation EMDR?

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

Shorter or Longer? Slower or Faster?

During the preparation phase, bilateral stimulation is originally introduced with the calm (or safe) place and any other resource enhancement or stabilization exercises deemed appropriate by the clinician prior to using EMDR and, then again, during reprocessing in the desensitization phase. There is a difference in the speed and number of bilateral sets of stimulation used in both. The recommended rate of speed is slower, and the number of round-trip passes is fewer (4–6), when using bilateral
stimulation with resource, coping, relaxation, and stress reduction exercises and strategies.

While using bilateral stimulation when reprocessing, including installation, the speed is tolerably comfortable (i.e., much faster) for the client and number of sets is increased (20–30 round-trips). Faster and longer sets of bilateral stimulation are more likely to activate disturbing material and trigger associated channels of information. Slower and shorter sets are utilized in stabilization efforts so as to not activate any disturbing material prior to actual reprocessing with EMDR.

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

**IMPORTANT CONCEPTS TO CONSIDER**

**What Once Was Adaptive Becomes Maladaptive**

Some behaviors are learned. Some serve us well and others do not. Some serve us for a period in our life and eventually become a nuisance. For example, a woman who was repeatedly sexually molested by a relative as a young child may have learned to dissociate during the molestation. This was her way of coping with the fear and pain of the trauma at the time of the abuse. Years later, as an adult, she may still find herself dissociating during stressful situations in her job. As a child, dissociation was the only way she knew to cope; and it worked well at the time. As a maturing adult, the dissociation begins to cause problems at home, at school, and/or at work.

**State vs. Trait Change**

Dr. Shapiro (2008) differentiated between a state and a trait change. She defined a state change as momentary or transitory, whereas a trait change reflected a permanent change. A state change is a change of mind. It
instills a sense of hope in the client. A state change also requires the use of coping mechanisms to continue the change, whereas a trait change no longer requires use of any. With a trait change, the client changes how he sees or views the event and, as a result, can experience it differently. When a client changes his perspective about a traumatic event that he has experienced in his life and has the needed skills, he is able to function more appropriately. An example of a state change is the client saying, “I am able to soothe myself by breathing and using my safe place when my boss asks me to come to his office. I feel much calmer.” A trait change may be, “I am no longer triggered when my boss asks me to come to his office.” To simplify, “states are weather” whereas “traits are climate.” “All traits are states” but “not all states are traits” (Shapiro, 2006).

Dual Awareness

Dual awareness or mindfulness or what Dr. Shapiro calls “dual focus of attention” (2001) allows the client to maintain a sense of present awareness and for the client’s internal processes to function without interference during EMDR. In essence, it allows the client to be a nonevaluative observer with respect to whatever emerges during an EMDR session. One of the primary reasons to teach a client grounding and breathing skills and anchoring him in the present is to help him learn to keep one foot in the present while reprocessing something traumatic from his past. This provides him with a dual focus of attention and reduces the possibility or risk of a client dissociating, blanking out, and/or resisting. Teaching him these skills prior to the EMDR processing will help facilitate a smoother EMDR experience. It also allows the client to maintain a sense of safety in the present while accessing and stimulating negative information from the past. The clinician can solidify the client’s connection to the present by utilizing verbal reassurances such as, “Good,” “You’re doing fine,” “It’s over,” or “You’re safe now.” The clinician may also change the direction or speed of the bilateral stimulation. When a client is in an abreactive state, these types of clinical strategies are particularly important to help the client maintain an external focus (Shapiro, 2001).

Ecological Validity (i.e., Soundness)

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

How does one recognize ecological validity? And how do you work with it within the EMDR framework? First, use Wolpe’s Subjective Units of Disturbance scale (SUD; Wolpe, 1990; see Figure 1.13).

The SUD scale is an 11-point Likert scale utilized to rate the anxiety level of a memory being accessed by a client in the present. When you ask the client to focus on the original event (or incident) and again ask, on a scale from “0” to “10,” “How disturbing does it feel now?” and the client says a “1,” you need to check out what is blocking (i.e., blocking belief) desensitization of the original target by asking, “What keeps it from being a ‘0’?” In the case of a rapist, the client might respond, “He’s still out there.” Ask the client to “go with that” and continue to process to a more complete resolution. Do not assume that the client has reached the end of the channel just yet. Continue to process and check the SUD again before proceeding to the installation phase.
If the client still clings to the “1” and “he’s still out there,” you can consider this to be ecologically valid. Ecological validity is the only reason you may go directly to the installation phase without the client’s SUD level getting down to a “0.” The SUD scale will be discussed in more depth in chapter 2 and chapter 3.

A blocking belief may also arise in the installation phase when evaluating the Validity of Cognition (VoC), a 7-point Likert scale which measures the validity (i.e., felt sense of the trueness or falseness) of the client’s stated positive cognition (PC). If the client reports a VoC of “6” or “6.5,” use the same questioning used above when the SUD does not equal ‘0’ (i.e., “What prevents it from being a ‘7?’”) to discern for: (a) a blocking belief; or (b) ecological validity.

