An EMDR Therapy Primer
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She is the creator of the Francine Shapiro Library, an online resource of EMDR research and writings. She is also the 2009 recipient of the distinguished Francine Shapiro Award for her extraordinary service and contributions to EMDR. Dr. Hensley is the co-founder of the Cincinnati Trauma Connection in Cincinnati, Ohio, an EMDR-based trauma center.
To Francine Shapiro,
creator of EMDR Therapy, a ripple in still water,

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

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

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

—Lee J. Colan (Orchestrating Attitude, 2005)

Fear will make you stand still.

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

BACK HISTORY

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

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

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

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

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

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

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

Jennifer Lendl, PhD

REFERENCES


Preface

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

TUNING INTO THE CREATIVE FORCE

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

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

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

From the day of her fateful walk in Vasona County Park in Los Gatos, California, in 1987, 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 EMD and PTSD appeared in the *Journal of Traumatic Stress* (1989). During this same year, controlled studies were also published on exposure therapy, psychodynamic therapy, and hypnosis for the treatment of PTSD. In 1990, Dr. Shapiro changed the name of EMD to EMDR to recognize and acknowledge the comprehensive reprocessing effect that was taking place. It was also during this time that other forms of bilateral stimulation (tones, taps, or music) were recognized as having the same effect and began to be utilized as an alternative to the preferred eye movement. Table 1.2 briefly describes EMD and EMDR.

<table>
<thead>
<tr>
<th>History of EMDR Therapy</th>
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<td>Many of you have repeatedly heard the story of Dr. Francine Shapiro's historic walk in Vasona County Park in Los Gatos, California, in 1987. While taking a walk, she noticed that the disturbing thoughts upon which she was focusing about a recent past traumatic event in her life were suddenly disappearing. When she tried to bring them back up, these thoughts did not seem to her to have the same negative charge or significance that they had at the beginning of her walk. She began to pay careful attention, and what she noticed when a negative thought went through her mind was that her eyes began to move spontaneously in a rapid, diagonal movement. Her thoughts had shifted; and, when she tried to bring them back up, they did not have the same charge. It was during this famous walk that Dr. Shapiro discovered the effects of spontaneous eye movement and began to develop procedures around the effects of bilateral eye movements. In 1989, she published the first controlled outcome study of EMD and PTSD in the <em>Journal of Traumatic Stress</em> (1989a). During this same year, controlled studies were also published on exposure therapy, psychodynamic therapy, and hypnosis for the treatment of PTSD. In 1990, Dr. Shapiro changed the name of EMD to EMDR to recognize and acknowledge the comprehensive reprocessing effect that was taking place. It was also during this time that other forms of bilateral stimulation (tones, taps, or music) were recognized as having the same effect and began to be utilized as an alternative to the preferred eye movement. Table 1.2 briefly describes EMD and EMDR.</td>
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From the day of her fateful walk in Vasona County Park in Los Gatos, California, Dr. Shapiro’s destiny began to change. Excited by her chance revelation, she leapt into action, finding friends and subjects to test her new discovery. She quickly set out to develop well-structured principles, protocols, and procedures around the effects of eye movements based on the consistent treatment results she and others had observed. She trained interested and excited clinicians who in turn encouraged others to learn this new methodology. The big-C ripple mounted as the first controlled study of EMDR Therapy appeared in the *Journal of Traumatic Stress* in 1989. Other studies were soon to follow, and the rest is history. Dr. Shapiro’s big-C creativity changed and continues to change the way trained clinicians conceptualize and treat trauma. EMDR Therapy has redefined the state of the art in terms of mental health.

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

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

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

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

WHAT IS INCLUDED

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

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

PURPOSE OF THE PRIMER

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

The Primer is laid out in the following manner:

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

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

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

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

EMDR THERAPY

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

_________________________

Eye Movement Desensitization and Reprocessing (EMDR) Therapy

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


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

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

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

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

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

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

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

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

Francine Shapiro, PhD
Notes From the Author

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

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

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

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

**Deany Laliotis, LCSW**, is a Licensed Clinical Social Worker in private practice in Bethesda, Maryland, specializing in the treatment of traumatic stress disorders and attachment issues with EMDR. She is currently an EMDRIA Certified Therapist, Approved Consultant, and senior EMDR Institute trainer and has presented at numerous conferences on the clinical application of EMDR both in the United States and abroad. Ms. Laliotis has also contributed a chapter in the book, *Psychotherapist Revealed: Therapists Speak About Self-Disclosure* (2009).
Contributing Editors

