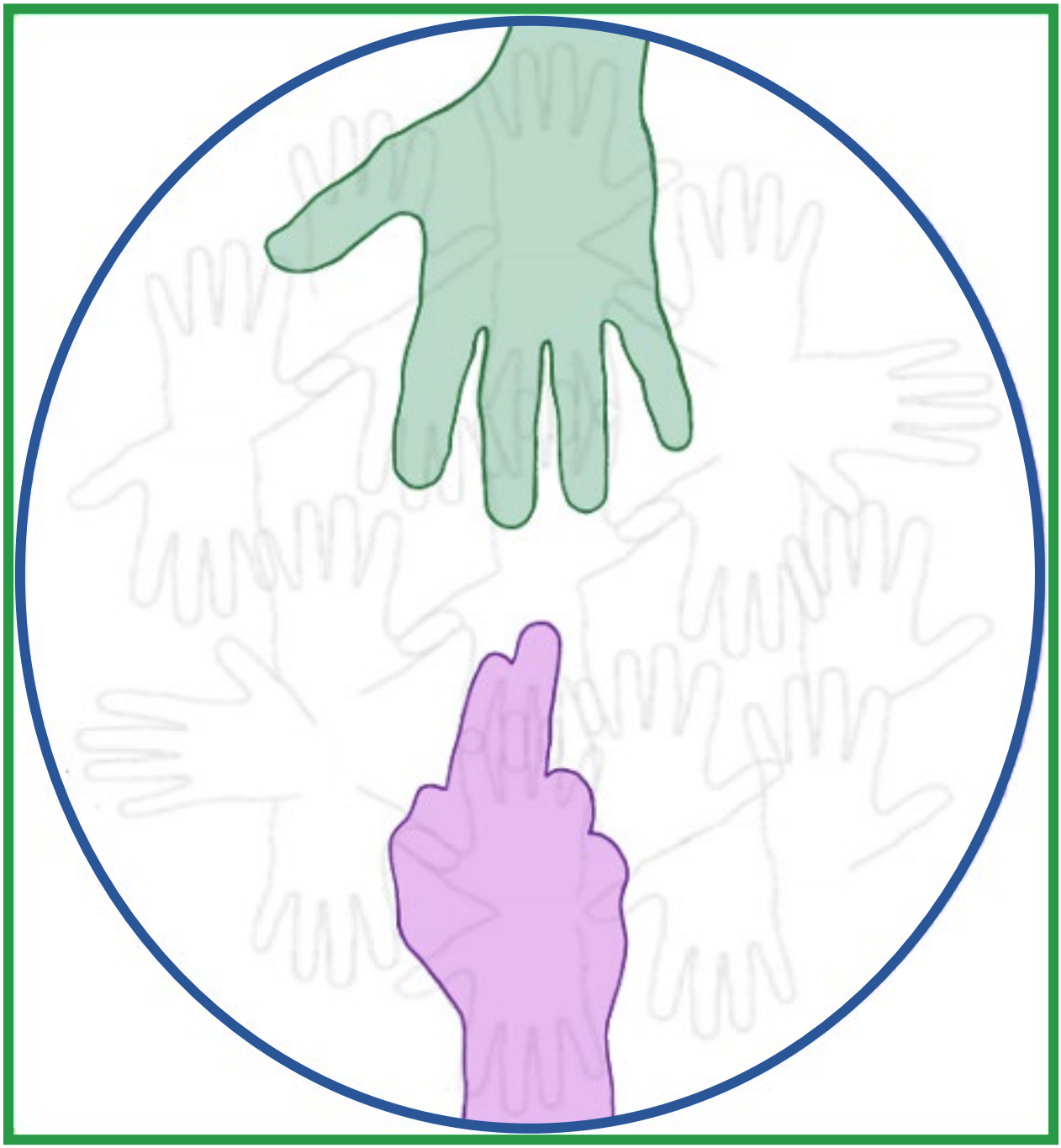
EMDR Therapy Basic Training Manual
Modules I – IV



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International Society for the Study of Trauma and Dissociation

The Center for Advanced Studies in Trauma & Dissociation

This training manual was originally developed by a Task Group comprised of members of the International Society for the Study of Trauma and Dissociation. Main contributors to this document and their current locations of practice are as follows:

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Introduction

Welcome to EMDR (Eye Movement Desensitization and Reprocessing) therapy training! This manual will serve as the foundation of your EMDR therapy training course, alongside the 3rd Edition of Francine Shapiro's text (2018), which is required for all EMDR International Association (EMDRIA)-Approved EMDR Trainings.

This training is the beginning of your learning journey in the practice of EMDR therapy - we hope to whet your appetite and get you off to a good start. EMDR therapy is an incredibly powerful therapeutic approach or tool (depending on how you're using it) to resolve unprocessed life experiences and their resulting symptomatic disturbances, from the simplest to the most unbelievably complex. Over the course of the coming months, you'll learn the skills necessary to work with clients dealing with the 'simpler' end of that spectrum in an EMDR therapy frame.

This training is offered through the Center for Advanced Studies in Trauma & Dissociation, the educational wing of the International Society for the Study of Trauma and Dissociation (ISSTD), and has been approved by the Board of ISSTD. It was developed and is taught by ISSTD members to bridge a long-standing gap between EMDR therapy training in its most basic form and the treatment of dissociation and dissociative disorders. This training will teach you to use EMDR therapy responsibly by helping you become more attuned to the presence and forms of simple trauma, complex trauma, and dissociation—and, perhaps most importantly, how to discern when (and how), at this stage in your learning, to use EMDR therapy to resolve a client's presenting issues.

EMDR therapy's original and, to date, most researched application is in the treatment of Posttraumatic Stress Disorder (PTSD). Trauma (literally 'wound' in Greek) is a universal human experience and, as such, affects people from all walks of life, races, genders, gender identities, sexual orientations, and ideologies. The language in this manual is gender neutral.

To aid different learning styles, throughout the training we will follow three fictitious, composite clients experiencing different severities of trauma and dissociation to illustrate the principles of treatment with EMDR therapy. Francine Shapiro (2018, Chapter 4 and Appendices A and E) noted that some clients may not yet be ready, or may be inappropriate candidates, for EMDR therapy. Accordingly, we will highlight both the standard 'red flags' for each of these composite clients (indicated by a red flag icon) and additional indications to proceed with caution. We will also rely heavily upon Shapiro's 'train' metaphor. The client engaging in EMDR therapy is on the train, looking out the window, watching previously unprocessed material pass by as they speed down the track toward adaptive resolution of the maladaptively stored memory. "During the accelerated processing that takes place with each set [of eye movements or other bilateral stimulation], the train travels one more stop along the line. At each "plateau," or stop, some dysfunctional information drops off and some adaptive (or less problematic) information is added, just as some passengers disembark and others get on a train at each stop. At the end of EMDR treatment, the information related to the targeted experience is fully processed, and the client reaches an adaptive resolution. Metaphorically speaking, the "train has arrived at the end of the line" (Shapiro, 2018, p.37).

At the conclusion of all four training modules and the required consultation hours that comprise this training, you will receive a certificate of completion and be able to refer to yourself as an "EMDR trained" clinician. You will have the skills to determine client suitability and readiness for trauma accessing in general, and the use of EMDR therapy methods for containment, stabilization and trauma resolution for clients with simple and moderately complex trauma presentations, within your established area(s) of expertise.

As you begin to establish mastery of the basic EMDR therapy protocols and procedures, we recommend that you explore online and print resources, advanced training, and further consultation on the use of adapted/modified protocols for special situations and populations, as they correspond to your clinical specializations. If you are new to understanding and treating dissociation, this training offers a foundation and a frame that may be expounded upon via advanced training in dissociation, and EMDR methods that have been adapted to effectively treat clients presenting with severe dissociation. Ways to formalize your training in and mastery of EMDR therapy have been determined by the EMDR International Association and are described in Appendix A of this manual, as well as sections later in the manual at the end of this document.

Part I - Trauma and Dissociation: The Basics

It is invaluable to have a clear understanding of what trauma and dissociation are before even thinking of treating them using such a powerful approach as EMDR therapy. Let's establish our frame.

Foundational Concepts

- Basic Hardware of the Brain
- The Window of Tolerance Model
- Neuroception and the Polyvagal Theory
- Trauma
  - How Does Trauma Manifest?
  - Key Neurological Mechanisms in Trauma and PTSD
  - The Development of PTSD
  - Recognized Forms of PTSD, and EMDR Therapy
  - A Focus on Flashbacks
- Beyond PTSD: Dissociation and the Dissociative Disorders
  - What is Dissociation?
  - The Development of 'Pathological' Dissociation
  - Recognized Forms of Dissociative Pathology, and EMDR Therapy
  - Forms of Dissociation Elsewhere Classified in DSM-5
  - Etiology, Correlates, Risk Factors, and Prevalence in the Western World
  - Comorbidity of Dissociative Disorders with Other Issues
  - Different Cultures, Different Understandings of Dissociation

Basic Hardware of the Brain

It's important that we have an understanding of some basic components and functions in the brain in order to get a clear sense of what we're doing and why we're doing it in trauma resolution work. So, let's dive in, shall we?

These are the aspects of the brain that we'll spend the most time with during this training:

Brainstem

Also known as the reptilian brain, the brainstem is responsible for managing communication between the brain and the body, and autonomic nervous system functions such as regulating breathing, swallowing, heart rate, blood pressure, consciousness, and one's degree of sleepiness/alertness.

Periaqueductal Gray (PAG)

Serving as a key component for the physiological experiences of all basic affects/emotions, the PAG is located in the mid-brain at the uppermost section of the brainstem. The PAG also contains mechanisms for propagating and modulating all autonomic nervous system responses, including perception of pain. It is the last part of the brain to remain active before brain death occurs. When threat is imminent and/or overwhelming, the PAG initiates basic defense responses (flight, fight, freeze/tonic immobility, collapse) after consultation with its immediate neighbors, the inferior and superior colliculi (Mokhtar & Singh, 2022; Panksepp & Biven, 2012).

Superior Colliculus (SC)

As the upper-most region of the brainstem, the general function of the SC is to orient the body/self in relation to the sensory environment. The superior and inferior colliculi collectively function as the integration center of sensory input (auditory, visual, and somatosensory) and localize protective motor responses initiated by the PAG – orienting toward or away from a perceived threat. EMDR therapy practitioners may find the superior colliculi to be particularly relevant because:

1) Top layers of the SC receive and facilitate orienting to visual stimuli (including eye movements);
2) Intermediate layers of the SC receive auditory and somatosensory input (tones and taps); and
3) Deep layers facilitate orienting (of the eyes and head) to the perceived stimuli (Benavidez et al. 2021).

The SC appears to play a role in initiating goal-directed behavior, laying a foundation for our first-person perspective (Merker, 2013), and determining whether the neural correlates for dissociation occur (Corrigan, 2022; Lanius, Paulsen, & Corrigan, 2014). Olivé et al. (2018) confirmed that the SC's role of detecting and initiating a response to a perceived threat was dampened in persons presenting with the dissociative subtype of PTSD.

Thalamus

The thalamus (Lanius, Paulsen, & Corrigan, 2014), *vertically* connects the lower reaches of the reptilian brain to the upper reaches of the neocortex, and aids the transfer of information between the right (emotional, concrete-thinking, time-unaware, language-absent) and the left (logical, shades-of-grey, time-aware, language-capable) hemispheres of the brain. Because of its positioning and multidirectional interfacing, the thalamus is identified to be where translation between defensive responses and emotion regulation occurs. In instances of unfamiliar or potentially harmful sensory information coming through, the thalamus will send one 'copy' of the information to the prefrontal cortex (PFC) and another to the *amygdalae*.

Corpus Callosum is the bundle of 'wiring' that connects the left and right brain, broadly speaking.

Limbic System

This is the mammalian, or 'horse, brain that manages our active defensive responses, is central to fear and fear conditioning and encodes memory. For our purposes, we need to know the following components of this system: The amygdala and the hippocampus.

Amygdala (plural: Amygdalae)

We have one in each of the two brain hemispheres, each with a job specific to its location. The amygdala is heavily involved in assessing risk and conditioning fear responses. Conditioning occurs when fear becomes associated with a stimulus that may have previously been seen as harmless, so that it is now perceived as dangerous (e.g., a child learning to stay away from a hot stove after getting burned). The amygdala is constantly comparing previously encountered

sensory experience to present sensory experience to determine what's safe and what's not safe *in the present moment*—even when we're asleep. Notably, the only form of sensory information that bypasses the thalamus and is sent directly to the amygdala is odor/scent. This appears to have evolved to ensure mammals can rapidly detect—and, if possible, avoid—predators. However, the amygdala itself cannot tell the difference between 'then' and 'now.' Its job is to help ensure survival; determining time frame is the job of the PFC.

Hippocampus (plural: Hippocampi)

Acting in concert with the amygdala, the hippocampi (these are also bi-laterally located in the brain) aid both in encoding long-term memory in terms of language/meaning and helping us remember—people, places, and things (including their locations)—after we initially encounter them. Thus, the hippocampus plays a critical role in the formation and maintenance of emotional attachments.

Prefrontal Cortex (PFC)

The PFC orchestrates thoughts and action, serves to mediate/manage strong emotion, helps us tell the difference between the past, the present, and the future, and plays an important role in evaluating whether stimuli are safe or dangerous. The PFC sits at the front of the brain and has many connections to the amygdala and hippocampus. It is the part of the brain that sets humans apart from other mammalian species.

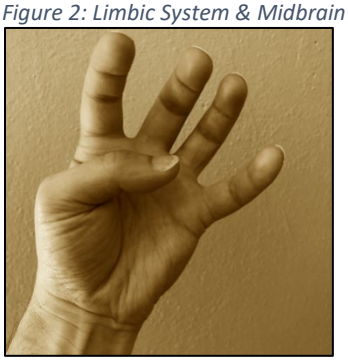
Broca's Area

Located in the left hemisphere (for most people), and responsible for language production, Broca's area is part of a 'language' loop, along with Wernicke's area (to process incoming communication), connected by a bundle of fibers called the *arcuate fasciculus*.

Daniel Siegel, MD (2012), uses a hand to demonstrate how the parts of the brain react in the face of overwhelming experience. The fist represents the whole brain. The back of the hand is the hindbrain (brain stem), which is the part of the brain focused on basic survival needs such as food, reproduction and defense. The middle of the brain, represented by the thumb tucked inside the fist, is the midbrain and limbic system, which is the mammalian center for emotion and connectivity with others. The fingers at the front of the fist represent the frontal cortex, which is the most evolved part of the brain responsible for rational thinking, knowledge, and deliberate action.

Figure 1: Whole Brain

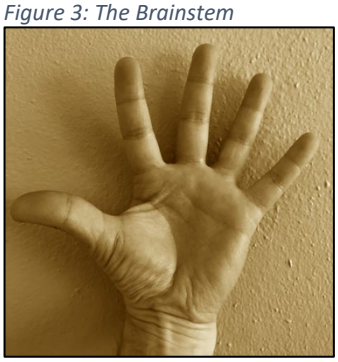
Figure 2: Limbic System & Midbrain



When acute hyper-arousal occurs, the frontal cortex goes offline, like the fingers flying open, leaving the limbic system (thumb) exposed and the brainstem and midbrain active and in charge. The PAG projects physiological information to the SC, where sensory input is integration and the eyes and head are prepared to orient toward or away from the perceived threat. Possible instinctual responses include the separation cry, flight, or fight.

Finally, when the trauma is extreme and the brain perceives a profound and imminent life threat, input is no longer received by the limbic system (deafferentation). The SC ceases to integrate current sensory information, and the PAG may initiate immobilization and/or anesthesia. Only primitive, immobilized defenses housed in the brain stem are left, resulting in freeze, collapse, or submit (also known as tonic immobility, 'playing possum', or 'playing' dead).