Dr. Shapiro has been known to say, “Forgiveness is like rain—it may or may not happen.” If a person forgives someone who has hurt her, it doesn’t mean she uses poor judgment with respect to that person (e.g., leaving the children with a past abuser). However, clients often arrive at forgiveness more quickly and more completely than they might with other forms of therapy. Clinicians must be alert to not use their own experiences or experiences of their other clients to determine “ecological validity” for any specific client. If processing stops at a certain place, first attempt to remove the block by changing the direction or modality of the bilateral stimulation. Always get the client’s permission before doing so. Then do a couple more sets of bilateral stimulation before determining if it is ecologically valid for the person to move further toward forgiveness.

**Side Benefits of EMDR**

The primary goal of EMDR is to clear out any irrational, negative cognitions, emotions, and physical sensations associated with a trauma. It does not, however, have the power to clean out rational, negative sensations and cognitions related to a traumatic event. In the rape example above, it may be important to the client’s stability that she maintains a healthy sense of fear and a high level of vigilance until after the rapist has been caught and her physical safety is ensured. Depending on the circumstance of the rape, it could be unlikely that her fear and vigilance will dissipate completely until the rapist is apprehended.

The EMDR process does not have the ability to clean out any negative thoughts, emotions, or physical sensations that are appropriate to the situation. For example, a client may hate his mother. His mother may have been abusive, neglectful, and distant. The client may have developed low
levels of self-esteem and confidence as a result. EMDR may be successful in raising the client’s self-esteem and other issues, but the client may or may not still feel hatred toward his mother after the EMDR work has been completed. EMDR does not have the potential for making you fall back in love with your significant other if you do not love him, attain a raise at your job if you do not deserve one, or make you the next race car champion of the Indy 500 if you do not have the ability to drive a race car. It cannot make the true untrue or the untrue true. It only has the ability to decompress the negative thoughts, feelings, and physical sensations from the client’s internal system so that natural healing can take place.

Another side benefit of EMDR is the resultant learning that is possible. In addition, new insights may occur, behavior, perceptions, and attitudes can shift, and physical and emotional responses can change.

**Holistic Nature of the Approach**

Even though it has been around for 20 years, EMDR is very much a “cutting edge” therapy. One of the reasons that it continues to be cutting edge is because it appears to be a permanent means of flushing traumatic memories and the negative cognitions, emotions, and physical sensations that accompany them from the client’s system in a way that talk therapy and some of the alternative therapies do not. It is a whole system approach. It can reach down into the depths of a client’s despair, attach itself to every negative element connected to a traumatic event, and then flush it out.

**Useful Train Metaphor**

Dr. Shapiro prescribes the use of a train metaphor to help clients move along their processing “tracks.” Reference to and use of this metaphor will be utilized frequently throughout this Primer. During the desensitization phase, this metaphor can be applied as a means of noticing, yet distancing the client from fear of the trauma. Dr. Shapiro favors this metaphor because it conveys a sense of movement and safety (Shapiro, 2006). The train metaphor may be used throughout the reprocessing as needed. It goes like this:

In order to help you “just notice” the experience, imagine riding on a train and the feelings, thoughts, etc., are just scenery going by” (Shapiro, 2001).
During the reprocessing, the image of the train going down the track is also used to encourage the client to continue. The passenger is the client, and the scenery represents the dysfunctional information that she is reprocessing. The clinician might say, “It’s just old scenery. Just watch it go by.” This metaphor is a reminder to the client that the train passes the scenery as quickly as it appears.

Dr. Shapiro describes the processing as “metaphorically like moving down a train track” (Shapiro, 2006). From the point of origination to the destination, there are freight depot stops where passengers get off (i.e., dysfunctional information is unloaded) and new passengers get on (i.e., adaptive information is loaded). In between stops, linkage to adaptive networks can occur. See Figure 1.14 for a pictorial rendition of this metaphor. Again, the damaged material is unloaded and discarded at the freight depots found along the track during the stopping and starting of the bilateral stimulation. It is also at this freight depot where adaptive information is loaded. When the train finally reaches its final destination, the client has reached adaptive resolution.

Whether recommending the train or another example, the metaphor is an option being offered to a client if the trauma becomes too much to bear and distancing from it will allow reprocessing to continue. Installation is unnecessary.
Dr. Shapiro also uses the train metaphor to describe information that moves adaptively from dysfunctional to functional. It is a common experience for a client’s once vivid negative images, affect, and cognitions to become less vivid and less valid while the opposite happens to the positive images, affect, and cognitions. Can you visualize a train traveling down its track? Each time the dysfunctional information is stimulated or when accelerated processing takes place, the train moves down the track and stops. At each stop, the client drops off dysfunctional information and boards more functional or adaptive information. The train continues on this route until it reaches its final destination (i.e., adaptive resolution).