Jennifer Lendl, PhD, is a Psychologist in San Jose, California, and was one of the first EMDR trainers. She is coauthor of *EMDR Performance Enhancement for the Workplace: A Practitioner’s Manual* (1997). Dr. Lendl is an EMDRIA Certified Therapist and Approved Consultant, EMDR Institute facilitator, and currently sits on the EMDRIA Conference Committee. She is also the 2006 recipient of the Francine Shapiro Award and is a frequent presenter at the annual EMDRIA Conferences.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I have always believed in the spirit of generosity, giving freely without strings attached. This philosophy includes making financial contributions, offering pro bono therapy services, and sharing personal and professional resources to support those who might need a step up. I am so rewarded in life for taking this stance. For me, EMDR Therapy is a work of the heart, spurred on by my belief in the power of EMDR’s healing properties. I chose to write and assist those beginning to study EMDR Therapy as a way of continuing to “pay forward.” In offering this Primer to the EMDR Therapy community, it is my hope that many clinicians and their clients will reap the benefits of my efforts.
Chapter 1

EMDR Therapy Overview

The world is round and the place which may seem like the end may also be the beginning.

—Ivy Baker Priest (Parade, 1958)

REINTRODUCTION TO EMDR THERAPY

The goal of EMDR is to achieve the most profound and comprehensive treatment effects possible in the shortest period of time, while maintaining client stability within a balanced system. (Shapiro, 2001, p. 6)

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

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

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

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

TRAUMA

What Is Trauma?

The diagnostic criteria for posttraumatic stress disorder (PTSD; 309.81) cited in the Diagnostic and Statistical Manual of Mental Disorders, 5th ed. (DSM-5; American Psychiatric Association [APA], 2013) is the definition used most frequently to describe acute trauma in adults. In essence, this definition describes trauma as an event experienced or witnessed by a person that results in intrusive symptoms, avoidance, negative alterations in cognitions...
and mood, and alterations in arousal and reactivity (APA, 2013). Flannery describes trauma as “the state of severe fright that we experience when we are confronted with a sudden, unexpected, potentially life-threatening event, over which we have no control, and to which we are unable to respond effectively no matter how hard we try” (1995).

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

Types of Trauma

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

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

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

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

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

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

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

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

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

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

**Examples:**
- Moving multiple times during childhood
- Excessive teasing or bullying
- Persistent physical illnesses
- Constant criticism
- Rejections
- Betrayals
- Disparaging remarks
- Losing jobs
- Divorce or witnessing parental conflict
- Unmet developmental needs
- Death of pets
- Public shaming, humiliation, or failure
- Unresolved guilt
- Physical or emotional neglect
- Getting lost
- Chronic harassment
EMDR Therapy is a distinct integrative psychotherapeutic approach and is compatible with other major orientations of psychotherapy. This eight-phase approach is led by an information processing model and guides clinical practice (i.e., case conceptualization and treatment planning) in general.

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

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

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

### TABLE 1.2

**Accelerated Information Processing vs. Adaptive Information Processing**

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

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

TABLE 1.3
Adaptive vs. Maladaptive Resolution

<table>
<thead>
<tr>
<th>ADAPTIVE</th>
<th>MALADAPTIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I survived.</td>
<td>Driving phobia</td>
</tr>
<tr>
<td>I can learn from this.</td>
<td>Flashbacks</td>
</tr>
<tr>
<td>I can protect myself.</td>
<td>Intense driving anxiety</td>
</tr>
<tr>
<td>I am safe.</td>
<td>Night terrors</td>
</tr>
</tbody>
</table>

**Large “T” (e.g., Safety)**

<table>
<thead>
<tr>
<th>ADAPTIVE</th>
<th>MALADAPTIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am fine as I am.</td>
<td>Low self-esteem</td>
</tr>
<tr>
<td>I did the best I could.</td>
<td>Irrational guilt</td>
</tr>
<tr>
<td>I am significant/important.</td>
<td>Self-neglect, codependence</td>
</tr>
</tbody>
</table>