Figure 3: The Brainstem



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The Window of Tolerance Model

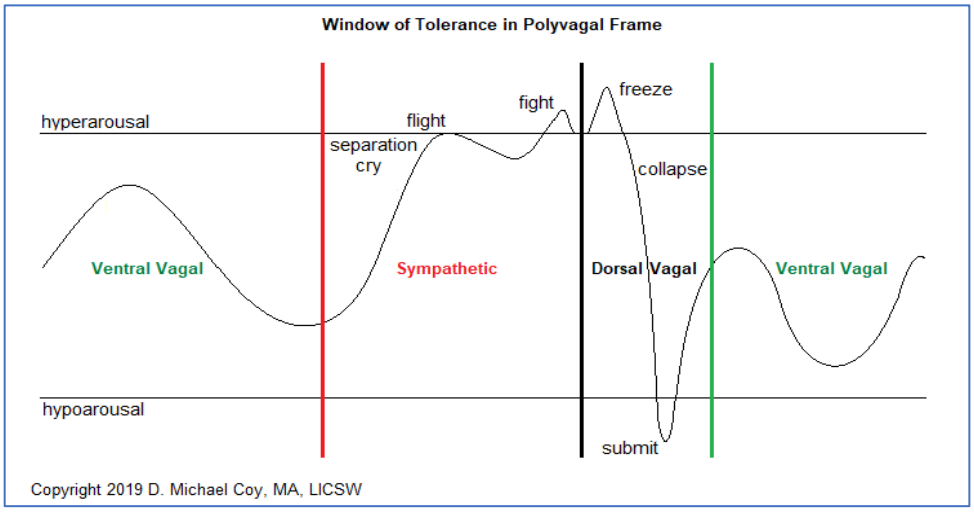
Daniel Siegel's (1999) concept of the *Window of Tolerance* (aka 'Window' or 'WoT'), which provides us a way to understand and track how the brain manages—and a person responds to—experience. Remember, when the brain neurocepts a stimulus to be beyond a person's ability to cope (outside one's Window), their brain instinctively compels them to react with either *hyper-arousal* or *hypo-arousal*.

For a person to respond to a situation in a conscious, intentional way, the intensity of the stimulus must remain within their Window of Tolerance. If the stimulus exceeds what they can tolerate, one of two things happens:

1) They become hyper-aroused 'above the Window'—highly emotional, reactive, frozen, and/or triggered into flashbacks. This is more than just emotional overload—their whole body is in sympathetic overdrive. They are not on the train watching the scenery pass by, they are outside the train hanging on for dear life.
2) They become hypo-aroused 'below the Window'—disengaged, emotionally flat, and unresponsive, with 'deeper' trance, depersonalization, derealization or even catatonia. This is a dorsal vagal parasympathetic body state.

We can take something critically important from this Window of Tolerance concept: Wounding is not necessarily defined exclusively by the severity of the external event. We must think both about the impact of the environment upon the person *and* how the person perceives, responds to, and manages (or has help managing) the event itself and its aftermath.

Figure 4: The Window of Tolerance Meets Polyvagal Theory



Notably, as a person's WoT narrows (see *Figure 4*, above), not only does their capacity to handle *unpleasant* experience (i.e., disturbance) diminish, but their capacity to tolerate pleasant experience (joy, being cared for etc.) may also become inhibited. This can happen because, as a person's Window becomes smaller and smaller, the top and bottom ranges begin to 'cut into' the fuller range of Ventral Vagal functioning (i.e., social engagement, cognitively-influenced problem solving, etc.).

With the narrower range of experience that can result from repeated harm or recurrent triggering, a person may lead an increasingly constricted existence in order to avoid not only future experiences of harm and triggering of old pain, but also any experience—*including engaging with other people*—that feels overstimulating. Thus, hypervigilance in the form of chronic anxiety may keep the person on alert for 'another bad thing' happening (even if they have no idea what that could be, or why they are so worried). More persistent phobias can develop that reinforce a person's need to avoid being pushed outside their significantly constricted WoT. The narrowed WoT may leave the client chronically situated closer to hyper-arousal, hypo-arousal, or somewhere between the two extremes, and may influence in which direction the client moves (up in to hyper-arousal or down into hypo-arousal) when they become triggered.

The work of therapy, whether in the early stages of treatment focused on stabilization and containment or later on in the midst of trauma accessing/resolution, should take place within the client's WoT, with the Prefrontal Cortex (PFC) active and in charge. Clients who are ready and appropriate candidates for standard EMDR therapy come into treatment with adequate neuroception of safety, a wide enough WoT *for both pleasant and unpleasant sensation/ emotion*, and a PFC that remains *online enough* in the face of overwhelm. Others who present with more complexity bring poorer neuroception of safety and a narrower Window, but still enough PFC presence to handle doing preparation work that will allow safe resolution of their trauma. Some clients will present with far more complex experience—a very narrow WoT, limited or noneuroception of safety, far less than optimal PFC functioning, or a combination of these and other trauma-related features. With these clients, the therapeutic work may focus solely upon enhancing neuroception of safety and helping widen their WoT, inch by inch, until they can tolerate the therapist, themselves, and the world around them.

Attachment, Neuroception, and the Polyvagal Theory

Attachment Strategy, Ability to Regulate Affect, and Associated Coping Behaviors

As the primary means to adapt and survive physically, humans are intrinsically motivated to form an attachment strategy specific to each primary caregiver from the beginnings of life (Bowlby, 1982) based upon the caregiver's responses to the infant's emotional needs and behaviors (Bowlby, 1988). These attachment relationships must be maintained by the infant/child at whatever cost to the child (Cassidy & Shaver, 2016). For instance, fear intensifies proximity-seeking behavior in mobile infants and young children, and if there's no one else available for safety, children will cling even to an abusing caregiver (Rutter, 1997). By the time individuals reach young adulthood and are no longer dependent on caregivers for physical survival, most people form a unified attachment strategy (Furman & Simon, 2004) that is based more so on emotional safety and security needs. Early attachment bonds formed with caregivers, in this sense, have to do with economizing mental, emotional, and behavioral efforts to avoid the anxiety which stems from a felt sense of not being safe and secure (Atkinson, 1997; Fonagy et al.,1997). This notion of attachment is distinct from the other ways in which humans bond with others in daily life, such as through the social engagement system, playfulness/ friendship, and caretaking (Panksepp,1998, 2011).

The translation of attachment theory to more systematic and practical understandings began in the late 1970s (Ainsworth, Blehar, Waters, & Wall,1978; Main & Solomon,1986). Scientists observing infants and their caregivers via the 'Strange Situation,' a 24-minute laboratory paradigm of brief caregiver-infant separations, yielded a categorical way to understand infant attachment system activation. Data analyses yielded the following attachment classification system:

Secure	**Insecure-Avoidant**	**Insecure-Anxious /Resistant**	**Disorganized**
Caregiver: exhibits consistent, predictable, emotionally responsive behavior toward infant/child *Infant/Child*: exhibits flexible behavior, quickly soothed by caregiver when in distress	*Caregiver*: exhibits consistent, predictable, emotionally unresponsive behavior toward infant/child *Infant/Child:* exhibits inflexible behavior and inhibits emotional expression when in distress	*Caregiver*: exhibits inconsistent, unpredictable, emotionally responsive behavior toward infant/child *Infant/Child*: exhibits inflexible behavior and cannot be soothed by caregiver when in distress	*Caregiver*: exhibits prolonged, inconsistent, unpredictable (frightened or frightening) behaviors toward infant/child *Infant/Child*: exhibits inflexible, disorganized behavior toward caregiver—with concurrent opposing urges of approach and avoid

Summarized from Ainsworth, Blehar, Waters & Wall, 1978, and Main & Solomon, 1986

When considering attachment classification, one is not "better" than the other. That is, *Secure* attachment is not preferable to either of the manifestations of *Insecure* attachment, nor is disorganized attachment predictive of psychopathology, but its presence does put a child at risk for later psychopathology. When the attachment strategy fails to be effective at warding off anxiety associated with (conscious or unconscious recognition of) a lack of safety and/or security, symptoms may manifest and develop into psychopathology (Atkinson,1997; Wallin, 2007.

In order to predict the relationship between caregiver and infant attachment strategy, the Adult Attachment Interview (AAI) was developed with the notion that a person's attachment strategy with caregivers in early childhood influences their attachment strategy in adulthood (Main, Kaplan, & Cassidy, 1985; Hesse, 2016). Unlike the 'Strange Situation' framework, which is a behavioral analysis, the AAI is built upon a linguistic analysis of the interviewee's responses to a set of 20 questions regarding childhood experiences of being parented, along with the interviewee's state of mind regarding those experiences (George, Kaplan, & Main, 1996). Specifically, the AAI requires the adult speaker to access semantic memory related to general propositions of significant attachment relationships as well as episodic memory of being parented in early childhood. The speaker's unconscious mind is "surprised." As such, the interaction of these two memory systems in the speaker's AAI narrative reveals the characteristic cognitive-affective balance, characteristic defensive maneuvers in response to attachment system activation, and stance toward the self in relation to experience, particularly vulnerable experience (Wallin, 2007; Duschinsky, 2020).

By early adulthood, *Secure* attachment is reflective of an understanding of both positive and painful caregiver-child dyad experiences, which is balanced and integrated into a positive view

of the self. The *Dismissing* attachment strategy is identified based on a tendency (in relation to caregivers) to deny negative experiences, to be unable to experience a felt sense of the emotions coupled with those negative experiences, or presentation of an idealized picture of the relationship with caregivers. The *Preoccupied* attachment strategy is associated with a preoccupation with significant caregiver figures or attachment-related experiences. A coherent, reflective overview of life history is largely absent. There may be significant, unresolved anger toward caregivers, or diffuse fears associated with their significant caregivers. The *Cannot Classify* classification is a binary attachment strategy which does not reflect an economy of mental energy; it is an admixture of both *Dismissing* and *Preoccupied* attachment strategies and is roughly analogous to the *Disorganized* category seen in infancy/early childhood (Main & Goldwyn, 1984/2003).

The AAI has been extensively researched all over the world with clinical, non-clinical, and at-risk adult communities, and attachment classification is a valid, consistent, and reliably measured construct worldwide (Hesse, 2016). Parents assessed via the AAI show a 75% concordance rate with their infant assessed via the 'Strange Situation.' The distribution of attachment classifications from secondary data analyses of over 10,000 AAIs stemming from over 200 research studies may be summarized as follows:

General Population

- roughly 50% Secure
- roughly 24% Dismissing
- roughly 10% Preoccupied
- roughly 16% Cannot Classify (aka, Disorganized)

Combined Clinical Samples

- 21% Secure
- 23% Dismissing
- 13% Preoccupied
- 43% Cannot Classify (aka, Disorganized)

Combined Clinical & At-Risk (low SES/Adolescent Parenthood)

- 25% Secure
- 27% Dismissing
- 10% Preoccupied
- 38% Cannot Classify (aka, Disorganized)

Bakermans-Kranenburg & Izendoorn, 2009

The AAI predicts parenting characteristics, subsequent infant/child-parent attachment, and the quality of relationship with significant others for adults. Classification via the AAI does not predict risk for particular clinical disorders or membership in any DSM diagnostic categories. There are, however, some important findings from the AAI literature which are generalizable. Results on the AAI are independent of age, country of origin, and gender. Clinical samples show an increased presence of insecure attachment and *Cannot Classify* (aka *Disorganized*) categories over the general population. Internalizing DSM disorders, such as Borderline Personality Disorder are more associated with *Preoccupied* and *Cannot Classify* (aka *Disorganized*). Externalizing DSM disorders, such as Antisocial Personality Disorder, are associated with increased *Dismissing* and *Preoccupied* classifications relative to the general population. Depression is associated with *Dismissing* and *Preoccupied*, but not with *Cannot Classify/Disorganized* classifications. Posttraumatic Stress Disorder and abuse experiences are associated most strongly with *Cannot Classify/Disorganized*. (Bakermans-Kranenburg & Izendoorn, 2009)

Below is a summary of the major attachment classifications in young adulthood and beyond based upon the AAI:

	Secure	Dismissing	Preoccupied	Cannot Classify
Expected Childhood Experience from Primary Caregivers	*Consistent*: affection, loving gestures, playful interactions, acceptance, emotional responsiveness, mentalization, quick acknowledgment of mistakes followed by repair efforts, protection; *Focus is on*: child's needs as of primary importance; *None to very low*: levels of rejection of child	*Minimal or No*: physical affection or loving gestures *Pressure for*: premature independence *Downplaying*: child's vulnerability & emotions *Focus is on*: instrumental care of child, activities & material things *Moderate to high*: levels of rejection of child	*Inconsistent*: affection and loving gestures; *Pressure for*: parentification of child and/or inappropriate attention toward caregiver's needs *Focus is on*: caregiver's experiences of distress and other needs *None to moderately low*: levels of rejection of child	A mixture of both Dismissing and Preoccupied indicators; A prior history of childhood neglect, physical abuse, sexual abuse, emotional abuse is associated with this category; A moderate correlation with adult psychopathology is associated with this category.
State of Mind in Adulthood	*Attachment to others*: strongly values meaningful connection; *Adverse early attachment experiences*: mostly resolved; *Perspective toward primary caregiver relationships*: shows a balanced perspective, insight, forgiveness, & compassion	*Attachment to others:* primarily does not value attachment; *Adverse early attachment experiences:* has not resolved; *Perspective toward primary caregiver relationships*: lack of specific memory for early attachment experiences and/or idealization of early attachment experiences; May hold a cool contempt toward primary caregivers	*Attachment to others*: values attachment; *Adverse early attachment experiences*: minimal resolution; *Perspective toward primary caregiver relationships*: shows lack of insight, forgiveness or compassion & excessive mental investment in family of origin; does not integrate effects of early attachment experiences; may have an angry, or a diffuse fearful preoccupation	*Attachment to others*: may both value and undervalue attachment in same discourse; *Adverse early attachment experiences*: has not resolved *Perspective toward primary caregiver relationships*: shows lack of insight, forgiveness or compassion; shows an admixture of remaining indicators for both Dismissive and Preoccupied categories

Summarized from Main & Goldwyn, 1984/2003

Attachment strategy has an inherent connection to the ability to manage and regulate affect which in turn, has everything to do with the ability to effectively maintain and reestablish functioning within the WoT. In response to threat cues (such as physical threat, rejection,

separation, loss, or abandonment), the attachment system becomes activated so that internal equilibrium can be regained by invoking longstanding reinforced emotional states that are linked to behaviors. Mikulincer and Shaver (2016) state that attachment figures' availability or unavailability to help rebalance the infant/child's activated attachment system over thousands of experiences determines the child's characteristic ability to regulate emotion. Ongoing interactions with consistently available, emotionally supportive, attachment figures reinforce an expectation to "...mitigate distress, promote optimism and hope, and help a person cope effectively with stressors." (p. 511) This quality of attachment relationship is reflective of Secure attachment and is associated with a flexible, modulated, and overall effective use of emotions and coping behavior under threatening conditions.

For the two insecurely attached classifications, persons with Dismissing and Preoccupied attachment strategies have developed internal working models which either hyperactivate or deactivate recognition of threat cues, respectively. People with a Dismissing attachment strategy downregulate or deactivate vulnerable affect recognition and emotional expression under threat and/or distress; coping behaviors of deactivating the attachment system itself, over self-reliance, and foregoing support seeking result from a consistently unavailable soothing presence/response from the primary caregiver. Characteristically, Dismissive types defensively attempt to control the expression of emotion and distance themselves from it.

Those with a Preoccupied attachment strategy upregulate affective recognition and an exaggerated emotional expression is seen under threat and/or distress; coping behaviors of clinginess and dependence on attachment figures is based on an historically intermittent availability of a soothing presence/response from the primary caregiver. Preoccupied types show a heightened sensitivity to negative emotional states, with a characteristically resistant return to equilibrium from unpleasant emotional states.

People possessing an admixture of the two insecure types of attachment strategy (Cannot Classify, aka Disorganized), are characteristically easily distressed showing jumbled coping behaviors that most often are inefficient at reestablishing equilibrium of emotional functioning when in distress. Importantly, Mikulincer and Shaver (2016) note that while the affect regulation strategies of Dismissing and Preoccupied classifications can be problematic on an individual relationship level in daily life, there is a proposed evolutionary value of them on a group level; Preoccupied types hold value for hyperactivation to perceive threats within the group/community, and Dismissing types hold value in enacting behaviors to handle threats efficiently. This understanding sheds light on the stable distribution of attachment classifications worldwide.

When attachment strategies breakdown in the face of overwhelming and ongoing stressors, humans are unable to integrate traumas because it is too much for the psyche to support. In this case, people may develop dissociative coping, or dissociative disorders. Dissociative disorders are associated with chronic early childhood emotional and or psychological neglect, and ongoing childhood physical and/or sexual abuse (Putnam, 1985).