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

PRACTICAL TIPS TO REMEMBER

Practice, Practice, Practice

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

Follow the Script Verbatim

Newly trained EMDR clinicians are strongly encouraged to follow Francine Shapiro’s script verbatim in the assessment phase. Dr. Shapiro
has chosen every word for a specific reason, and these words have been tested and validated over and over again in one context or another in session after session with clients presenting various mental health issues. It is important for the reader to appreciate the wording of her famous protocol before implementing individual styles of eliciting the same information. Clinicians who learned the script in the early days of EMDR may notice how it has been refined throughout the past 20 years.

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

Consider logging onto the EMDR Humanitarian Assistance Programs (EMDR-HAP) Web site and ordering the EMDR Progress Note-pad. The monies contribute to a good cause, and the worksheets can assist you in being more consistent and successful from client to client. You may also consider purchasing the laminated SUD/VoC Scale Chart. These items may be purchased online at the EMDR-HAP Store (http://www.emdrhap.org). It is not an uncommon reaction for a client to look like a deer caught in the headlights when asked, “What words go best with the picture that express your negative belief about yourself now?” The laminated scale can save time and also help the client to distinguish a belief from a feeling and to select a negative belief appropriate to his situation.

**Know Your Client**

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

Stay off the Tracks

After completion of the assessment phase, the clinician is encouraged to be very limited in what she says, such as “Let it go” or “rest” or “blank it out” (i.e., meaning take a break or clear your mind). “Let it go. Take a deep breath.” “What are you noticing now?” “Good.” “Go with that.” “Notice that.” The clinician does not say much of anything else unless the client appears stuck in the process.

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

Tracking the Client

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

**Keep It Simple**

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

**Then or Now?**

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

The clinician may need to repeat the “now” over and over to a client. A client may get confused between how she felt “then” about an incident and how she feels “now” and ask questions that indicate her confusion. “Do you mean then or now?” And she could say, “Then it felt awful, but now it does not feel so bad.” If this happens during the assessment phase, the clinician may need to reevaluate whether or not the client has chosen an appropriate target. Remember, the clinician is looking to relieve the client of a memory that is charged with negativity. Use Figure 1.15 to help remember this important point.
A good rule to remember during EMDR reprocessing with a client is that, any time something is positively reinforced with bilateral stimulation, it strengthens the focus of reinforcement. So, when a client reports a positive direction in the reprocessing, “Go with that,” just one more time before returning to target. After the client reaches the SUD of “0,” VoC of “7,” and a clear body scan, say, “Go with that,” one or more times to reinforce the positive treatment effect and/or to allow deepening of the positive cognition (Shapiro, 2001, 2009). If the clinician is consistent with this rule, the success of the EMDR will be enhanced. In any case, it is important to continue bilateral stimulation as long as positive material continues to emerge or strengthen in any part of the client’s reprocessing experience.

When reinforcing a positive effect during the desensitization, installation, and body scan phases, the bilateral stimulation will be faster and the length of the sets longer (i.e., 20–30 round-trip passes) than during the preparation phase when using the calm (or safe)
place and other resource building exercises (i.e., slower 4–6 round-trip passes).

**Solo Run**

Client selection is an important part of the EMDR process but more so when a clinician is choosing clients for a first solo run. Clinicians may want to select clients with whom they have healthy client–clinician relationships. There is nothing wrong with selecting clients with issues that maximize a clinician being successful in the early days of usage. Pick the easiest cases. Imagine that the client is an onion and his layers of trauma are as the layers of the onion. How many are there? How thick? How thin? So, when looking at the onion, look for the one- or thin-layered skins. And go slowly. Do not expect to utilize EMDR on the most difficult client and for it to go without some frayed ends here and there.

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

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

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

**SUMMARY STATEMENTS**

1. EMDR is an integrative psychotherapeutic approach and is guided by the information processing model. The AIP model “provides the theoretical framework and principles for treatment and an explanation of the basis of pathology and personality development” (Shapiro, 2001). As an integrative psychotherapeutic approach, EMDR is distinct from CBT, experiential, and psychodynamic approaches although it is not exclusive and may be informed by or used together with these approaches.

2. EMDR has eight distinct phases.

3. EMDR is a three-pronged approach addressing the past, the present, and the future.

4. Dual attention stimulation using bilateral stimulation is not EMDR. It is only one component.

5. EMDR is a fluid, dynamic approach that entails the clinician using all her clinical skills. It is neither mechanistic nor a cookbook approach.

6. The heart of EMDR is the AIP model. As such, it is critical that the clinician have a clear understanding of it in order to proceed with EMDR practice.

7. Practice, practice, practice. This is how to learn the model.

8. Know your client, inside and out.

9. Stay out of the client’s way. The reprocessing is about the client, not the clinician.