**Small “t” (i.e., Disturbing Life Events) (e.g., Responsibility)**

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

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

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

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

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

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

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

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

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

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

**MODEL, METHODOLOGY, AND MECHANISM OF EMDR THERAPY**

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

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

---

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

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

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

### TABLE 1.7
**Client’s Experience: AIP in Action**

<table>
<thead>
<tr>
<th>BEFORE</th>
<th>AFTER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client experiences negative event, resulting in:</strong></td>
<td><strong>Client experiences adaptive learning, resulting in:</strong></td>
</tr>
<tr>
<td>Intrusive images</td>
<td>No intrusive images</td>
</tr>
<tr>
<td>Negative thoughts or beliefs</td>
<td>No negative thoughts or beliefs</td>
</tr>
<tr>
<td>Negative emotions and associated physical sensations</td>
<td>No negative emotional and/or physical sensations</td>
</tr>
<tr>
<td><strong>What happens?</strong></td>
<td><strong>What happens?</strong></td>
</tr>
<tr>
<td>Information is insufficiently (dysfunctionally) stored</td>
<td>Information is sufficiently (adaptively) processed</td>
</tr>
<tr>
<td>Dysfunctional information gets replayed</td>
<td>Adequate learning has taken place</td>
</tr>
<tr>
<td>Developmental windows may be closed</td>
<td>Development continues on a normal trajectory</td>
</tr>
<tr>
<td><strong>Resulting in:</strong></td>
<td><strong>Resulting in:</strong></td>
</tr>
<tr>
<td>Depression</td>
<td>Sense of well-being</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Self-efficacy</td>
</tr>
<tr>
<td>Low self-esteem</td>
<td>Understanding</td>
</tr>
<tr>
<td>Self-deprecation</td>
<td>Catalyzed learning</td>
</tr>
<tr>
<td>Powerlessness</td>
<td>Appropriate changes in behavior</td>
</tr>
<tr>
<td>Inadequacy</td>
<td>Emergence of adult perspective</td>
</tr>
<tr>
<td>Lack of choice</td>
<td>Self-acceptance</td>
</tr>
<tr>
<td>Lack of control</td>
<td>Ability to be present</td>
</tr>
<tr>
<td>Dissociation</td>
<td></td>
</tr>
</tbody>
</table>
There is a body of literature including both research and case reports on a variety of clinical complaints that illustrates the predictive value of the AIP in terms of body dysmorphic disorder (Brown, McGoldrick, & Buchanan, 1997); generalized anxiety disorder (Gauvreau & Bouchard, 2008); olfactory reference syndrome (McGoldrick, Begum, & Brown, 2008); adolescent depression (Bae, Kim & Park, 2008); posttraumatic stress disorder (Mol et al., 2005; Raboni, Tufnik, & Suchecki, 2006); the role of EMDR Therapy in medicine (Shapiro, 2014); dental phobia (Doering, Ohlmeier, de Jongh, Hofmann, & Bisping, 2013); perpetrators with a trauma history (Ricci, Clayton, & Shapiro, 2006); adult attachment (Wesselman & Potter, 2009); psychosis (van den Berg & van den Gaag, 2012; Varese et al., 2012); peer verbal abuse (Teicher, Samson, Sheu, Polcari, & McGreener, 2010); obsessive-compulsive disorder (Nazari, Momeni, Jariani, & Tarrahi, 2011); and phantom limb pain (de Roos et al., 2010; Russell, 2008; Schneider, Hofmann, Rost, & Shapiro, 2007, 2008; Wilensky, 2006).

**TABLE 1.8**

**Important Components of the Information Processing Model**

| The AIP model views maladaptive/negative memory networks as the “underlying basis of both pathology and mental health.” |
| Disturbing memories are dysfunctionally stored (i.e., perceived in the same way as when the memory was originally formed) and may disrupt the information processing system. |
| Emotions, physical sensations, and thoughts and beliefs associated with unprocessed memories are experienced by the client as his perceptions in the present link to the historical memory networks. |
| In order to be interpreted, a client’s perceptions of present situations link into networks of physically stored memories (negative or dysfunctional) from the past. In other words, the past is present. |
| As the processing begins, disruptions may be caused by high levels of emotional disturbance or dissociation, which can block adaptive processing. |
| When a client is processing the memory of a traumatic event, he has the opportunity to forge adaptive associations with memory networks of functional information stored in the brain. This EMDR associative process allows these connections to be made. |
| During processing, the unprocessed elements of a client’s memory (i.e., image, thoughts, sounds, emotional and physical sensations, beliefs) have the ability to transform/transmute to an adaptive resolution. At this point, learning may take place. By discarding maladaptive information and storing adaptive information, a client has new learning that may better inform future experiences and choices. |
Methodology—How/What?

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

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

<table>
<thead>
<tr>
<th>TABLE 1.9</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Model—Adaptive Information Processing (AIP) and EMDR Therapy Procedures: How/What?</strong></td>
</tr>
<tr>
<td>1997</td>
</tr>
<tr>
<td>1998</td>
</tr>
<tr>
<td>2001</td>
</tr>
<tr>
<td>2002</td>
</tr>
</tbody>
</table>

(continued)
<table>
<thead>
<tr>
<th>Year</th>
<th>Author(s) and Title</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Shapiro, F.</td>
<td><em>New notes on adaptive information processing: Case formulation principles, scripts, and worksheets</em>. Hamden, CT: EMDR Humanitarian Assistance Programs.</td>
</tr>
</tbody>
</table>
### TABLE 1.9 (continued)
Model—Adaptive Information Processing (AIP) and EMDR Therapy Procedures: How/What?