Dynamic Maturation Model - AAI-DMM

In 2011, a student of Mary Main by the name of Patricia Crittenden led the development of the *Adult Attachment Interview - Dynamic Maturational Model* (AAI-DMM), which offered a new way of analyzing the information obtained through the AAI process. This adaptation to the analysis centered around a divergence between observed behavior during the AAI (the content) and the meaning of the observed behavior (the discourse). The DMM seeks to understand the meaning

of behavior, proposing that all humans seek to understand and make meaning of their experiences. However, early in life "... some dangerous experiences cannot be understood" and result in dynamic relational adaptations that function to promote and preserve safety (Crittenden & Landini, 2011, p. 4). Through DMM analysis, these adaptations and implicit memory systems are exposed. The DMM further understands humans, relationships, and attachment as dynamic and ever changing across the lifespan, with information about danger and comfort residing within implicit memory systems and guiding interactions via learned adaptations to danger. It understands attachment as a relationship, as information processing, and as self-protective, which in turn organizes behavioral and mental strategies. Self-protective adaptations to danger that emerge within adult relationships are understood to be an individual's greatest attempt to apply learned attachment strategies in childhood to manage danger. These strategies are then applied in the present "...to the adult tasks of self-protection, reproduction, and protection of children" (Crittenden & Landini, 2011, p. 4).

The DMM expands the Main & Goldwyn classifications. adding in eight A classifications (cognitively organized with dismissing/avoidant strategies), five B classifications (balanced and integrated strategies), eight C classifications (affectively organized with anxious/preoccupied strategies), and an A/C classification (psychopathy is the extreme AC blend), which highlight attachment strategies and patterns that are used dynamically. These additions are based on additional ways in which cognitive and affective information is transformed within the AAI, which includes transformation in relationship to the interviewer and the impact of unresolved loss and psychological trauma.

Neuroception and the Polyvagal Theory

A valuable companion to the Window of Tolerance Model is the Polyvagal Theory. Stephen Porges, PhD (2011), the developer of the Polyvagal Theory, suggests that "our range of social behavior is limited by our physiology" (p.19). Thus, mammalian physiology appears to have developed to accommodate our survival needs—both for connection and protection. The mediator of these competing needs (i.e., socialization and survival) is a limbic system-managed mechanism that Porges (2009) calls *neuroception*: "A neural process that enables humans and other mammals to engage in social behaviors by distinguishing safe [contexts] from dangerous contexts (ibid, p. 19)." In brief, the vagus nerve, which connects the brainstem to the facial muscles, ears, throat, and major organs (lungs, heart, spleen, liver, stomach, kidneys, and small and large intestines), has been found to have three 'branches,' comprising a 'vagal complex.'

Active Defenses: The Sympathetic Nervous System

When a human perceives an unfamiliar or potentially dangerous stimulus, the brain compels them to first attempt to orient to the source of the threat. If the stimulus is determined to be safe or non-life-threatening, then the person will return to a state of calm. If the stimulus is known to be dangerous or perceived to be potentially harmful, then an appropriate active or inactive defensive response will follow—with or without the involvement of the pre-frontal cortex (i.e., the person actively engaging it consciously).

The active defenses are primitive, reflexive actions that include calling out for help (e.g., a baby who is afraid and cries for its caregiver), fleeing (attempting to escape the danger by running away or hiding), or fighting (because escape is not possible). It's ideal if a person can resolve the dangerous situation via an active defense rather than be forced to resort to a passive defense—but, any defense that preserves life is better than no defense at all.

Active Defenses in the Real World

Take a moment to think about clients who described growing up in a family where they felt as though they had to compete with siblings or fight with caregivers in order to get attention, and who often find themselves struggling to control angry impulses when dealing with work colleagues or authority figures in their adult life.

Growing up in that environment, do you think their brain neurocepted safety, or something else? Might they have become conditioned into fighting first and thinking later, and could that be contributing to their current challenges?

Dissociative Defenses: The Dorsal Vagal Parasympathetic Nervous System

When calling out for help, fleeing, and fighting are not possible, then the next line of defense is tonic immobility: the hyper- (high) arousal of a *freeze* response or the hypo- (low)-arousal of *collapse-submit*. We can think of the freeze response as a state of being "all dressed up in adrenaline with nowhere to go," like the deer caught in the headlights of a fast-approaching vehicle. The necessity of the freeze response triggers the release of *endogenous* (naturally-produced) *cannabinoids*, which inhibit motor activity, reduce pain, and interfere with encoding of explicit memory by the hippocampus, among other effects (Starowicz, Malek, & Przewlocka, 2013). Freeze can be accompanied by reflexive, psychological distancing maneuvers such as depersonalization, derealization, somatic dissociation, and spontaneous (autohypnotic) trance, the latter of which may open the door to a much greater variety, and severity, of dissociative responses.

A hypo-aroused collapse-submit response, also known as *dorsal-vagal shutdown,* is a bit easier to grasp if we think of a rabbit instinctively collapsing into seeming lifelessness to reduce the possibility of further harm, while in the maw of a predator. Once the predator has dropped it and gone off to signal others in the pack that dinner is ready, it springs back to life and scampers away. Dorsal-vagal shutdown is facilitated by the release of both endogenous cannabinoids (as with the freeze response) and *endogenous opioids*, which further enhance one's capacity for analgesia (the inability to feel pain). Submission is the last mammalian defense prior to the onset of death. This last-ditch defensive response in humans can look like fainting, becoming very sleepy, or even spontaneously falling asleep. In the context of day-to-day functioning, hypo-arousal can include collapsing into paralyzing experiences of depression, shame, or emotional and physical numbness, as well as pathological forms of dissociation.

Dissociative Defenses in the Real World

An opioid-dependent client says their mother described them as a 'good' baby—'good' meaning that they slept a lot, and didn't make much of a fuss while awake, even in the midst of a chaotic home life.

Were they 'good,' or were they in a chronic state of dorsal vagal shutdown because their brain neurocepted that no one was there to help? And, were that the case, what connection might there be between their early life experience and their struggles with opioids in adulthood?

Social Engagement: The Ventral Vagal Parasympathetic Nervous System

Porges (2011) has expanded our understanding of mammalian functioning by describing a *third* autonomic nervous system: The ventral vagal parasympathetic system. He posits that one of

the roles of this system is to facilitate social engagement, which includes social communication, self-soothing, and calming behaviors—including the capacity to seek safety from a caregiver. Most importantly, it can regulate sympathetic "flight-or-fight" behaviors and the immobility defenses in service of social-affiliative behaviors. Thus, humans have developed a mechanism that overrides the primitive fear (limbic) mechanism, which is the only line of defense for most other vertebrates. Social behavior may also serve as a regulator of physiology (Porges, 2011). We have a need for other humans to keep us safe. This may be why human-to-human harm is so damaging.

Social Engagement in the Real World

Many instances of play involve the mimicking of defensive responses that arise when we're in danger.

Think about a child playing hide-and-seek with their peers—the seeker is likely experiencing a high level of excitement (it's a game!) and perhaps frustration (if they can't find anyone), and the hiders are likely experiencing some form of excitement/anticipatory fear of being found (heart racing, dilated pupils, constricted breathing), as well as a degree of motionlessness to avoid drawing attention to their location—and even momentary fright, if they are unexpectedly found.

Or, think about a teen who loves seeing scary movies with their friends. Even though they might be having the stuffing frightened out of them, they love it! It's fun—and, they're socially engaged in a group dynamic, even beyond their friends, since they're in a theater full of people they don't know.

In both examples, the brain neurocepts basic safety, so the social engagement system stays online. Even though the sympathetic and parasympathetic systems are also playing an active role in the person's experience, the experiencer is able to continue functioning within what is called their Window of Tolerance.

Trauma

As we noted in the introduction, the Greek term *trauma* literally translates to English as '(physical) wound.' Freud (1963) described *psychic* trauma as, "An experience which within a short period of time presents the mind with an increase of stimulus too powerful to be dealt with or worked off in the normal way, and thus must result in permanent disturbances of the manner in which energy operates" (p. 275).

All traumas are not created equal

There are single-event traumas, from mild to severe, that involve one isolated traumatic experience. This could be any event that overwhelms the person's ability to cope.

Complex trauma refers to when the person has had multiple traumatic experiences, with insufficient time and resources to recover before being traumatized again. When complex trauma is experienced by children, it will include *developmental trauma*, due to shifting the child's focus from normal developmental tasks to survival. This may result in profound gaps in the child's psychological and social-emotional development. Complex trauma may also arise from the 'death by a thousand cuts'—oppression of various kinds, micro-aggressions, ongoing (direct or indirect) exposure to community violence, and persistently painful, frightful, or disempowering events of a physical, emotional, or sexual nature. The harm can even be

intergenerational in nature, accumulating and being passed down from grandparent, to parent, to child.

Not everyone is equally 'resilient'

A person who experienced (or is experiencing) an early life full of nurturing and emotional attunement is likely to fare comparatively better in the face of overwhelming experience. An individual with a rich spiritual life—or even a sense of being a part of something greater than themselves, such as a tightly-knit community of peers—may be more able to come through a crisis relatively (or wholly) intact. A person whose emotional and physical health is robust may be more likely to thrive in the face of betrayal than someone whose attachment via their intergenerational trauma history have handed them significant challenges from a time before they were even born.

Other factors to consider when assessing the breadth and depth of impact that an overwhelming experience has had upon a person include:

- Whether they were the victim or a witness
- The degree of perceived helplessness
- The form of the danger, and the degree of unpredictability involved
- Physical consequences such as pain, injury, exhaustion, and hunger; how the event was made sense of by the person
- Whether the overwhelming experience was interpersonal
- Where the person is a member of a marginalized population
- Whether the event was perceived as intentional or accidental
- Whether the crisis was a natural disaster or an act of terrorism
- And, in the case of interpersonal harm, the perception of—and need for—loyalty to the perpetrator

In the Western conceptualization of mental health, we hew closely to the medical model of understanding "illness." Thus, the effect of overwhelming experience is determined by "signs and symptoms," just as in Western medicine. Similarly, in determining whether an experience was life-threatening for someone, we tend to bias toward the idea that a life-threatening experience is something that can be objectively assessed. Life-threatening trauma that meets the DSM-5-TR *Criterion A* definition for PTSD requires exposure to actual or threatened death, serious injury, or sexual violence (often referred to as 'big T' trauma). However, experiences that do not meet that definition, such as material and emotional neglect, ongoing emotional abuse, and so on (which have been called 'small t' traumas) may be *perceived* by the self as equally or more life threatening than the 'big Ts,' as they gravely confront the existence of a sense of self (Shapiro & Maxfield, 2002). To Francine Shapiro's credit, EMDR therapy and its underlying Adaptive Information Processing (AIP) model make quite clear that if an experience undermines an individual's sense of self-worth or safety, inhibits their capacity to attribute (or accept) proper responsibility, or limits one's sense of control or choices in the here-and-now, then it adversely affects (and is thus traumatizing to) the individual.

How Does Trauma Manifest?

DSM-5-TR (APA, 2022) determines diagnostic criteria based on signs and symptoms. Progressing understanding of how the brain actually works has given us greater clarity about what's going on in the brain when a person experiences an overwhelming event. Let's work our way from the inside, out.

How the Brain Responds When We're Overwhelmed

When we encounter something that the brain neurocepts as life-threatening or harmful, this is (roughly) what happens:

- The amygdala sets off the fire alarm, which in turn sends signals to release adrenaline, a hormone that produces a short-term burst of energy), *noradrenaline* (a neurotransmitter that supports alertness, attention, and memory retrieval/formation), and *cortisol* (a hormone that helps maintain energy under long-term stress) into the bloodstream to ensure that the brain and body can mobilize—via hyper-arousal at or above the WoT—to do what it needs to do to survive the perceived threat. Amygdala activity is *enhanced* by adrenaline.
- The normal functioning of the PFC is pre-empted, going off-line in favor of instinctual, life-preserving actions such as flight, fight, freeze, etc. Because the PFC has been temporarily 'short-circuited,' it cannot inhibit the excessive emotion or manage the overwhelming experience. Without the PFC on-line, the person is unable to help themselves remain in (or return to) a calmer state (i.e., their WoT).
- The hippocampus is also short-circuited, due to cortisol release, and thus is unable to do its normal job of storing the overwhelming experience in the usual explicit, episodic, verbal (narrative) memory storage areas in the cortex. (In the face of *chronic* threat, the near-constant release of cortisol may actually lead to cell death in the hippocampus.)
- Without the PFC and the hippocampus running at full capacity, the overwhelming experience is inappropriately, incompletely, or incoherently encoded. The AIP model refers to this as unprocessed or maladaptively processed experience.
- Some aspects of the experience *may be consciously accessible*, via the hippocampus, in left-brained, explicit, episodic, verbal memory. This may include the perceived meaning of the experience, such as, 'I'm not safe.'
- Other aspects of the experience, though, may be held, via the amygdala, in their own right-brained, implicit, *nonverbal* memory network(s) as fragmented images, sensations, emotions, smells, tastes, sounds, etc. The AIP model refers to such memories as 'unconsolidated.'

The Development of Posttraumatic Stress Disorder

In the aftermath of the overwhelming experience, we try to move on, but this process may include any of the following:

- We may experience symptoms reflecting the implicitly held material such as nightmares, or feelings of impending death—or, we may feel depressed, on-edge, or find ourselves ruminating on the experience.
- At some point in day-to-day life, the brain neurocepts a present stimulus (whether within or outside the self) as similar to some aspect of that past experience.
- In the process of assessing the present stimulus, fragmented, implicitly held material is re-accessed. The present stimulus is also known as a 'present trigger.'
- We become flooded with overwhelming sensory information, and we react to the present trigger, in one or many dimensions, as though we are in the past experience and re-experience it. This flooding is called a *flashback* and can involve components of hyper- and/or hypo-arousal. We may have a very difficult time figuring out exactly what the precipitating trigger is—especially if the flooding material lacks imagery.
- Because the PFC and hippocampus are also short-circuited, we are left without enough access to our thinking brain to accurately assess our present safety and remain in (or return to) a calmer state. Essentially, more evolved ways of thinking and reasoning go offline (Forner, 2017).
- Under typical circumstances, we naturally learn to fear/avoid something that elicits feelings of unsafety. Repeated exposure to present triggers that bring on flashbacks leads us to avoid the perceived triggers—or anything associated with them. (This process is called 'generalization'). Thus, as the number of triggers increases, the cycle of triggering and trigger avoidance is repeatedly reinforced, and post-traumatic stress may now be a major factor impacting our day-to-day life functioning.

Post-traumatic stress disorder *can*, but does not *always*, develop, depending on the variety of resilience-related factors discussed earlier. A 'classic' presentation of PTSD—stemming from an objectively recognizable, life-threatening event—tends to be obvious even to an inexperienced clinician, owing to explicit symptoms and public acceptance of the diagnosis. More deeply-set forms of post-traumatic stress, such as Complex PTSD (C-PTSD; ICD-11, 2018; Herman, 1992) and Dissociative Disorders, can be much more nuanced, and difficult to detect, diagnose, and treat.

Flashbacks as a Sign of Posttraumatic Stress

We mentioned above that the posttraumatic flooding that happens in the face of a present trigger is called a 'flashback.' The reason a flashback can occur at all is because elements of the traumatic memory are stored in isolated neural network(s), which: 1) contain mostly sensory and emotional material, and 2) have not been integrated into the brain's everyday networks and remain unprocessed as if "frozen" in time. So, here's what happens, roughly:

- A person feels like the traumatic event is recurring because they experience a replaying of some or all of the memory's components (images, sensations, emotions, sounds, smells, tastes) in a raw, unchanged form.
- Even though the person is *physically* in the present, their brain perceives present reality as if it were the past. In this state, the person becomes partially or completely "dissociated" from present reality.
- This dissociation is often accompanied by an autohypnotic, or spontaneous, form of *trance:* An altered state of consciousness in which rational logic and awareness take a back seat to perceptual distortions allowing an irrational, emotionally-influenced way of perceiving oneself and the world. This distorted way of thinking, whether or not one is in the midst of a flashback, is called 'trance logic' (Beshai, 2004). *A very basic example of trance logic could be when a person believes that they can remain safe so long as they stay in a physically dangerous relationship.*
- The degree of dissociation can vary from some to no awareness that the flashback is past experience (a.k.a. 're-experiencing'). Re-experiencing can be dangerous if the person becomes trapped in the flashback, and misperceives a bystander, loved one, or even a therapist as a perpetrator from the original traumatic event.
- Partial forms of flashback are common: auditory "hallucinations," somatic memories, smells, irrational emotion-driven reactions. As noted above, emotion-driven reactions rooted in past hurt can feel very confusing for the experiencer and others, especially because they frequently cannot be traced back to a single experience or an explicit, traumatic event*. Emotional flashbacks seem to be more commonplace in Complex PTSD and the Dissociative Disorders.*
- Because the brain and body may be re-experiencing what was perceived as a life-threatening crisis during a flashback, the stress, whether acute or chronic, can result in problematic medical issues.