<table>
<thead>
<tr>
<th>Year</th>
<th>Author(s)</th>
<th>Title</th>
<th>Journal</th>
<th>Volume</th>
<th>Pages</th>
<th>DOI</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>Shapiro, F.</td>
<td>EMDR, adaptive information processing, and case conceptualization.</td>
<td>Journal of EMDR Practice and Research</td>
<td>1(2)</td>
<td>68–87</td>
<td>10.1891/1933-3196.1.2.68</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Year</th>
<th>Author(s)</th>
</tr>
</thead>
</table>

(continued)
Mechanism—Why?

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

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

<table>
<thead>
<tr>
<th>Model—Adaptive Information Processing (AIP) and EMDR Therapy Procedures: How/What?</th>
</tr>
</thead>
</table>

THREE-PRONGED APPROACH

**Past, Present, Future**

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

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

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

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

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

(continued)
TABLE 1.10 (continued)  
Mechanism of Action—Why?

<table>
<thead>
<tr>
<th>Year</th>
<th>Study (Reference)</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>El Khoury-Malhame et al. (2011)</td>
<td>Supported the existence of an attentional bias in PTSD patients due to a disengagement difficulty. Kristjánsdóttir and Lee (2011) found that eye movement produced the greatest benefit and that the vividness and emotionality associated with memories decreased significantly after eye movement and counting.</td>
</tr>
<tr>
<td>2012</td>
<td>van den Hout et al. (2012)</td>
<td>Found tones inferior to eye movements in the EMDR treatment of PTSD.</td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

![Three-pronged targets: order of reprocessing.](image)

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

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

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

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

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

TARGETING POSSIBILITIES

Targets May Arise in Any Part of the EMDR Therapy Process

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

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

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

Targets From the Past

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

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

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

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

Targets From the Present

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

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

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

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

**Targets From the Future**

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

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

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

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

Other Potential Targets

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

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

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

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

**Progression.** A progression is a potential node. It generally arises in the course of the reprocessing of an identified target during or between sets (Shapiro, 2001).


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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**BILATERAL STIMULATION (BLS)**

**What Does It Do?**

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

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

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

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**FIGURE 1.8** Three-pronged targets: types of targets with examples.

<table>
<thead>
<tr>
<th>Past</th>
<th>Present</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Touchstone Memory</strong>&lt;br&gt;Failed first spelling test</td>
<td><strong>Present Circumstances</strong>&lt;br&gt;On probation at place of employment&lt;br&gt;Can’t get ahead financially</td>
<td><strong>Future Desired State</strong>&lt;br&gt;Being successful</td>
</tr>
<tr>
<td><strong>Single Event</strong>&lt;br&gt;Failed college entrance exam</td>
<td><strong>Internal/External Triggers</strong>&lt;br&gt;Upcoming exams&lt;br&gt;Performance reviews&lt;br&gt;Being summoned to boss’s office&lt;br&gt;Smell of beer (perpetrator’s breath smelled of beer)</td>
<td><strong>Future, Imaginal Template</strong>&lt;br&gt;Imagining successful outcomes&lt;br&gt;Role play being successful</td>
</tr>
<tr>
<td><strong>Recent Event</strong>&lt;br&gt;Business burned down 2 weeks ago, 20 employees were killed</td>
<td></td>
<td></td>
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**Cluster Memories**
- Failed driver’s license test first time
- Flunked gym in 7th grade
- Was asked to quit church choir by music director

**Progression**
- Was kicked off the football team because he witnessed sexual misconduct between another player and coach

**ANCILLARY TARGETS**
- **Feeder Memory**
  - I will fail.
- **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?
1 EMDR Therapy Overview

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

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

Preferred Means of Bilateral Stimulation (BLS)

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

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

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

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

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

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

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

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

*continued*
<table>
<thead>
<tr>
<th>Year</th>
<th>Study Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>Barrowcliff, A. L., Gray, N. S., Freeman, T. C. A., &amp; MacCulloch, M. J. (2004, June). Eye-movements reduce the vividness, emotional valence and electrodermal arousal associated with negative autobiographical memories. <em>Journal of Forensic Psychiatry and Psychology, 15</em>(2), 325–345. doi:10.1080/14789940410001673042. In testing the reassurance reflex model, it was found that eye movements were found to be superior to control conditions in terms of reducing image vividness and emotionality.</td>
</tr>
<tr>
<td>2007</td>
<td>Parker, A., &amp; Dagnall, N. (2007). Effects of bilateral eye movements on gist based false recognition in the DRM paradigm. <em>Brain and Cognition, 63</em>, 221–225. doi:10.1016/j.bandc.2006.08.005. Bilateral saccadic eye movement groups “were more likely to recognize previously presented words and less likely to falsely recognize critical non-studies associates.”</td>
</tr>
</tbody>
</table>
## TABLE 1.11 (continued)

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

<table>
<thead>
<tr>
<th>Year</th>
<th>Study Details</th>
</tr>
</thead>
</table>
### TABLE 1.11 (continued)

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

<table>
<thead>
<tr>
<th>Year</th>
<th>Study Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>Schubert, S. J., Lee, C. W., &amp; Drummond, P. D. (2011). The efficacy and psychophysiological correlates of dual-attention tasks in eye movement desensitization and reprocessing (EMDR). <em>Journal of Anxiety Disorders, 25</em>, 1–11. doi:10.1016/j.janxdis.2010.06.024. Eye movements led to increased reduction in distress, decrease in heart rate at onset of EMs, decrease in skin conductance during EMs, increase in heart rate variability and respiration as EMs continued, and increased frequency of orienting responses at the start of exposure.</td>
</tr>
</tbody>
</table>
During the Desensitization Phase, the suggested average number of BLS sets (i.e., 24 longer, faster sets) is only a starting point for the client’s processing. As the clinician wants to avoid sets that are too long or too short, it is suggested that she begin with 20 or more passes and watch the client’s facial expressions and body language to determine the best length for any particular set. After this initial set, the clinician may customize the number of sets according to the client’s need or response.

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

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

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

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

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

### Continuous Bilateral Stimulation (BLS)

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

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

### How to Do Eye Movements

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

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

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

### IMPORTANT CONCEPTS TO CONSIDER

**Memory Network Associations**

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

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

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Using long and fast sets when doing stabilization.</strong></td>
<td>Doing so may activate processing prematurely (i.e., speeds up the train) and cause a client to begin processing any dysfunctionally stored past memories or present triggers.</td>
</tr>
<tr>
<td><strong>Using short and slow sets when doing reprocessing.</strong></td>
<td>Slow, short BLS may stimulate a relaxation response and inhibit a client from being appropriately activated by the targeted incident/event. When doing reprocessing, the BLS should be tolerably uncomfortable for the client. Using slow, short sets may also not facilitate dual awareness. It becomes too easy for a client to become absorbed in the memory when following eye movements that are too slow or too short. Note: Wilson, Silver, Covi, and Foster (1996) and Schubert, Lee, &amp; Drummond (2011) found that faster BLS may, at times, cause a compelled relaxation response.</td>
</tr>
<tr>
<td><strong>Continuing with eye movements if a client reports pain or dryness because of the process.</strong></td>
<td>If this occurs, switch to a previously agreed-on, alternate form of BLS. For example, if a client was reportedly poked in the eye when he was a child, auditory or tactile stimulation may be a better alternative.</td>
</tr>
<tr>
<td><strong>Pausing too long in between sets.</strong></td>
<td>There should be a specific reason for pausing too long between sets. Maybe the client is overwhelmed, “needs” to talk, or wants assurance that she is “doing it right.” If the client tends to relay everything that happened between sets, gently explain the information he gives is for baseline reasons only (i.e., to let the clinician know where the client is in the process), that the “mind is faster than the mouth,” and only minimal information is needed between sets. When a clinician or client talks excessively between sets, it inhibits the reprocessing (i.e., slows the train) of the targeted material.</td>
</tr>
<tr>
<td><strong>During reprocessing, using sets that are too long or too short.</strong></td>
<td>Using sets that are too long may cause a client to lose track of the primary event and become overwhelmed with too many thoughts, images, and emotions, and may inhibit or derail processing. Sets that are too short may inhibit processing by not giving a client enough time to initiate complete processing. The rule of thumb is to start with 20 plus sets of eye movements and judge from a client’s response (i.e., facial expression and body language) to determine what the appropriate number of sets is for each individual client. However subtle, a client will usually give a clue as to when a set is complete.</td>
</tr>
</tbody>
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(continued)
TABLE 1.14 (continued)
Derailment Possibilities—Bilateral Stimulation (BLS) Errors

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

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

TABLE 1.15
How to Do Eye Movements

**BEFORE CONCENTRATING ON EMOTIONALLY DISTURBING MATERIAL**

Initially using horizontal or diagonal eye movements, find the best fit for a client (e.g., horizontal, vertical, diagonal).

*Note:* The vertical eye movements may be preferred if a client has a history of vertigo. It is also reported to be helpful in reducing extreme emotional nausea, agitation, eye tension, or dizziness. Vertical eye movements have been known to produce a calming effect.

Experiment to find a client’s comfort level (i.e., distancing, speed, height). Switch immediately to an alternate form of BLS if a client reports eye pain or dryness.

Generate a full eye movement set by moving a clinician’s hand from one side of a client’s range of vision to the other.

The speed of the eye movement should be as rapid as possible and without any undue physical discomfort to a client.