In the midst of a flashback, it is ideal if a person can develop the capacity to maintain 'one foot in the past and one foot in the present,' metaphorically speaking (Knipe, 2007). The more weight they can keep on the foot in the present, the more able they will be to pull themselves out of the flashback, or at least manage it. Grounding, containment, and re-orienting skills can be extremely useful in managing flashbacks and help anchor the self to a sense of safety and control in the here-and-now. Allowing a client to remain trapped in a flashback without awareness of the present is re-traumatizing. It is the pairing of present-moment safety with sensory awareness of the traumatic material from the past that enables the brain to fully digest the traumatic memory.

Recognized Forms of Posttraumatic Stress Disorder, and EMDR Therapy

Different presentations and timing of therapy after traumatic event(s) require different therapeutic interventions, both in general and in EMDR therapy. While much more discussion (and practice!) will follow, a brief outline is introduced here.

Acute Stress Disorder

This diagnosis is valid three days to one month after an overwhelming experience has occurred. The criteria are very similar to PTSD (see below) except for the addition of dissociative symptoms in the form of depersonalization/derealization ("An altered sense of the reality of one's surroundings or oneself, e.g., seeing oneself from another's perspective, being in a daze, time slowing") and amnesia (American Psychiatric Association (APA), 2022, p. 315).

EMDR treatment: Modified versions of the standard EMDR therapy protocol are used in the immediate aftermath of a traumatic event. (See Recent Traumatic Events Protocol)

Posttraumatic Stress Disorder (PTSD)

PTSD develops when the person is unable to integrate the experience of a traumatic event (or events) with other life events (memory networks). Thus, they become stuck in a cycle of being overwhelmed by flashbacks and avoiding flashback triggers. Their view of themselves and the world change, and they may act as if they are still stuck in the trauma as discussed above.

The presence of peritraumatic dissociation during or soon after an event is the single biggest predictor of a person developing PTSD (APA, 2022). *Peritraumatic dissociation* is "a complex array of reactions at the time of the trauma that include depersonalization, derealization, dissociative amnesia, out-of-body experiences, emotional numbness, and altered time perception" (Thompson-Hollands, Jun, & Sloan, 2017, p. 190). The immediate function of peritraumatic dissociation is thought to be distancing from unbearable pain, but the long-term effect is that dissociation prevents the integration of traumatic memories. These and other peritraumatic phenomena come into increasingly stark relief when the traumatic experience is chronic and ongoing.

EMDR treatment: EMDR therapy "standard" protocol, which you'll be learning to use during this training, is ideal for treating PTSD (See outcome studies in Appendix D).

Posttraumatic Stress Disorder, with Dissociative Features (PTSD, Dissociative Subtype)

Since DSM-5 (2013), the specifier "with dissociative symptoms" has been included as a feature of PTSD. In this form of PTSD, a person's symptoms meet standard criteria *and* they experience persistent or recurrent symptoms of depersonalization and/or derealization:

> *Depersonalization* is defined by DSM-5-TR (APA, 2022, p. 344) as "persistent or recurrent […] [e]xperiences of unreality, detachment, or being an outside observer with respect to one's thoughts, feelings, sensations, body, or actions (e.g., perceptual alterations, distorted sense of time, unreal or absent self, emotional and/or physical numbing)."
>
> *Derealization* is defined as "persistent or recurrent […] [e]xperiences of unreality or detachment with respect to surroundings (e.g., individuals or objects are experienced as unreal, dreamlike, foggy, lifeless, or visually distorted)" (ibid).

In order to meet criteria for this sub-type of PTSD, the dissociative symptoms *must not be attributable to the physiological effects of a substance or a medical condition* (ibid).

This diagnosis is supported by research in PTSD patients, where about 30% displayed a dissociated, numb response with a significantly lower heart rate, and symptoms of depersonalization and/or derealization. fMRI scans of the brain in subjects in this dissociated PTSD subgroup showed enhanced suppression of the amygdala by the prefrontal cortical areas (Frewen & Lanius, 2006).

EMDR treatment: Screening/assessment for pathological dissociation is essential. Assuming a severe dissociative disorder, including symptoms such as partially-dissociated intrusions into executive functioning and amnesia (both for historical and day-to-day experience), has been ruled out, EMDR therapy "standard" protocol with some extended Preparation will aid with resolution of the symptoms of clients with PTSD with dissociative features (See Knipe's Back-of-the-Head scale and CIPOS).

Beyond PTSD: Complex Trauma, Dissociation, and the Dissociative Disorders

In This Section

Complex Trauma

The phenomenon of complex trauma was originally described by Judith Herman, MD (1992) in her ground-breaking book, *Trauma and Recovery.* Herman observed that existing diagnostic categories were/are not descriptive of the complex symptoms experienced by survivors of extreme and prolonged trauma (e.g., hostages, survivors of childhood physical or sexual abuse, domestic battering, organized sexual exploitation, and concentration camps). Those additional symptoms include:

- Alterations in affect regulation
- Chronic suicidal or self-injurious thoughts
- Compulsive or inhibited sexuality
- Amnesia
- Depersonalization
- Alterations in systems of meaning

- Alterations in the perception of self (helpless, self-blame, defilement, utter aloneness), the perpetrator (idealization), and others (distrust, failure or self-protection, re-enactments, difficulty with intimacy, isolation)
- Somatization (e.g., body pain)

The complex presentations of trauma have also been described in subsequent literature as Disorders of Extreme Stress, Not Otherwise Specific (DESNOS, Luxenberg, Spinazzolla, & Van der Kolk, 2001; Van der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005). Although a diagnosis consistent with these features does not yet exist in the DSM, it *has* been added to the International Classification of Diseases, Eleventh Revision (ICD-11; World Health Organization, 2018) as 'Complex PTSD', or C-PTSD.

EMDR treatment: An extended Stabilization/Preparation phase is frequently necessary prior to accessing trauma material. Knowledge and understanding of 1) dissociation in its various forms and 2) appropriate modifications of EMDR therapy for dissociative symptoms, advanced training and professional consultation in EMDR therapy are vital for working with persons with features of complex PTSD.

'Simpler' Versus Complex Trauma

Why is it important to differentiate between simple (single event, or multiple discrete events) and complex trauma?

Treatment of a singular, discrete traumatic memory is more straightforward because 'simpler' trauma creates fewer discontinuities within the person's sense of self and their experience of others and the world around them; there typically exists an established fabric of stable, predictable experiences stemming from early life that reinforce the person's resilience in the face of overwhelm; and, there is less neurochemical damage to the brain.

With complex trauma, there are often present stressors and comorbid diagnoses which complicate treatment and require an extensive Stabilization phase. We alluded to the importance of stability when we discussed the Window of Tolerance and working with clients' trauma in general, and it applies here, as well: "Exposing these patients too directly to their trauma history in the absence of their ability to maintain safety in their lives leads to retraumatization" (Courtois, 2004, p. 415).

Developmental Trauma Disorder (DTD)

Developmental Trauma Disorder was first described by Bessel van der Kolk, PhD, in 2005. He conceptualized a new provisional diagnosis for children with complex histories because the adult diagnosis of PTSD did not (and still doesn't) capture the developmental impact of "a multiplicity of exposures [to trauma] over critical developmental periods and the very complex emotional, behavioral and neurobiological sequelae" (Van der Kolk, 2005, p. 406). Repeated exposure to interpersonal trauma, such as abandonment, betrayal, physical or sexual assaults, or witnessing domestic violence, "engenders 1) intense affects such as rage, betrayal, fear, resignation, defeat and shame, and 2) efforts to ward off the recurrence of those emotions, including the avoidance of experiences that precipitate them or engaging in behaviors that convey a sense of control in the face of potential threats. These children tend to behaviorally re-enact their traumas either as perpetrators, in aggressive or sexual acting out against other children, or in frozen avoidance reactions" (Van der Kolk, 2007, p. 233).

Persistent sensitivity to reminders (triggers) interferes with the development of emotion regulation. Over- and under-reactivity is manifested on multiple levels: emotional, physical, behavioral, cognitive and relational. After becoming destabilized, these children have a great deal of difficulty restoring a subjective sense of stability and balance, or *homeostasis*, and returning to healthy baseline functioning.

Other symptoms of developmental trauma include: "disturbed attachment patterns, the failure to achieve developmental competencies, the loss of sleep, feeding and self-care regulation, multiple somatic problems, self-endangering behaviors, the loss of autonomous strivings, self-hatred, self-blame and chronic feelings of ineffectiveness" (Van der Kolk, 2005, p. 406). Chronically traumatized children unconsciously (and, at times, consciously) anticipate and expect betrayal and trauma to recur. They react to even minor stressors with hyperactivity, aggression, defeat, disorientation, dissociation, or freeze responses. Expectations of a recurrence of trauma permeate their relationships with excessive clinging, compliance, oppositional defiance, as well as revengeful and distrustful behavior. All of these problems are expressed in dysfunction in multiple areas, including, educational, familial, peer relationships, legal problems and vocational difficulties.

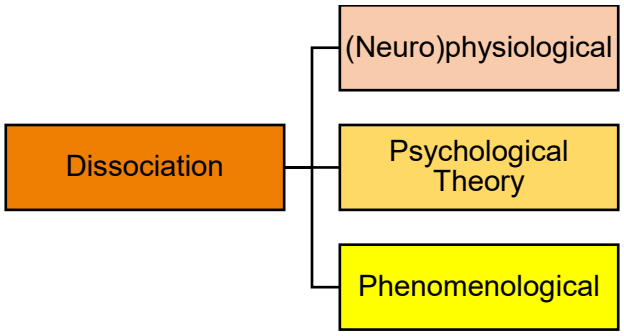
EMDR treatment: As with C-PTSD, advanced training and professional consultation in EMDR therapy—particularly those that focus on the treatment of children and adolescents—are strongly recommended to ensure ethical practice and positive treatment outcomes. Several resources are listed under the section in this manual entitled, EMDR with Children and Adolescents.

Attachment Trauma versus Non-Attachment Trauma

For children, attachment is survival. A 'good enough' caregiver (Winnicott, 1953) ensures that the child can gradually develop an integrated sense of self and others, safety, and choice in a world that they cannot yet understand, navigate, or manage on their own. When attachment is marred, lost, or otherwise inadequate or damaged, this can create the experience for the child that the world is generally unsafe – without any explicit memory or experiences to point to as specifically overwhelming or 'traumatic.' Chronic physical symptoms and relational patterns often develop, and they may eventually meet criteria for Complex PTSD (ICD-11; APA, 2018), a dissociative disorder, and/or other DSM-recognized disorders – or not.

What is Dissociation?

First, let's examine dissociation at its most basic level. Dissociative symptoms involve the total or partial loss of awareness or knowledge, inner body sensation, five-sense perception (sight, hearing, taste, touch, and smell), emotions, thoughts, perceptions, explicitly recallable memories, impulses, and/or one's sense of self. The phenomena of dissociation appear to develop as an adaptive protection against neurocepted harm, which results in overwhelming experiences not being fully—sometimes, not at all—integrated into one's developing sense of self, often making those experiences unavailable as part of the 'story' of who that person understands themselves to be. There are at least three levels of explanation for dissociative symptoms (Dell, 2009):



People who develop a chronic pattern of dissociation often have trouble identifying their bodily sensations, moving their body, feeling and interpreting their emotions, and/or feeling a sense of being real and existing in the world. In more severe cases, a person may not have a unified sense of who they are or they may experience a sense of multiple 'whens' or 'me's. This is the result of different aspects of self (a.k.a. parts, ego states, or alters) that do not share the same experience, points of view, motivations, or behaviors. More severely still, they may experience amnesia for past and present experience due to disruptions in moment-to-moment functioning as these different aspects of self are independently and asynchronously 'in charge' of the self (Dell & O'Neil, 2009; Frewen & Lanius, 2015; Lanius, Paulsen & Corrigan, 2014; Reinders, et. al., 2003).

Dissociation, in its various manifestations, can be viewed as the brain's attempt to survive traumatic experience, maintain attachments, and to keep the self within their WoT over the long term. Dissociation as a form of psychic protection is an "evolution-prepared defense" (Dell, 2009, p. 760), and evolved and persists as a coping mechanism because it has survival value. Some hypothesize that one's capacity for autohypnotic (involuntary) trance may play a significant role in facilitating the protective splitting off of traumatic material (Bliss, 1988; Dell, 2018) and the variability in symptoms and presentation in different people (Dell, 2018). This would mean that only individuals with a high autohypnotic capacity can, when exposed to prolonged, inescapable pain, develop a dissociative disorder. (See below - General Dissociative Symptoms in the Subjective-Phenomenological Model of Dissociation).

The Development of 'Pathological' Dissociation

Let's be clear at the start: Not *all* dissociation is a sign that harm has occurred. Some forms of dissociation are the result of common, naturally occurring experience.

'Normal' dissociative experiences include periodic daydreaming, 'highway hypnosis' on a long drive, distractedness and even some memory problems in the face of heightened day-to-day stress, and absorption in a movie, video game, or a good book. Depersonalization and derealization, which tend to occur in response to overwhelming experience, can occur and then fade without any long-term impact. So, what separates these common forms of dissociation from what we might think of as problematic dissociation?

You may recall that, when a person is faced with a situation that the brain perceives as dangerous or threatening, they will generally first respond with sympathetic *hyperarousal*—an active attempt to call for help, flee, or fight. When an active defense such as these isn't possible, a person will reflexively resort to a passive, freeze response or, as a final defense, spontaneously drop below their WoT into a hypoaroused state of collapse-submit.

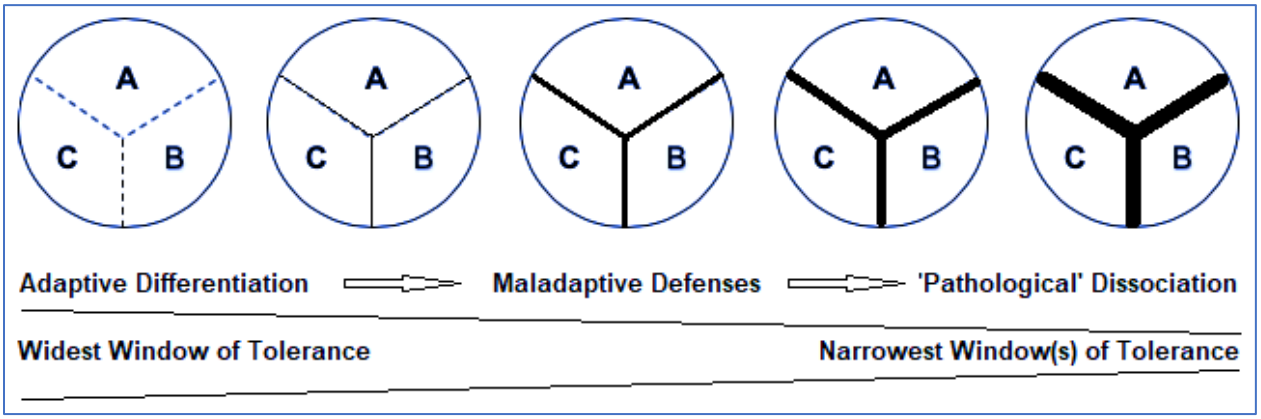
Earlier, we mentioned the part of the brain called the thalamus, which serves as the brain's sensory integration center, identifying and routing sensory information from within and outside the body to whichever area of the brain is designated to handle it.

Remember the mention of *peritraumatic dissociation* when we discussed PTSD? The immediate purpose of peritraumatic dissociation is reflexive, instinctual distancing from unbearable pain. What happens, though, when thalamic functioning is *chronically* disrupted by traumatic experience? In the short term, this is a valuable and necessary strategy for sustaining life—but, in the longer term, dissociation of these forms prevents the natural integration of traumatic experience into autobiographical episodic memory, which by its nature is explicit in the person's awareness. In other words, this kind of disruption really mucks up the works. Without that integration offered by the thalamus in concert with the limbic system and the pre-frontal cortex, a person cannot truly move beyond the time of the traumatic event.

Broadly speaking, Frank Putnam's (1989, 1997) Discrete Behavioral States Model of Dissociation defines '*pathological' dissociation* as *trauma-induced behavioral states that are separate from normal states of consciousness*. Waller and Ross (1997) verified that 'pathological' dissociation is not a severe form of normal dissociation, but rather a separate category of experience, or *taxon*. (A taxon is an organized statistical classification of features or symptoms that share common traits.) Lanius, Paulsen, and Corrigan (2014) bring us back to the brain by asserting that "the phenomenon of peritraumatic dissociation…is associated with the release of anesthetic neurochemicals that alter the communication between lower and higher brain structures, leading to a lack of integration of traumatic experience, somatoform symptoms, as well as *separate self-states* (emphasis added)." (p. 1)

Watkins and Watkins (1997) offered up the following visual model for understanding the increasingly thick barriers between self-states as traumatization compounds:

Figure 5: The Ego State Differentiation-Dissociation Continuum & The Window of Tolerance



So, the "problem" of dissociation arises when it becomes a *typical* way for the brain to manage painful experience rather than just being a sporadic, infrequent neurological event in a moment of overwhelming stress.

> Dissociation becomes a problem rather than a solution when it occurs frequently, is activated in inappropriate circumstances, interferes with daily life functioning, or involves the symptom of *identity alteration*.

With these mentions of *trauma-induced behavioral states*, *separate self-states*, and *identity alteration*, we're no longer just talking about PTSD or even C-PTSD. We're talking about dissociation on a multidimensional scale: Not just a few symptoms, but potentially a number of them, functioning in tandem—or even in conflict—with one another to ensure survival, possibly well beyond the time when the 'source' of danger has ended.

Key Dissociative Symptoms Defined

These five symptoms are broadly emblematic of dissociative disorders.

- **Depersonalization:** The experience of feeling detached from, and as if one is an outside observer of, one's mental processes, body, or actions.
- **Derealization:** Persistent or recurrent experiences of unreality of one's surroundings and/or oneself.

Depersonalization and derealization are more general posttraumatic symptoms, but they can also manifest in more severe forms (dissociative disorders).

- **Identity Confusion:** An inner struggle about one's sense of self and identity.
- **Identity Alteration:** A sense of acting like a different person (Steinberg, 1994) or feeling/ being somehow different than oneself.

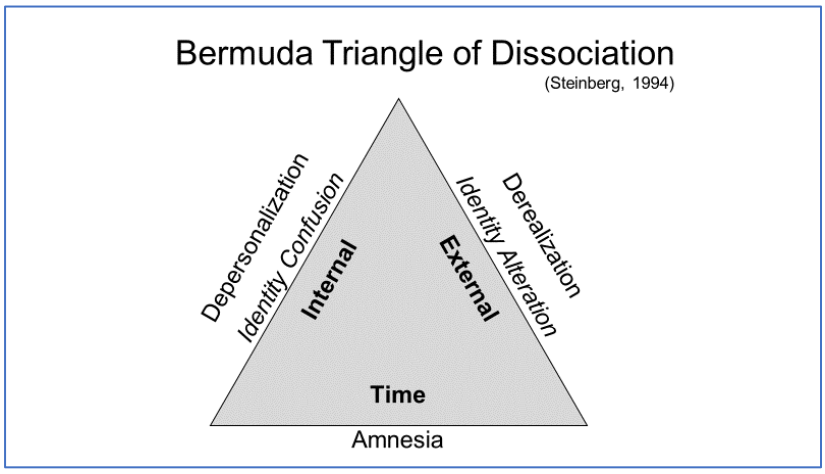
Identify confusion and identity alteration are the result of more fully-formed parts of self that are borne out of traumatic experience.

- **Amnesia:** Literally 'lack of/absence of memory' in Greek, amnesia is the inability to recall autobiographical information of various kinds.

Amnesia is highly disruptive to a person's sense of continuity and capacity to remain present, aware, and 'in control.' Thus, it is recognized as the fullest expression of 'pathological' dissociation a defining characteristic of Dissociative Identity Disorder.

The illustration below may further clarify your understanding of these symptoms as we move into discussion of current DSM-5-TR diagnostic categories.

Figure 6: Steinberg's 'Bermuda Triangle' of Dissociation (1994)



The outer layer of the 'tent,' Depersonalization and Derealization, are allowed for to some degree within the diagnostic criteria of PTSD. Persistent *Identify Confusion* and relational factors are indicative of C-PTSD, and *Identity Alteration* indicates presence of self-states that hold isolated/dissociated aspects of traumatic experience. Thus, presence of symptoms aligned with the slanted lines making a 'tent' shape above indicate probable C-PTSD or other trauma-related disorder beyond PTSD. The addition of evidence of significant symptoms related to **Time**/Amnesia suggests likely presence of a Dissociative Disorder.

These symptoms have been measured and classified by Marlene Steinberg (1994) and several others to enable accurate assessment and diagnosis of dissociative symptoms and disorders. Several screening and assessment tools will be discussed below, and are invaluable toward understanding a person in terms of how their whole *self-system*—with its varied characteristics, behaviors, points of view, roles, fears, and so much more—functions.

Recognized Forms of Dissociative Pathology

The DSM-5-TR (APA, 2022) describes dissociation as being "characterized by a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior", with dissociative symptoms experienced as "unbidden intrusions into awareness and behavior, with accompanying losses of continuity in subjective experience (i.e., 'positive' dissociative symptoms such as division of identity, depersonalization, and derealization) and/or inability to access information or to control mental functions that normally are readily amenable to access or control (i.e., 'negative' dissociative symptoms such as amnesia)" (p. 330).

For the purpose of supporting our later discussions, current criteria for the dissociative disorders will be summarized below. NOTE: Common to these diagnoses are the following, essential criteria:

> 1) The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning; and,
>
> 2) The disturbance is not a normal part of a broadly accepted cultural or religious practice. (In children, the symptoms are not better explained by imaginary playmates or other fantasy play.)
>
> 3) The symptoms are not attributable to the physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).
>
> APA, 2022, p. 331

Dissociative Amnesia (DA)

In this manifestation of dissociation, a person experiences "an inability to recall autobiographical information, usually of a traumatic or stressful nature, that is inconsistent with ordinary forgetting" (APA, 2022, p. 338), which most often consists of localized or selective amnesia for a specific event or events, or generalized amnesia for identity and aspects of life history.

The disturbance cannot be better explained by Dissociative Identity Disorder, Acute Stress Disorder, PTSD, Somatic Symptom Disorder, or a neurocognitive disorder.

Amnesia may be accompanied by what is called *dissociative fugue*: "Apparently purposeful travel or bewildered wandering that is associated with amnesia for identity or for other important autobiographical information" (ibid).

Depersonalization (DP) / Derealization (DR) Disorder

This diagnosis is exactly what its name suggests: The presence of persistent or recurrent experiences of depersonalization, derealization, or both. Within this classification, DSM-5-TR defines each of these phenomena slightly differently from above, as follows:

Depersonalization: "Experiences of unreality, detachment, or being an outside observer with respect to one's thoughts, feelings, sensations, body, or actions (e.g., perceptual alterations, distorted sense of time, unreal or absent self, emotional and/or physical numbing).") (APA, 2022, p. 344).

Derealization: "Experiences of unreality or detachment with respect to surroundings (e.g., individuals or objects are experienced as unreal, dreamlike, foggy, lifeless, or visually distorted)." (ibid).

The person's reality testing must remain intact during experiences of depersonalization/ derealization, and the phenomena cannot be better explained by another condition, such as Schizophrenia, Panic Disorder, Major Depressive Disorder, Acute Stress Disorder, PTSD, or another Dissociative Disorder.

Dissociative Identity Disorder (DID)

DSM-5-TR (2022) characterizes DID as

> "The disruption of identity characterized by two or more distinct personality states, which may be described in some cultures as an experience of possession. The disruption in identity involves marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, emotion, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual. Recurrent gaps in the recall for everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting. And, *the disturbance cannot be part of a broadly accepted cultural or religious practice"* (APA, 2022, p. 331)
>
> …or, as the result of a mind-altering substance or another medical condition.

Dissociative Identity Disorder (DID) is a complex, post-traumatic developmental disorder. The core features of DID are usually accompanied by a mixture of psychiatric symptoms which, rather than dissociative symptoms, are typically the client's presenting complaint (Brand, Webermann & Frankel, 2016). The core feature of DID is the presence of one or more alternate identity (or *alter,* referring to a dissociated part or aspect of self). Within DID, these dissociated aspects of self often hold and exhibit different affects, behaviors, cognition patterns, memories, sensory-motor patterns, and even Windows of Tolerance.

At the time of diagnosis, many if not most dissociative self-states may have amnesia for one another. The person presenting with DID will often report what seem like 'intrusions' into their consciousness from the other self-states (e.g., voices; made emotions, impulses, or actions; speech or thought insertion; bodily sensations), though they may not recognize or be willing/able to acknowledge the source of the intrusions; or, they may have complete amnesia for the behavior of other parts and discover evidence or are told of their behavior; or, they may be passive observers of their own behavior without being able to control it. People with DID may perceive their identity as fragmented and usually have memory gaps for significant chunks of time, historically (memory problems) and in their day-to-day life (amnesia), although they may not be consciously aware of 'blanking out.'

Ego states (another term used to identify self-states), dissociated ego states, and alternate personalities vary in severity of amnesia and sense of agency or identity in relation to one another and the self as a whole. Persons who are non-dissociative can and do have ego states. However, *dissociated* ego states are kept in a state of separateness through compartmentalization-type dissociation (more on that shortly) and are perceived by the

presenting, executive part of the self as “not me,” “abnormal,” or even threatening—which makes those parts well worth denying, disowning, or avoiding due to the fear, shame, anger, sadness, and other unpleasant experiences they bring.

Dissociated self-states are found in many instances of Other Specified Dissociative Disorder and also in persons with Dissociative Amnesia. Alternate personalities, as compared to dissociated ego states, generally have a firm sense of self and denser amnestic barriers between them and the part of self that perceives itself to be ‘in charge’ of day-to-day life.

Other Specified Dissociative Disorder (OSDD)

This classification “applies to presentations in which symptoms characteristic of a dissociative disorder cause clinically significant distress or impairment, in social, occupational or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the dissociative disorders diagnostic class” (APA, 2013, p. 348).

Examples of presentations that can be specified using the “other specified” designation include the following:

- **Type 1 (OSDD-1): Chronic and recurrent syndromes of mixed dissociative symptoms:** “Identity disturbance associated with less-than-marked discontinuities in sense of self and agency, or alterations of identity of episodes of possession in an individual who reports *no dissociative amnesia”* (APA, 2022, p. 348; italics added).

- **Type 2 (OSDD-2): Identity disturbance due to prolonged and intense coercive persuasion: “**Individuals who have been subjected to intense coercive persuasion (e.g., brainwashing, thought reform, indoctrination while captive, torture, long-term political imprisonment, recruitment by sects/cults or by terror organizations) may present with prolonged changes in, or conscious questioning of, their identity” (ibid).

- **Type 3 (OSDD-3): Acute dissociative reactions to stressful events: “**Acute, transient conditions that typically last less than 1 month, and sometimes only a few hours or days. These conditions are characterized by constriction of consciousness: depersonalization; derealization; perceptual disturbances (e.g., time slowing, macropsia); microamnesias; transient stupor; and/or alterations in sensory-motor functioning (e.g., analgesia, paralysis). (ibid, p. 349).

- **Type 4 (OSDD-4): Dissociative trance:** “[A]n acute narrowing or complete loss of awareness of immediate surroundings that manifests as profound unresponsiveness or insensitivity to environmental stimuli. The unresponsiveness may be accompanied by minor stereotyped behaviors (e.g., finger movements) of which the individual is unaware and/or that he or she (sic) cannot control, as well as transient paralysis or loss of consciousness. The dissociative trance is *not a normal part of a broadly accepted collective cultural or religious practice*” (ibid, p. 349; italics added).

Unspecified Dissociative Disorder (UDD)

“This category applies to presentations in which symptoms characteristic of a dissociative disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for *any* of the disorders in the dissociative disorders diagnostic class. This category is used in situations in which the clinician chooses *not* to specify the reason that the criteria are not met for a specific

dissociative disorder and includes presentations for which there is insufficient information to make a more specific diagnosis […]" (APA, 2022, p. 349).

Examples of situations when this diagnosis might be used:

- An emergency room-based clinician sees evidence of dissociative features, but they are not prepared or equipped to conduct a full diagnostic evaluation.
- A clinician sees diagnostic evidence of dissociative features, but the features are as-yet-insufficient to support the diagnosis of any of the DSM-5-TR dissociative disorders.

It is not unusual for a more highly traumatized client to present with either conflicting self-report (due to internal struggle) or an impaired capacity for accurate self-report (due to amnesia, thought withdrawal, or internal dynamics that inhibit disclosure). In such instances, there may be a 'wait and see' period as the client either develops more awareness of their symptoms or other self-states begin to allow material to be more fully revealed in session.

EMDR treatment: All of the manifestations of dissociation described above are at least moderately complex, and their treatment in an EMDR therapy frame is largely beyond the scope of what you will receive this training. There are a lot of opportunities for advanced training with the ISSTD once you've earned your Certificate of Completion. Refer below for information regarding treatment of dissociative symptoms using modified EMDR therapy methods.

Forms of Dissociation Elsewhere Classified in DSM-5

Functional Neurological Symptom Disorder (Conversion Disorder)

Functional Neurological Symptom Disorder involves a neurological symptom with no underlying medical cause, which is thought to be psychological in origin. Examples include non-epileptic seizures, paralysis or weakness, abnormal movements or sensations, or difficulty with vision, speech or hearing. As a somatoform dissociative symptom (Nijenhuis, 2004), conversion can be understood as a self-hypnotic negation of a bodily function (Dell, 2009). The psychological mechanism is rooted in an unconscious conflict that is linked with and transformed into a bodily symptom, thus reducing the anxiety and often functioning as a form of self-punishment (Howell, 2005). The conversion symptom can combine the body part, the wish, and the defense all in one symbol, e.g., a paralyzed arm in a person who used it to kill – the paralysis functions to prevent the arm from killing again (defense) and the paralysis is the self-punishment wish (Cameron & Rychlak, 1985). About 70% of Conversion Disorder cases are trauma-related.

Somatic Symptom Disorder

Somatic Symptom Disorder (SSD) involves somatic symptoms that are distressing or disruptive. The experiencer has disproportionate thoughts about the seriousness of the symptom, a high level of anxiety about the symptom, and spends excessive time and energy on the symptom. The symptom may be a normal bodily sensation or may have a medical cause. Examples include pain symptoms, excessive disability after an illness, or undue fatigue. SSD may be related to dissociation of anger or other emotions (APA, 2013). Both the Somatoform Dissociation Questionnaire, in both its standard version (SDQ-20; Nijenhuis, Spinhoven, Van Dyck, Van der Hart, & Vanderlinden, (1996) and brief version (SDQ-5; Nijenhuis, Spinhoven, Van Dyck, Van der Hart, & Vanderlinden (1997)), and Dell's Multidimensional Inventory of Dissociation (MID; 2006) focus on manifestations of somatic symptoms that do not have an underlying medical explanation and are more likely to be trauma-related.

Etiology, Correlates, Risk Factors, and Prevalence of DID in the Western World

The development of Dissociative Identity Disorder, in a majority of cases, is thought to begin with disorganized attachment in infancy. Infants with this attachment pattern display odd and conflicting behaviors in their caregiver's presence. An example of this include instances when a child approaches their parent with their head turned to the side, which suggests contradicting intentions on the child's part; or sudden immobility accompanied by a dazed expression indicating that the child lacks full orientation to their present environment. Liotti (1992) showed that a disorganized attachment pattern is the result of *frightened or frightening* parental behavior, which may result from unresolved parental grief or traumatic experience. For the child, fright activates the attachment system, whereby the child seeks comfort from the caregiver. Unfortunately, this is the very person who has frightened them, leading to a "breakdown in attachment strategy." Liotti proposes that the child's attempts to adapt to this situation gives rise to "multiple internal working models of self" which he believes are a necessary precursor to the development of a dissociative disorder.

Kluft postulated that DID develops when the child, who is highly hypnotizable, is subjected to overwhelming traumatic experiences with an absence of soothing and restorative experiences (Kluft, 1984). A more recent formulation would add that this child probably has multiple internal working models of self from disordered attachment. Regarding trauma histories found in DID cases, in a survey of 9 studies totaling 1085 subjects diagnosed with DID, the rates of any childhood abuse were 89-98%, child sexual abuse, 68-92% and child physical abuse 45-95% (Korzekwa, Webb, & Dell, 2006). Finally, different psychodynamic processes (e.g., observer states, introjection, identification), familial factors, shaping influences (e.g., fictional characters), non-abuse experiences, and temperamental factors appear to play a role in the development of the alter (dissociative parts) system in DID (Kluft, 1984).