Use at least two fingers as a focal point (i.e., two fingers held together is usually the preferred number in American culture).

With palm up approximately 12–14 inches from a client’s face (i.e., preferably chin to chin or contralateral eyebrow, some say shoulder to shoulder), hold two fingers upright and ask a client, “Is this comfortable?”

*Note:* It is important to determine distance and placement of the eye movement with which a client is the most comfortable prior to the Assessment Phase.

Demonstrate the direction of the eye movements by starting in the middle and slowly moving the fingers back and forth in a client’s visual field, and then ending in the center.

(continued)
TABLE 1.15 (continued)
How to Do Eye Movements
Evaluate and monitor a client’s ability to track the moving fingers. Start slowly and increase the rate of speed to the fastest a client can comfortably tolerate physically and still keep in her window of emotional intensity. Ask a client during this testing phase if he has any preferences in terms of speed, distance, and height prior to concentrating on any negative emotions or dysfunctional material.

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

**Stop Signal**

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

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

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

**EMDR Therapy Is Not Hypnosis**

A frequent question asked by clients is “Is EMDR hypnosis?” When this question is asked, the clinician may want to spend some time with the client explaining the basic differences between the two. Clients may be concerned
TABLE 1.16
Stop Signals

“If at any time you feel you have to stop, (fill in the blank).” “Is this a comfortable distance and speed?”

<table>
<thead>
<tr>
<th>HAND GESTURES</th>
<th>Time-out signal</th>
</tr>
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<tbody>
<tr>
<td>Hand signal</td>
<td>T</td>
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</table>

<table>
<thead>
<tr>
<th>BODY GESTURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standing up</td>
</tr>
<tr>
<td>Crossing arms or knees</td>
</tr>
<tr>
<td>Putting hands over mouth, ears, or eyes</td>
</tr>
<tr>
<td>Cyclist stop signal</td>
</tr>
</tbody>
</table>

that EMDR reprocessing will induce a deep trance state where he may lack control. Unlike hypnosis, EMDR reprocessing causes a state of heightened emotional arousal. This is an important distinction for the clinician to make when this question arises.

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

What Once Was Adaptive Becomes Maladaptive

Some behaviors are learned. Some serve us well and others do not. Some serve us for a period in our life and eventually become a nuisance. For example, a woman who was repeatedly sexually molested by a relative as a young child may have learned to dissociate during the molestation. This was her automatic coping response to the fear and pain of the trauma at the time of the abuse. Years later, as an adult, she may still find herself dissociating during stressful situations in her work and life. As a child, dissociation was the only response available and allowed her to cope; it worked well at the time. As a maturing adult, the dissociation begins to cause problems at home, at school, and/or at work.
### TABLE 1.17
Differences Between EMDR Therapy and Hypnosis

<table>
<thead>
<tr>
<th>EMDR</th>
<th>HYPNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrative psychotherapy model</td>
<td>Medium within which EMDR may be practiced and enhanced (Brown, 2006)</td>
</tr>
<tr>
<td>Efficacious treatment for PTSD (Bisson et al., 2007; Spates, Koch, Cusack, Pagoto, &amp; Waller, 2009)</td>
<td>Case reports available that suggest the efficacy of hypnosis for trauma treatment outcomes (Cardena, Maldonado, van der Hart, &amp; Spiegel, 2009)</td>
</tr>
<tr>
<td>EEG readings taken during EMDR reprocessing show a brain-wave pattern within normal waking parameters (Nicosia, 1995)</td>
<td>Theta (Sabourin, Cutcomb, Crawford, &amp; Pribram, 1990), beta (DePascalis &amp; Perrone, 1990), or alpha (Meares, 1960) waves are characteristic of hypnotized subjects</td>
</tr>
<tr>
<td>During desensitization, the client may be in a state of heightened emotional arousal</td>
<td>After induction, the client usually is in a deep hypnotic state</td>
</tr>
<tr>
<td>Therapist follows a set procedure and generally does not include therapist-generated suggestions (i.e., lacks suggestibility; Hekmat, Groth, &amp; Rogers, 1994)</td>
<td>There is no set procedure and includes therapist-generated suggestions (i.e., encourage suggestibility)</td>
</tr>
<tr>
<td>Each set of eye movements lasts about 30 seconds</td>
<td>Client is in a trance lasting anywhere from 15 to 45 minutes or longer</td>
</tr>
<tr>
<td>Memories may emerge, but memory retrieval is not the primary purpose</td>
<td>Is often used for memory retrieval</td>
</tr>
<tr>
<td>Images of memories generally become more distant and less vivid and more historical</td>
<td>Images of memories are generally enhanced and made more vivid and experienced in real time</td>
</tr>
<tr>
<td>Clients tend to jump from one associative memory to another</td>
<td>Clients follow a moment-by-moment (“frame-by-frame”) sequence of events</td>
</tr>
<tr>
<td>Eyes are usually open</td>
<td>Eyes are closed throughout the induction and treatment phase</td>
</tr>
<tr>
<td>Uses BLS (e.g., eye movements, taps, tones)</td>
<td>Does not use BLS</td>
</tr>
<tr>
<td>Clients appear more alert, remain conscious, and are less susceptible to inappropriate suggestion</td>
<td>Clients are less alert, not conscious, and more susceptible to suggestion</td>
</tr>
</tbody>
</table>