The forms of abuse most correlated with the development of pathological dissociation are childhood sexual abuse (Allen, Fultz, Huntoon, & Brethour, 2002), co-occurring childhood sexual and physical abuse (Draijer & Langeland, 1999), and early and severe abuse (Carlson et al., 2001; Ogawa, Sroufe, Weinfield & Carlson, 1997). Emotional neglect, markedly poor emotional attunement between caregiver and child, and early medical trauma have also been observed to contribute to the development of dissociative features (ISSTD, 2011; Diseth, 2006).

Persons at higher risk for developing pathological dissociation include females, highly hypnotizable persons, those who were traumatized at a younger age, as well as those whose traumatic experience was inescapable, resulted in a sense of helplessness, or included prolonged pain/torture (Perry, Pollard, Blakely, Baker & Vigilante, 1995). It is worth noting, as well, that a person does not need to be the direct recipient of harm to be traumatized by it (e.g., exposure to community violence, domestic abuse, etc.). Regardless of its source(s), the early onset of dissociation as a stress-management strategy has a catastrophic impact on the developing child, especially if the dissociation occurs in response to repeated incidents, over a long period of time (Putnam, 1989). Additionally, being a member of a marginalized or oppressed group increases one's exposure to traumatic experience and has been positively correlated with increased risk for developing dissociative symptoms (Keating & Muller, 2020; Polanco-Roman et al., 2016).

Notably, two dissociative symptoms—*depersonalization* and *derealization*, have been cited as the third most prevalent psychiatric symptoms after depression and anxiety (Simeon, et al., 1997). The estimated prevalence of Dissociative Disorders in the general population is 2-11% and 5-46% in inpatient samples. The prevalence of the most severe disorder, DID, is 0.5-1.3% in the community and 0.4-12% in inpatient samples (Ross, 1991; Ross, Duffy, & Ellason, 2002; Saxe, et al. 1993; Vanderlinden, Van Dyck, Van der Eycken, & Vertommen, 1993).

Comorbidity of Dissociative Disorders with Other Issues

Individuals with more complex dissociative features, and particularly DID, usually present multiple comorbid disorders. In particular, most develop PTSD following discrete traumatic events later in life. Other disorders that are highly comorbid include other anxiety disorders, depressive disorders, trauma and stressor related disorders, personality disorders (especially avoidant and borderline personality disorders), conversion disorder (functional neurological symptom disorder), somatic symptom disorder, eating disorders, substance-related disorders, obsessive compulsive disorder, and sleep disorders. Dissociative alterations in identity, memory, and consciousness may affect the symptom presentation of comorbid disorders (APA, 2022, p. 338).

Treatment of individuals who meet criteria for a dissociative disorder must consider and address the features of the dissociative disorder directly. When the features are recognized but not directly treated, they (and often the comorbid diagnoses) do not appear to resolve (Brand, Webermann, & Frankel, 2016; Kluft, 1985).

Memory Consolidation in Dissociative Disorders

When dissociative processes are operating, memory is not consolidated in a unified way. Some memories may be stored in fragments - behavior, affect, sensation, and knowledge (BASK) which may become separated. Other memories may be fairly intact, but may be held by one or more dissociated self-states and thus not consistently (or at all) available to the part of self currently presenting in the room. Memories may resonate across emotional states, or in separate, state-determined parts.

Each person's internal configuration is unique. While our basic underlying physiology and neurobiology is the same, each person has their own complex combination of personality, culture, and environment that requires the therapist to be mindful of assumptions when creating any intervention.

> "All interventions are risky when you don't know your client"
>
> *Phil Kinsler, ISSTD webinar, 2018*

Different Cultures, Different Understandings of Dissociation

Eli Somer (2006) has highlighted a significant bias toward Western, and specifically North American, understandings of dissociation. Both DSM-IV-TR (1994), on which Somer's article was based, subsequent editions of DSM state that pathological dissociation as observed in the dissociative disorders is characterized by disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior (p. 291).

Somer (2006) suggests that a broader, more inclusive definition of dissociation could be of value to resolve discrepancies between Western and non-Western understandings, and offers up the following, alternate language:

> Dissociation is the experience of having a mind in which there can be at least two independent streams of consciousness flowing concurrently, allowing some thoughts, feelings, sensations, and behaviors to occur simultaneously or outside awareness. (p. 213).

Ultimately, we recommend that clinicians replace a pathologizing perspective with a stance of curiosity about how the presenting issue(s) make sense in the broader context of the client's life: Family, spiritual life, culture of origin, current cultural context, and so on. These cultural

considerations are the reason that the word ‘pathological’ will appear in single quotes throughout this training.

Foundational Concepts in the Treatment of Complex Trauma and Dissociation

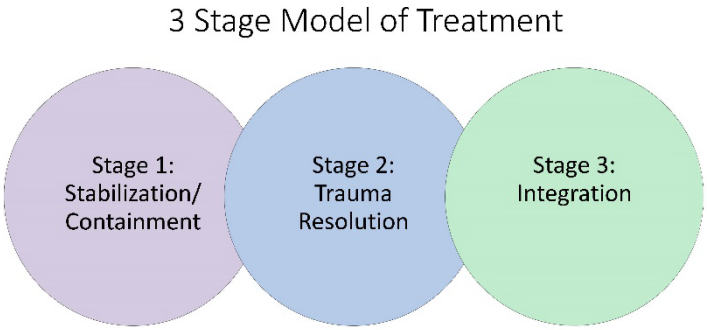
In This Section

- Three Stages of Complex Trauma Treatment
- Treatment Trajectories
- Conceptualizing and Discerning Dissociative Features
  - Working Models of Dissociation
  - Discerning the Subtleties of Dissociation: Now you see it, now you don’t
  - How Dissociation May Show Up in Your Office

Three Stages of Complex Trauma Treatment

Around the turn of the 20th century, Pierre Janet (1907) began writing and lecturing about a specialized, three-phase treatment for what we now term complex trauma. His ideas fell out of favor in the academic community around the time of Freud’s rise to prominence. It was not until Janet’s ideas became popularized again beginning in the 1980’s that Judith Herman (1992) described the need for an extensive stabilization stage in the treatment of complex trauma/PTSD, and the importance of a phased/stage-based treatment of persons with complex trauma. While specific verbiage varies depending on the author(s), the essence of each stage remains the same. We have adapted Janina Fisher’s descriptions of them here:

Figure 8: The Three Stages of Treatment



© 2018 J.A. Madere. Adapted from Herman (1992)

Notably, the Three Stages of Treatment do not explicitly encompass history taking or diagnostic work, seemingly because it was assumed that these tasks are a necessary prelude and accompaniment to treatment. However, it’s important for us to establish that treatment begins the moment a client walks through your door—virtually or otherwise.

Stage 1: Stabilization/Containment

The first stage of trauma treatment focuses on helping the client identify/clarify the specific challenges that brought them to treatment, learn to manage dysregulation, and develop internal and external resources, and resolve any major internal conflicts in preparation for trauma resolution in Stage 2.

It is critical to establish the quality of a client's present functioning prior to delving deeply into history taking or even resource-building when there is evidence of a complex trauma history, as either can be destabilizing given the right (i.e., wrong) conditions.
Owing to this, initially in Stage 1, we want to:

- Identify presenting issues and concerns, including current risk factors
- Identify current and historical sources of resilience
- Identify medical and trauma-related symptoms that may either interfere with successful treatment or contraindicate the use of particular interventions
- Take a thorough bio/psycho/social/spiritual history (possibly over time)
- Develop an initial plan for the work that will take place in subsequent treatment stages

Why might history taking occur over time? If a client comes into treatment without explicitly knowing/recalling their history or lacking a relatively clear, linear way of describing it, either of these is an additional red flag for the presence of dissociative features. So, we must make certain that we have all the information we need—even when it takes time to obtain it—to ensure treatment success.

There may be instances when it is challenging to complete these initial tasks upfront, particularly when a client is highly activated or 'all over the place' walking in the door for treatment. However, the more information we can gather early on, the easier it will be to address the core tasks in Stage 1, which include:

- Educating the client about trauma, including its effects and symptoms
- Helping the client establish a sense of safety within the self and in daily life
    - Orienting the client to the reality that the trauma is over
    - Reducing/eliminating self-harming behaviors
    - Reducing/eliminating re-enactments of the trauma and re-victimization of oneself and others
- Addressing co-morbid conditions that pose a risk of harm, including substance abuse
- Establishing a treatment frame that fosters trust, respect, connection, and hope
- Supporting the client in recognizing, understanding, and managing their emotions, hyper- and hypo-arousal, triggers to flashbacks, and dissociative symptoms
- Helping the client widen their Window of Tolerance for social engagement, healthy self-soothing, and tolerating elevated levels of arousal to ensure successful trauma resolution in Stage 2
- Using current, historical, and newly introduced resources to increase resilience/ cognitive presence in the face of emotional disturbance
- Helping the client establish and/or strengthen their self-care strategies, as indicated by daily routines, adequate sleep, proper nutrition, exercise, and successful stress management (i.e., structure)
- Address secondary-gain issues that prevent the client from moving forward in their healing process
- Supporting the client in stabilizing their present-day life: Relationships, finances, daily functioning, adequate social-emotional supports, developing appropriate parenting skills
- Helping the client overcome dynamics of betrayal-trauma and ambivalent or self-destructive attachments to abusive and non-protective caregivers

For clients who are more highly dissociative, Stage 1 will also include:

- Mapping and understanding how the self is organized

- Working with aspects of the self to orient them to the present (including the realities of the single body in which they live) and identify, manage, and resolve conflicts amongst different parts
- Obtaining ongoing consent from self-states to begin managing/containing disturbance, including triggers to flashbacks and other dissociative symptoms

An extensive Stabilization stage may be required when the following factors are present (Courtois & Ford, 2009)**:**

- An extensive history of childhood abuse or neglect
- Evidence of prolonged, repetitive trauma in adolescence or adulthood
- Active self-harm, suicidality, or ongoing aggressive behavior
- A lack of physical and/or emotional safety and stability in the present
- Active comorbidities such as depression, substance abuse, or disordered eating behaviors
- Evidence of a severe personality dysfunction
- Evidence of limited or poor affect regulation skills
- Significant dissociative features, beyond PTSD-type flashbacks
- Evidence of chaotic relationships or inconsistent/absent social support in the present
- The client struggles to forge a therapeutic alliance, establish an initial degree of trust, or maintain consistent attendance/engagement despite genuine effort on the part of the therapist
- Unstable medical problems

For some clients, the entirety of treatment may occur within Stage 1—particularly if age, health issues, or other factors suggest that trauma accessing would be detrimental or even harmful to the client's long-term stability.

Stage 2: Trauma Resolution

This stage of treatment centers upon coming to terms with and resolving past, painful experience and what Shapiro (2018) called 'present triggers' to that pain. The tasks in this stage include:

- Overcoming fears of the memory, triggers, cognitions
- Accessing and resolving old, painful experience
- Accessing and resolving 'present triggers' that connect back to old, painful experience

In other treatment frames outside EMDR therapy, an additional task in Stage 2 is that of restructuring trauma-based personal schemas (thought processes, perceptions, narratives, etc.), but in EMDR therapy, this happens naturally as a direct result of reprocessing dysfunctionally-stored memory material.

For more dissociative clients, Stage 2 will necessarily include:

- Working with aspects of the self to organize/manage the pacing, content, and amount of painful experience tapped into
- Working with aspects of the self to manage/resolve any new conflicts that arise in the course of trauma resolution work

It is important to for us to establish that these Stages of Treatment do not exist separately from one another. Instead, it is quite typical for treatment to 'shuttle' back and forth amongst the stages. As such, Stage 2 will often involve temporarily shifting back into Stage 1 to strengthen

resources and manage newly emerging issues in the process of resolving old, painful experience and 'present triggers.' Reasons why this might occur include:

- A crisis arises in the client's life that requires focusing elsewhere besides trauma-focused work
- A need to develop new affect management strategies surfaces
- Newly emerging aspects of self may require preparatory work (including conflict resolution) prior to engaging with other parts in trauma resolution work
- The client feels the need to 'take a break' from trauma work for a period of time
- It becomes necessary to re-establish the treatment frame or review progress prior to engaging in further trauma-focused work

Additionally, it could be that the work temporarily shifts from Stage 2 to Stage 3. For instance, the resolution of residual anticipatory anxiety of future similar events/experiences/exposures, etc., using the Future Prong of EMDR may be necessary to address as part of the treatment plan.

Stage 3: Integration

The focus of this stage of treatment is upon integrating the changes within the self and in day-to-day life, consolidating gains, and moving on. Herman (1992) referred to this stage as 'Rehabilitation.' Regardless of the verbiage, the tasks addressed during Stage 3 include:

- Addressing any existential, identity, and attachment-related issues:
  - *"Who am I now, in the present, when I am no longer defined or held back by my trauma?"*
  - *"What does this mean for my relationship to myself and others, my job, my life, etc.?"*
- Developing a more consistent sense of life mastery and self-sufficiency
  - Creating new templates for handling stressful situations differently in the future
- Moving towards longer-term life goals
- Achieving relief of any residual symptoms
- Establishing relapse prevention strategies, plans, etc.:
  - Substance use issues, disordered eating, self-harm, etc.
  - Emotional first-aid in the case of re-traumatization
- Concluding the therapy relationship (i.e., termination):
  - *"What does it mean that we won't be working together any longer?"*
  - *"Will you still be here if I need you in the future?"*
  - Closure rituals marking the end of a chapter in both the client's and the therapist's life (<u>always</u> at the discretion of the client)

As with the other Stages of Treatment, for more highly dissociative clients, there will be additional work to do, including:

- Working with new aspects of the self that emerge who still hold old, painful experience
- Integrating and 'smoothing out' how self-states work together to achieve shared goals

Just as it may be necessary to 'shuttle' between Stages 1 and 2, there may be temporary shifts from Stage 2 to 3, or from Stage 3 to 2 or 1, as needed:

- Stage 2 to 3
  - In an EMDR therapy frame, creating new templates for handling stressful situations differently in the future, before moving on to other areas of focus for trauma resolution work

    - Taking time to assess any immediate existential, identity- and/or attachment-related issues arising directly from the adaptive resolution of a long-term issue that may previously have been experienced as intractable or 'incurable'
- Stage 3 to 2
    - Returning to trauma resolution work when additional old, painful experience and/or new 'present triggers' (present-day situations, etc., that open up old, painful experience) surface
- Stage 3 to 1
    - Returning to conflict resolution or stabilization work when newly emerging aspects of the self are found to hold old, painful experience but may not yet be prepared to resolve it

For further reading and learning, a comprehensive review of 3-Stage treatment of dissociative disorders is included as a resource for this training. The document may also be accessed, free of charge, at www.isst-d.org, or by directing your web browser to the *Guidelines for Treating Dissociative Identity Disorder in Adults* (ISSTD, 2011).

Treatment Trajectories

Recognizing the variety of factors that influence treatment success (or failure), Kluft (1994a) developed an instrument called the Dimensions of Therapeutic Movement Instrument (DTMI) to measure the "treatment trajectories" of clients with Dissociative Identity Disorder and OSDD. The 12 dimensions that are measured by the DTMI include: therapeutic alliance, integration, capacity for adaptive change, management of life stressors, alters' responsibility for self-management, restraint from self-endangerment, quality of interpersonal relationships, need for medication, need for hospital care, resolution of transference phenomena, inter-session contacts and subjective well-being (ibid).

Comparing follow-up scores to the baseline score gives the therapist an idea of whether the client's treatment trajectory is high, intermediate, or low (Kluft, 1994b). Kluft characterized the different treatment trajectories as follows:

- **High trajectory** clients "get the hang of therapy," rapidly form a good therapeutic alliance, commit themselves to the therapeutic work, and rule out suicide and self-harm as an appropriate option.
- **Intermediate trajectory** clients have a variety of presentations and their issues may include: complicating comorbid conditions, complicating characterological features, impulsiveness, denial of the dissociative diagnosis, and difficulty accessing the alter system.
- **Low trajectory** clients are preoccupied with the pursuit of nurturing and support, their locus of control is external, characterological issues are prominent, their self-systems are often complex and may involve sadomasochism or a dominance of child parts, and suicide and self-injury issues are rarely resolved.

Conceptualizing and Discerning Dissociative Features

If we're going to attempt to diagnose something—to truly understand what we're looking for, how to look for it, and how to recognize it when we find it—it can be helpful to establish a frame.

Working Models of Dissociation

To date, no singular model that explains the varied manifestations of traumatic dissociation has been established as hard fact. Although the DSM discusses the most common signs and symptoms of dissociative disorders, the evolving criteria for DID have resulted in diagnostic criteria that may inadequately reflect people's lived experience. However, there is a long tradition of theoretical conceptualization, as well as a burgeoning field of neurobiological

research, which can prove the existence of dissociative features but cannot yet fully connect the dots between etiology (source) and the varied manifestations of dissociation. For our purposes, we'll look at a couple of specific, working models of dissociation that are comprehensive enough to inform conceptualization and treatment planning in an EMDR therapy frame.

The Structural Theory of Dissociation

The structural theory, a working model of dissociation described by Van der Hart, Nijenhuis, and Steele in their book, *The Haunted Self* (2006), descends directly from the observations and theories of Pierre Janet in the early-1900s. The premise of this theory is relatively straightforward: When an infant/child (who, during normal development, has not yet developed an integrated personality) is traumatized and the caregiver provides insufficient soothing or calming and doesn't teach them how to regulate emotions, the child may never develop a normal, healthy personality system. Under traumatic conditions, the personality tends to divide on 'fault-lines,' resulting in a "structural dissociation" of the personality (i.e., the organization of the personality is based on dissociative structures that are not integrated).

For Van der Hart and colleagues, these dissociative structures are based on action systems (see also, Panksepp (1998/2011) for a discussion of the neuroscience of emotion underlying these systems). There are two basic categories of action systems, which are psychobiological systems that involve an innate readiness or tendency to act. The first category promotes functioning in daily life and reproduction, and the second promotes defense in the face of threat. These two categories of action systems tend to mutually inhibit each other because only either daily life activities or defensive activities can occur at any given time. Thus, the 'fault lines' in structural dissociation tend to occur between these two categories of action systems. Dissociation between the action systems of daily life and of defense is proposed as an explanation of the alternating pattern of numbing and intrusions in trauma-related disorders.

Apparently Normal Personality (ANP) and Emotional Personality (EP)

A so-called Apparently Normal (part of the) Personality (ANP) is fixated on performing normal life functions while at the same time being (consciously and/or unconsciously) phobically avoidant of one or more traumatic memories (or trauma-related parts of the personality, also known as emotional parts, or EPs), manifesting in degrees of detachment, numbing, depersonalization, and partial or complete amnesia. An ANP is focused on the activities of daily living, such as caretaking, attachment, enjoyment, exploration of the environment (including work and study), play, energy management (sleeping and eating), sociability, and reproduction/ sexuality—*but frequently within a very circumscribed Window of Tolerance*. An ANP tries to avoid the traumatic memories and any intrusions from trauma-associated self-states (EPs). ANPs are focused on the present and future, the continuation of life and/or attachments. ANPs are essentially blind to trauma and to the parts associated with trauma, and may in fact develop a number of different, illogical explanations for any dissociative intrusions they experience in their day-to-day life.

An Emotional (part of the) Personality (EP) is fixated on everything that exists outside the ANPs Window of Tolerance (WoT) and full conscious awareness, including past traumatic experience(s) and the detection of threat, which activates the action systems associated with defense: attachment cry, "hypervigilance and scanning the environment, flight, freeze with analgesia, fight, total submission with anesthesia, and recuperative states" (Van der hart, Nijenhuis & Steele, 2006, p.37) and other life preserving activities. EPs are stuck in a never-ending 'past-as-present'—frozen in or constantly re-experiencing/re-enacting some aspect(s) of the traumatic experience. They have a persistent, recurring need to understand or master the trauma or to complete an act of self-protection that was not completed during a trauma. (This phenomenon is referred to as 'trauma mastery' or a 'repetition compulsion'). EPs are often too

preoccupied with survival to recognize or assist other EPs, may have little to no awareness that they are part of a larger self-system, and predominantly lack any perception of past, present, or future. Each EP has its own WoT: experience/action outside one EP's Window may be taken on by another EP (or ANP, in some cases of DID), whose role it is to 'handle' that emotion, sensation, behavior, etc.

ANPs and EPs are unduly rigid (owing to their respective Windows of Tolerance) and closed off to each other (harking back to the Watkinses' (1997) differentiation-dissociation continuum). All parts are trapped in maladaptive action tendencies that maintain dissociation, including a range of phobias to ensure that they each remain within their respective WoT. We will discuss dissociative phobias in further depth later in the training.

Table 1: Levels of Structural Dissociation

Level	Structure	Diagnostic Presentation	Degree of Prep Needed to Begin Trauma Work
Primary	A single ANP and a single EP	PTSD and Acute Stress Disorder	Low to Medium
Secondary	A single ANP and multiple EPs	Complex PTSD, trauma-related Borderline Personality Disorder, and Other Specified Dissociative Disorder(primarily Type 1), and Unspecified Dissociative Disorder	Medium to High
Tertiary	Multiple ANPs and multiple EPs	Dissociative Identity Disorder	High

In tertiary structural dissociation, ANPs (more than one) may, due to triggers or poor stress tolerance, be divided along action systems (e.g., the worker, the caretaker, the sexual partner) (van der Hart, Nijenhuis, and Steele, 2006).The more complex the dissociation—and the more elaborated the structure of the self—the greater the training and skill, integration amongst approaches, and client preparation, necessary to ensure that the client can achieve positive results using EMDR therapy methods.

The Subjective-Phenomenological Model of Dissociation

Paul F. Dell and John O'Neil have suggested that "dissociation" connotes two distinct sets of phenomena whose relationship remains uncertain and which commonly co-occur: *faculty dissociation* and *multiplicity*.

1) *Faculty dissociation* implies a disruption in the normal integration of the psychological faculties without major disruption in the sense of self. In other words, dissociation interrupts things like the senses, (such as taste, touch, smell, hearing, seeing) and the sense of oneself in the world. Symptoms include blurred vision, feeling numb or foggy, hearing buzzing, feeling unreal in the world, and/or experiencing the world at a distance. These would be classified as *depersonalization* and *derealization.*
2) *Multiplicity* implies the presence of "more than one center of consciousness, more than one self" (Dell & O'Neil, 2009, p. xx (Preface)). Alterations between/among these centers of consciousness may be accompanied by amnesia, but need not—or in some cases

just not uniformly. This phenomenon is seen specifically in the DSM-5-TR dissociative disorders.

Paul Dell, who also developed the *Multidimensional Inventory of Dissociation* diagnostic instrument, observed that, broadly speaking, "[t]he phenomena of pathological dissociation *are recurrent, jarring, involuntary intrusions into executive [cognitive] functioning and sense of self"* (2009, p.226). In attempting to conceptualize and understand how faculty dissociation and multiplicity manifest and interact, Dell developed a taxonomy of dissociative symptoms that he organized into three sets of criteria, similarly to diagnostic criteria for DSM dissociative disorders diagnoses, based both on observable signs and subjectively experienced symptoms:

Criterion A: General Posttraumatic Dissociative Symptoms

General postrraumatic dissociative symptoms occur not only in persons with a dissociative disorder, but also in persons with certain other disorders: PTSD, acute stress disorder, somatic symptom disorder, conversion disorder, panic disorder, major depression, schizotypal personality disorder, and borderline personality disorder. (The following material derives from Coy, Madere, and Dell, 2020).

- **General memory problems**
  Memory problems include day-to-day experiences such as forgetfulness—working memory issues that can be caused by chronic distress—and difficulties with remote memory, like struggling to recall childhood and other history, having large gaps in one's memory of the past, and struggling to recall important life events.
- **Depersonalization**
  Depersonalization involves odd changes of one's internal experience of self, mind, or body. Examples include feeling unreal, being a 'detached observer' of oneself, and feeling distant, changed, estranged, or disconnected from one's sense of self, one's mind, or one's body.
- **Derealization**
  An experience during which the outside world feels unreal, strange, foggy, unfamiliar, distorted, distant, or changed. Vision may seem more vivid, colorful, or sharp. Time may feel as if it has slowed down or entirely stopped. People or surroundings suddenly seeming/feeling strange or unfamiliar, for no obvious reason. Often (but not always) co-occurs with depersonalization.
- **Post-traumatic flashbacks**
  Flashbacks typically manifest as sudden intrusive memories, pictures, internal 'videotapes,' nightmares, or tastes, or body sensations of previous traumatic experiences. During dissociative flashbacks, a person may lose contact with the 'here and now', and suddenly be back 'there and then.'
- **Somatoform symptoms**
  Somatoform (conversion) symptoms are bodily experiences and symptoms that have no medical basis. These symptoms may affect vision, hearing, sight, smell, taste, body sensation, body functions, or physical abilities. They are often a partial re-experiencing of a past traumatic event.
- **Trance**
  An altered state of consciousness that, in this case, occurs spontaneously. During a 'deep' trance, a person loses conscious contact with what is going on around them and may not respond to attempts to gain their attention. They may stare off into space, thinking about nothing, or 'go away' into their own mind when something upsetting starts to happen. *NOTE: Dell's definition of trance refers specifically to 'deeper,' dissociated*

trance states in which a person has 'zoned out,' as opposed to a mild-to-moderate form of trance from which a person can be (comparatively) easily re-alerted.

Criterion B: Partially-Dissociated Intrusions of Another Self-State into Executive Functioning and Sense of Self

The symptoms in Criterion B are described as "partially dissociated" because the experiencer registers them as being generated from outside their conscious intention or choice—though not from outside themselves as a person—and thus, frequently, as intrusive or disruptive.

- **Child voices**
  The voice of a child is heard inside the head. The voice may speak, cry, or create a sense of 'noise' in the head that makes it difficult to focus on or attend to the present moment.
- **Two or more parts that converse, argue, or struggle**
  Dissociative self-states, or 'parts', may argue, comment on, or struggle/interfere with one another, including the front part(s). This may manifest as voices or loud thoughts that argue, or even as a non-auditory internal presence/influence. Internal Struggle is the first of the two most frequently elevated MID scales for persons with a complex dissociative disorder (i.e., DID and OSDD-1).
- **Persecutory voices**
  Persecutory voices are heard to call others names, are harshly disparaging, and command other self-states to commit acts of self-injury or suicide. Persecutory self-states may be internal representations of outside abusers or self-identifying states that hold rage energy.

Do Loud Thoughts Count as 'Voices'?

Şar and Öztürk (2009) note that loud thoughts in dissociative patients

> *…feel intrusive, and are perceived as discordant with the person's own tendencies and identity ('not-me' quality). They may be even attributed to a 'foreign entity' (i.e. alter personality)* ***inside of the person*** *(bolded emphasis added).*

So, some people may experience their "voices" as "loud thoughts" and, for a variety of reasons, reject the label "voices" for their internal experience (p. 166).

- **Speech insertion**
  A dissociative self-state 'intrudes' into the executive functioning of an executive self-state by seizing control of what is being said. With this experience, a person may feel that the words coming out of their mouth are being controlled by someone or something else.

- **Thought insertion**
  The ideas of a dissociated self-state suddenly 'intrude' into conscious awareness. Intrusive thoughts feel like they have 'come out of nowhere' and may feel like they do not really 'belong' to an executive self-state.
- **'Made' / intrusive emotions**
  Intrusive emotions (or feelings) are experienced as 'coming from out of nowhere' or quickly disappearing. They may also be experienced as rapid, moment-to-moment shifts in mood, often with no apparent reason. The person often experiences intrusive emotions as 'made' or manufactured—essentially, as 'not real' or as 'not mine'.

- **'Made' / intrusive impulses**
  These are often strong and seemingly inexplicable urges, or an experience of one's urges and behaviors as being controlled by something or someone inside them. As with other 'made' experiences, a person often registers these impulses as 'not real' or as 'not mine'.
- **'Made' / intrusive actions**
  Intrusive actions tend to feel as if they are under someone else's control or done by someone or something else inside. This may be accompanied a sense of being controlled and depersonalization. This is a particularly common, 'ego-alien' experience in persons with a dissociative disorder.

- **Temporary loss of (well-rehearsed skills and) knowledge**
  Suddenly and inexplicably, a well-rehearsed skill or knowledge is just 'gone'. What should be there is suddenly absent. This is a consciously experienced form of in-the-moment amnesia in which a person forgets their age, how to do their job, how to drive the car, and so on. This experience is intensely puzzling to the person.

  This is a unique dimension of amnesia because it is consciously experienced at the time that it occurs. Thus, it is a both a partially-dissociated symptom and an amnesia symptom—though it sits in contrast to the more common, fully-dissociated forms of amnesia reflected in Criterion C (see below).
- **Experiences of self-alteration**
  These kinds of experience are disconcerting. They involve very odd but discernible changes in one's sense of self. Examples include feeling like a different person, switching back and forth between feeling like a child and an adult, a sudden shift in one's sense of gender, seeing someone else (or not recognizing oneself) in the mirror, and so on.
- **Puzzlement about oneself**
  Unlike the other 10 consciously-experienced, partially-dissociated intrusions, self-puzzlement is not a dissociative symptom, per se. Rather, ***it is the result of dissociative experiences.*** The more dissociative experiences, the more self-puzzlement a person may experience. It may also result in defensive denial that anything dissociative is happening. Persons who experience these kinds of symptoms are recurrently puzzled by their inexplicable thoughts, feelings, impulses, behaviors, etc. Self-puzzlement is the second of the two most frequently elevated scales in clients with a complex dissociative disorder (i.e., DID and OSDD-1).

Criterion C: Fully-Dissociated Actions of Another Self-State (Amnesia)

'Amnesia' here describes an in-the-moment experience of 'not knowing', during which another self-state has completely taken over executive functioning and control, rendering the immediately previous 'executive' and, potentially, other non-executive self-states, completely unaware of what is happening during that time. The 'blank' period can last minutes, hours, day(s) or more, and is often precipitated by distress for one or more self-states. The symptoms in Criterion C are different manifestations of amnesia (literally 'lack of/absence of memory' in Greek), the fullest expression of 'pathological' dissociation and therefore the hallmark of DID.

- **Time loss**
  Time loss involves incidents of "losing time". A person DISCOVERS that they cannot account for several minutes, hours, a day, or even longer. They have a total "blank" for what happened during that period of time.

- **"Coming to"**
  A person suddenly "comes to" and (1) DISCOVERS that they have done something, but they have no memory of having done it, or (2) becomes aware that they are in the middle of doing something that they have no memory of having started doing in the first place.
- **Fugues**
  Incidents in which a person suddenly DISCOVERS that they are somewhere, but they have no memory whatsoever of going to that place. Such travel may occur within the home, such as when as a person walks from the living room to the kitchen or hides in a closet or under the bed after waking up from a nightmare without awareness of having done so, or outside, in public. An example of this would be traveling to work or a dance club, but without being aware of the trip.
- **Being told of one's recent disremembered actions**
  Persons with a severe dissociative disorder may be told about their recent statements or actions but have absolutely no memory of having said/done those things. Thus, the experiencer DISCOVERS what they have done based on another person's report.
- **Finding objects among one's possessions**
  Persons with a severe dissociative disorder may DISCOVER objects, writings, or drawings amongst their possessions, but have no idea where those things came from. They may DISCOVER purchases that they do not recall making, which may be inconsistent with their tastes, interests, or maturity level.
- **Finding evidence of one's recent actions**
  Persons with a severe dissociative disorder may DISCOVER evidence of their recent actions, but they will have no memory of having done those things. They may DISCOVER items at home inexplicably being moved around or changed when they are the only person who could have done so, tasks thay only the experiencer is capable of being mysteriously completed, or previously unnoticed or unexplained injuries—even a fully-dissociated suicide attempt.

We'll return to these concepts further along in the manual when we begin to look at practical applications of this knowledge for the purposes of screening and diagnosis in an EMDR therapy frame.

Discerning the Subtleties of Dissociation: Now You See It, Now You Don't

Historically, dissociation has often eluded detection by clinicians. They may not 'believe' in it and therefore do not notice it; they may believe in it but do not see it; or, they see it but attribute what they see to another (partially or wholly inaccurate) diagnosis. Given the generalized lack of training in identifying and treating dissociative issues, this is not a surprise. Also, dissociative defenses, when working well, can be difficult to discern.