(continued)
TABLE 1.17 (continued)
Differences Between EMDR Therapy and Hypnosis

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

Developing and Enhancing Adaptive Networks of Association

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

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

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

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

### State vs. Trait Change

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

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

### Dual Awareness—Internal/External Balance

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

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

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

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

### Table 1.18

<table>
<thead>
<tr>
<th>State vs. Trait</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STATE</strong></td>
<td><strong>TRAIT</strong></td>
</tr>
<tr>
<td>Momentary or transitory change</td>
<td>Permanent change</td>
</tr>
<tr>
<td>Change of mind</td>
<td>Changes the way a client sees or views an event and thus can experience it differently</td>
</tr>
<tr>
<td>Coping skills may be required</td>
<td>Coping skills are not required</td>
</tr>
<tr>
<td>“I am able to soothe myself by breathing and using my calm/safe place when my boss asks me to come to this office. I feel much calmer.”</td>
<td>“I am no longer triggered when my boss asks me to come to his office.”</td>
</tr>
<tr>
<td>Resourcing tends to cause state changes</td>
<td>Processing tends to lead to trait changes</td>
</tr>
<tr>
<td>States are weather</td>
<td>Traits are climate</td>
</tr>
</tbody>
</table>

*All traits are states but not all states are traits*
How does one recognize ecological validity? And how do you work with it within the EMDR Therapy framework? First, use Wolpe’s SUD scale (SUD; Wolpe, 1990; see Figure 1.9).

The SUD scale is an 11-point Likert scale utilized to rate the anxiety level of a memory being accessed by a client in the present. When you ask the client during the Desensitization Phase to focus on the original event (incident, experience) and again ask, on a scale from 0 to 10, “How disturbing does it feel now?” and the client says a 1, the clinician needs to check out what is blocking (i.e., blocking belief) desensitization of the original target by: (a) having the client focus on where she feels it in her body; and by asking (b) “What keeps it a __?”; or (c) “What 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 Chapters 2 and 3.

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

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

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

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

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

**Side Benefits of EMDR Therapy**

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

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

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

**Holistic Nature of the Approach**

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

**USEFUL METAPHORS**

**Train Metaphor**

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

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

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

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

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

Dr. Shapiro also uses the train metaphor to describe information that moves adaptively from dysfunctional to functional. It is a common experience for a client’s once-vivid negative images, affect, and cognitions to become less vivid and less valid while the opposite happens to the
**FIGURE 1.10** Adaptive Information Processing model: metaphoric train moving down the track toward a more adaptive, functional resolution.
positive images, affect, and cognitions. Can you visualize a train traveling down its track? Each time the dysfunctional information is stimulated or when accelerated processing takes place, the train moves down the track and stops. At each stop, the client unloads dysfunctional information and loads more functional or adaptive information. The train continues on this route until it reaches its final destination (i.e., adaptive resolution).

**Tunnel Metaphor**

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

**ANCILLARY TARGETS**

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

**Secondary Gains**

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

**Blocking Beliefs**

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

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

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

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

Body Scan and the Emergence of Blocking Beliefs

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

Feeder Memories

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

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

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

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

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

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

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

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

EMD VS. EMDR THERAPY

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

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

If during BLS, the client reports a free association that appears unrelated to the precipitating event, gently say “Ok, now I would like you to go back to the bombing incident (name the event), what do you notice now?” Obtain a SUDS rating each time the client returns to the target memory. After obtaining the SUDS instruct, “Just think of that…” (and then initiate the next set of BLS). (Russell & Figley, 2013, p. 99)
<table>
<thead>
<tr>
<th>CHANGES IN MULTI-MEMORY ASSOCIATIVE CHANNELS</th>
<th>EXAMPLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dominant belief inherent in trauma</td>
<td>The memory of a boat accident brings up an associated memory of being bullied and physically assaulted by classmates in the second grade (both shared the same negative belief, “I am powerless”).</td>
</tr>
<tr>
<td>Major participant or perpetrator</td>
<td>A client associates being beaten by his mother with his mother driving drunk while he was in the car.</td>
</tr>
<tr>
<td>Pronounced stimuli</td>
<td>While processing waking up to a bedroom fire set by a lit cigarette, a firefighter remembers an associative memory of being overcome by smoke in a raging prairie fire.</td>
</tr>
<tr>
<td>Specific type of event</td>
<td>During the processing of a memory when a teller was robbed at gun point, an associated memory of being pistol whipped in a previous robbery years earlier emerges.</td>
</tr>
<tr>
<td>Dominant physical sensations</td>
<td>As a client processes his childhood memories of being tied to a bedpost by a babysitter while his parents were away, an associated memory of being assaulted and tied up so the perpetrator can flee spontaneously surfaces.</td>
</tr>
<tr>
<td>Dominant emotions</td>
<td>Disappointment over being looked over for a much-deserved promotion is shared with an associated memory of failing a CPA examination for the third time.</td>
</tr>
</tbody>
</table>

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

(continued)
### TABLE 1.19  (continued)
Patterns of Response

<table>
<thead>
<tr>
<th>CHANGES IN SINGLE-EVENT ASPECTS OF MEMORY</th>
<th>EXAMPLES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shift in perspective</strong>: A son begins to see the image of his father’s outraged face as more pathetic or laughable.**</td>
<td></td>
</tr>
<tr>
<td><strong>Expansion of a scene to include more details</strong>: Original image picture is one where a son sees the outrage on his father’s face on hearing that his son was expelled from school. As processing continued, the scene opened up; and he suddenly remembered that he was expelled because of a physical fight that ensued on school property between his father and himself. The father started the fight.</td>
<td></td>
</tr>
<tr>
<td><strong>Shifts in the appearance of an image</strong>: The image of an outraged father may become larger (or smaller), blur or fade, become closer (or more distant), turn gray or black or white, transform into a still image, or disappear altogether.</td>
<td></td>
</tr>
</tbody>
</table>

**Sounds**

| **Shifts in the sound of a voice**: The voice of an outraged father’s voice may become softer, louder, quieter, distorted, or simply become mute. |
| **Shifts in dialogue**: The son suddenly commences to voice words of assertiveness toward his outraged father. |
| **Shifts in language**: The son is from Germany and reverted to his first language to express his assertiveness toward his outraged father. |

**Cognitions**

| **Emergence of insight**: As processing continues, the son suddenly realizes that the outrage his father demonstrates toward him is really about his father’s sense of failure. |
| **A polar shift occurs**: In the earlier part of processing, the son’s negative cognition (e.g., “I am not good enough”) is replaced by a positive one (e.g., “I am okay as I am”). |
### TABLE 1.19  
Patterns of Response

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

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

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

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

Table 1.20 outlines the differences between EMD and EMDR.

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

**Assessment Phase**

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

**Desensitization Phase**

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

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

**PRACTICAL TIPS TO REMEMBER**

**Practice, Practice, Practice**

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

Follow the Script Verbatim

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

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

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

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

Stay Off the Tracks

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

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

Tracking the Client

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

**Keep It Simple**

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

**Power of Now**

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

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

**One More Time**

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

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

**Solo Run**

Client selection is an important part of the EMDR Therapy process but more so when a clinician is choosing clients for a first solo run. Clinicians may want to select clients with whom they have a strong client–clinician relationship. Pick the less complicated cases. Think of a client’s trauma as an

![Past, present, future.

How we feel and react to something in the

- present
- that happened in the
- past
- that we do not want to happen in the
- future

**FIGURE 1.11** Past, present, future.
onion. How many layers are there? How thick? How thin? So, when looking at the onion, look for the one- or thin-layered skins. And go slowly.

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

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

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

**SUMMARY STATEMENTS**

1. EMDR Therapy is an integrative psychotherapeutic approach and is guided by the AIP model. The AIP model “provides the theoretical framework and principles for treatment and an explanation of the basis of pathology and personality development” (Shapiro, 2001). As an integrative psychotherapeutic approach, EMDR Therapy is distinct from cognitive behavioral therapy (CBT), experiential, and psychodynamic approaches, although it is not exclusive and may be informed by or used together with these approaches.
2. EMDR Therapy has eight distinct phases.
3. EMDR Therapy is a three-pronged approach addressing the past, the present, and the future.
4. BLS is not EMDR Therapy. It is only one component.
5. During the active reprocessing phases of EMDR Therapy, dual awareness should be maintained at all times: one foot in the present, and one foot in the past.
6. EMDR Therapy is a fluid, dynamic approach that entails the clinician using all her clinical skills. It is neither mechanistic nor a cookbook approach.
7. The heart of EMDR Therapy is the AIP model. As such, it is critical that the clinician have a clear understanding of it in order to proceed with EMDR practice.
8. Practice, practice, practice. This is how we learn the model.
10. Stay out of the client’s way. The reprocessing is about the client, not the clinician.