The easiest diagnoses are made with a client who exhibits the most extreme dissociative features, and even those are often misdiagnosed. In recent years, common misdiagnoses have included Schizophrenia, Borderline Personality Disorder, Bipolar Disorder, and ADHD. Misdiagnosis may arise from seeing some, but not all, of the symptoms the person is experiencing, such as depression and/or anxiety—particularly if the clinician fails to inquire more carefully about how the person experiences themselves or about any history of trauma and neglect. The clinician may not know what to do with memory issues determined to be psychological in nature, and as a result they may fail to dig deeper to discover underlying dissociative processes at play. Other symptoms may demand the clinician's immediate attention, delaying their ability to engage in more comprehensive assessment. Those 'immediate attention required' symptoms may include intense phobia of the therapist/therapy,

eating disorders, substance abuse, domestic violence, self-harm, and suicidal behaviors, among others.

Because we will address formal screening and diagnosis further along, in the context of the practicalities of EMDR therapy, here will restrict our exploration to tips on 'eyeballing' for dissociative symptoms.

At-a-Glance: Discerning the Presence of Dissociative Features
adapted from Loewenstein, 1991

- **NOTICE if the client**
  - Offers vague, inconsistent, contradictory, or poor chronological history
  - Has been given three or more prior diagnoses
  - Has experienced prior failed/ineffective treatments
  - Reports/exhibits concurrent psychiatric and physical symptoms
  - Has PTSD symptoms **plus** other features in this list
  - Reports a history of abuse or emotional/material neglect in childhood
- **ASK about Amnesia, including instances of**
  - Temporary loss of well-rehearsed skills and knowledge *(under Dell's Criterion B symptoms)*
  - Experiencing any features of Dell's Criterion C symptoms
- **ASK about Identity Alteration, including instances when the client…**
  - Acted as if they were a child, or were told that they did
  - Acted like a completely different person, or were told that they did
  - Found objects in their possession that they don't remember acquiring, which did not suit their professed tastes/interests
  - Referred to themselves by a different name (other than nickname), or were told that they did
  - Noticed rapid changes in their capabilities, knowledge, or talents (absence or presence)
  - Heard voices (usually inside the head) or loud, insistent, or jarring thoughts
  - Noticed radical handwriting changes
- **OBSERVE any in-session evidence of the client**
  - "Switching," as evidenced by distinct changes in voice, speech, behavior, movement, or appearance (e.g., looking older/younger). (Though note that many people with DID will attempt to hide visible evidence of 'switching.'
  - Spontaneously regressing in their level of maturity (aka *age regression*)
  - Referring to the self as "we" or in third person "he/she/they"
  - Experiencing In-session amnesia, depersonalization, or derealization (any of which may be accompanied by fear or self-puzzlement)
  - Offering puzzled, ambivalent, or oddly conflicting responses to basic questions
  - Exhibiting a significant emotional response to questions about dissociation
  - Exhibiting eye rolling (to the back of the head), repeated heavy blinking, or keeping their eyes closed for no apparent reason
  - Offering 'blank' looks or seeming to be off in a trance

Many more questions could be asked about depersonalization, derealization, Schneiderian first-rank symptoms (Schneider, 1959), intrusive symptoms, passive influence symptoms, switching symptoms, identity confusion, somatoform, and PTSD symptoms. However, after asking the above questions, the clinician should have a fairly good diagnostic 'clue.' But what happens when your client is unable to offer you information about their experience, but something still seems 'not quite right' when you're sitting with them?

How Dissociation May Show Up in Session

Dissociative Phobias: Containment and Protection Against Further Harm

In working with clients with complex trauma histories, Van der Hart, Nijenhuis & Steele (2006) observe that "phobias are a major focus of treatment" (p. 234). We can think of the phobias that a traumatized person accumulates as a series of layers of insulation which distance the self-system (as a whole and throughout the self) from emotion, sensation, and knowledge perceived as life-threatening or in some other way harming. These phobias manifest in a number of ways and do not exist independent of one another. In many respects, they overlap with, interact with, and magnify one another.

Although we will not go into great depth in discussing these phobias, they are important to recognize as a major factor that can complicate, slow down, or entirely thwart successful adaptive resolution of traumatic memories.

Table 2: Shapiro's 'Red Flags' in Relation to Dissociative Phobias

'Red Flag(s)' *Shapiro, 2018, pp. 85-97*	***Related Dissociative Phobia(s)*** *Adapted from Gonzales & Mosquera, 2012, pp. 142-143*	***Possible Manifestations****
Level of Rapport (Shapiro, 2018, p. 87) *Stability (Shapiro, 2018, pp. 88-89)* *Life Supports (Shapiro, 2018, p. 89)*	Phobia of Attachment to the Therapist ***MID: Criterion A Symptoms*** ***MID: Criterion B Symptoms***	• Difficulty offering honest or accurate self-report • Fear of 'being seen' by the therapist due to perceived risk of vulnerability or harm • Impaired/limited expression of emotion to accommodate the therapist's perceived tolerance for them • Being overly attuned to/regulating the therapist's behavior, emotions, and needs in service of self-preservation • Disorganized/confusing attachment behaviors (due to ongoing conflict between attachment and defense needs) • Enactment of Karpman's Drama Triangle
Emotional Disturbance (Shapiro, 2018, pp. 87-88) *Timing (Shapiro, 2018, p. 93)* *Drug and Alcohol Abuse (Shapiro, 2018, p. 92)*	Phobia of Trauma-derived Mental Actions *"what we feel, think, wish, need, and sense" (Van der Hart, et al.,(2006), p. 281)* ***MID: Criterion B Symptoms*** ***MID: Criterion C Symptoms***	• Difficulty offering honest or accurate self-report • Minimization/denial of the existence of internal stimuli (such as intrusive thoughts, sensations, impulses, voices arguing, etc.) • Denial of responsiveness to internal stimuli, even when witnessed by the therapist or other people
Emotional Disturbance (Shapiro, 2018, pp. 87-88) *Drug and Alcohol Abuse (Shapiro, 2018, pp. 92-93)* *Timing (Shapiro, 2018, pp. 93-94)*	Phobia of Dissociative Aspects of Self ***MID: Criterion B Symptoms*** ***MID: Criterion C Symptoms***	• Denial of self: 'They're not there; they're not me' • Fear of particular parts or kinds of parts (e.g., angry parts, substance-using parts) • Denial of intrusive actions • Conflict between parts, including conflicting feelings about doing therapeutic work

Emotional Disturbance (Shapiro, 2018, pp. 87-88)
 	
Stability (Shapiro, 2018, pp. 88-89)
 	
Life Supports (Shapiro, 2018, p. 89)
 	
Timing (Shapiro, 2018, pp. 93-94)
	Attachment Phobias Related to the Perpetrator
	
	MID: Criterion B Symptoms
		• Conflicted feelings of loyalty
		  • Feeling pressured to 'choose sides')
		  • Fear of betraying a beloved caregiver
		• Reticence to disclose information to the therapist for fear of being 'found out' and punished by perpetrator(s)
		• Double bound thinking (e.g., 'You can hurt me as much as you want as long as you protect me,' which can lead to a variety of challenges in achieving adaptive resolution of traumatic memory material
		• Enactment of Karpman's Drama Triangle

Emotional Disturbance (Shapiro, 2018, pp. 87-88) *Stability (Shapiro, 2018, pp. 88-89)* *Timing (Shapiro, 2018, pp. 93-94)*	Attachment Phobias in Other Self-States ***MID: Criterion B Symptoms*** ***MID: Criterion C Symptoms***	Similar to *Phobia of Attachment to the Therapist*, but also includes parts' fear, anger/hatred, or shame in relation to one another, as well as parts' fears of being 'tricked by,' harmed, destroyed, or 'gotten rid of' by the therapist, etc. • Disorganized/confusing attachment behaviors (due to ongoing conflict between attachment and defense needs of different self-states) • Enactment of Karpman's Drama Triangle
Emotional Disturbance (Shapiro, 2018, pp. 87-88) *Stability (Shapiro, 2018, pp. 88-89)* *Office Consultation versus Inpatient Treatment (Shapiro, 2018, p. 89-90)* *Drug and Alcohol Abuse (Shapiro, 2018, pp. 91-92)* *Medication Needs (Shapiro, 2018, p. 92)* *Timing (Shapiro, 2018, pp. 93-94)*	Phobia of Traumatic Memory Material ***MID: Criterion A Symptoms*** ***MID: Criterion B Symptoms*** ***MID: Criterion C Symptoms***	• affect/soma intolerance • substance use • disordered eating behaviors • self-harming behaviors • characterological dysfunction • avoidance of trauma accessing, even after a successful reprocessing session *resulting in an increasingly narrow aggregate Window of Tolerance*
Systems Control (Shapiro, 2018, p. 92) *Secondary Gains (Shapiro, 2018, p. 93)* *Timing (Shapiro, 2018, pp. 93-94)*	Phobia of Life Change / Instability *e.g., loss of benefits, change in relationships as a result of improvement, etc.* ***MID: Criterion B Symptoms*** ***MID: Criterion C Symptoms***	• malingering • factitious behavior • avoidance of trauma accessing, even after a successful reprocessing session • decompensating/destabilizing after a (positive or negative) session • treatment regression after gains are made • parts 'shutting down' or complicating the work, even when a front part wants their functioning to improve

**This is not an exhaustive list of possible manifestations*

As we begin to explore the applications of EMDR therapy to work with traumatic memory material, it will become clearer how a clinician experienced in treating persons with complex

trauma histories could integrate EMDR therapy techniques to treat different dissociative phobias effectively and safely. Let's look at a couple of specific dimensions of how dissociative phobias might show up in client sessions.

The Therapist's Responses to Their Client

Dissociation is internal, hidden, and often invisible. Because of this reality, it can be very useful to keep in mind the question, "Is this client dissociating, and if so, how?' You can consider the possibility that your client has dissociative features when you find that your own behavior is different with this client than with others. You may even stumble upon the existence of a client's hidden dissociative phobias in the course of a session, and only later become aware that your experience pointed directly to them. The therapist-experienced phenomena noted below are potential clues pointing to dissociation in your client:

- **Feeling confused**
  Dissociation disrupts linear thinking, and/or emotional congruity. Your client may shift from one subject to another or from one emotional state to another, for no apparent reason. As this happens, you may find yourself unable to follow what's happening for your client. Additionally, your client may not respond in anticipated ways, leaving you rather confused about what exactly is happening.
- **Feeling sleepy**
  If you find yourself feeling very sleepy only with certain clients, your client may be dissociating—partially 'present' in the room, and partially absent. The feeling of struggling to stay awake that you feel may reflect the client's struggle to stay consciously present in the way they want/need to be. Sometimes, your client is both actively engaging with you while also blocking intense feelings about things that have not (yet) been verbalized. If you sense that your client has not disclosed information that is perhaps resulting in you feeling sleepy, you might ask your client, "So, what are we *not* talking about?"
- **Yawning uncontrollably**
  You may actually have experienced this with clients and assumed you were just tired. We name this as distinct from feeling sleepy because you may find yourself yawning repeatedly and be fully aware that you're not at all tired. Sometimes this yawning is an indicator that dissociated memory material is emerging, outside your client's conscious awareness (Coy, 2019).
- **Feeling like you're in a dream**
  Sitting with someone who is dissociating may cause you to feel as if you've drifted into an altered state of consciousness, as if you're floating away, or as if you're being (or have been) pulled into a trance.
- **Feeling ungrounded**
  Clients with dissociative features may evoke conflicting emotions, perceptions, and reactions in you that reflect alternate perceptions, experiences, needs, and goals within your client. They may appear young and vulnerable, hostile, or remote in ways that are either subtle or alarmingly blatant. You may have difficulty tracking the shifts, feel unsure of what's going on, and struggle to intervene in a way that is attuned to the needs of the client.
- **Playing a role in your client's private drama**
  You may find yourself in a re-enactment of the trauma emerging in the midst of the therapeutic relationship, feeling as if you and your client are reading from radically different scripts.
- **Having a sense of not knowing the client**
  You may have more than the usual difficulty evaluating or diagnosing the person.

- **Sensing nothing at all from your client**
  For those who are clairsentient (acquiring knowledge through inner-body felt sense), this phenomenon could be described as feeling as if your client has no 'heat signature'—they're physically present, but somehow, it's as if there's no emotional presence at all, no resonance.
- **Wondering who came to therapy last week…?**
  Your client may come to therapy with different presentations, such as very different wardrobe choices, hairstyles, mannerisms, gaits, vocabularies, attitudes, and manner of relating to you that seem oddly out of character. You may notice that these different presentations are accompanied by notably different goals in therapy, different levels of engagement, and different relationships with you.
- ***Who* has the memory problem?**
  Your client may be partially or completely amnestic for previous sessions. They may deny it or simply be unaware of it, suggesting instead that it is you who has mis-remembered, 'because they never said/did that.'
- **Karpman's Drama Triangle**
  You may alternately feel pulled to rescue your client, to feel rescued by the client, be perceived by your client as a perpetrator/abuser, and perceive your client to be a perpetrator/abuser—sometimes all in the same session. These are all re-enactments of Karpman's Triangle (Danylchuk and Connors, 2023), and the result of emotional flashbacks and/or actions by self-states who do not know who you are, who they are, or the fact that they are no longer in the past.

  Stephen Karpman developed the Drama Triangle in 1968 to model the connection between personal responsibility and power in conflicts, and the destructive and shifting roles people play. He defined three roles in the conflict: Persecutor, Rescuer (the 'one up' position), and Victim (the 'one down' position). He chose the term "drama triangle" rather than the term "conflict triangle" as the participants in his model are taking on a role (e.g., feeling or acting like a victim). A drama triangle arises when one person in a relational dynamic takes on the role of a victim or persecutor and then engages other players in the ensuing conflict. These roles bind a person into behaviors that ultimately don't work to provide personal growth and empowerment.

Figure 9: Karpman's Drama Triangle

Illustration © 2017 Lynette Danylchuk, PhD

Trauma results in these roles becoming rigid and fixed because they are defense-driven. Dissociation helps maintain these roles, in part, by negatively impacting a person's ability to process information, both emotional and historical. In DID, often there are self-states who behave in ways aligned with the roles of perpetrator, victim, or rescuer. In

therapy, when your client presents in any of these roles, you will be (unwittingly) emotionally pulled into one of the other two roles in this triangle. When that happens, effective therapy ceases. Once you are able to step out of the triangle, maintain the ability to consciously recognize the dynamic, and reflect that awareness back to your client, it becomes (more) possible for *all* of you to escape the trap of the Triangle.

The Client's Behavior and Attitude

Sometimes, it's the 'little things' that offer us our first clue that something just isn't 'right.' Here is a handful of additional indicators that might tip you off when nothing else does:

- Your client seems very vulnerable and reliant upon you, then distances themselves or becomes aggressive, then attempts to appease you (i.e., disorganized attachment pattern)
- Your client seems notably emotionally dysregulated—their mood swings up and down rapidly
- Your client seems unable to track from one session to the next—they have little, if any, sense of an organic, ongoing therapeutic process
- Your client often seems overwhelmed or bored (or both)—they seem to alternate between crisis and 'shutdown'
- Your client bounces back and forth between self-disclosure and 'covering their tracks'—after they share a revelation, either via email or in the next session, you might hear something like, "I made it all up, I'm a liar," accompanied by flashbacks, and then a denial, in a repeating pattern. (Danylchuk & Connors, 2016).

And with that, it's time to delve into the world of EMDR therapy practice.

PART II - EMDR THERAPY

Introducing Our Example Clients

With what you have read and learned so far, it is time to hear more detail about our example clients. Examples referencing these composite cases will be given below at various points to illustrate application of and readiness for EMDR therapy based on everything you've learned thus far.

Pablo

Pablo is a 29-year-old, married father of two, who sought counseling because his wife was concerned about his moods. Two years ago, he was involved in a car accident and he says he "hasn't been the same since." His knee had to be reconstructed, causing chronic pain. He experiences disturbing flashbacks and mood-related difficulties, which have made returning to full-time work difficult. We'll be learning a lot about how Pablo's therapist used EMDR therapy to help him find resolution to his presenting issues.

Elise

Elise is a 44-year-old, divorced woman with a 22-year-old daughter who works as a nursing assistant. Elise sought counseling after an overdose. Her rage attacks had ruined yet another relationship.

Elise says that, when she is emotionally or physically hurt, she becomes enraged and does and says things that are very much out of character. This can happen several times a month. She also experiences frequent panic attacks and flashbacks, both of being raped at age 15 and from her physically and sexually abusive marriage, from age 22 to 28.

Elise was adopted at the age of 3 by a fairly nice family. She has no information on the adoption. The rest of her story will unfold, and we'll learn which of the standard EMDR therapy treatment methods are right for Elise…

Carol

Carol is a 32-year-old married woman who started experiencing flashbacks of her father's sexual abuse of her as a child after he raped her a year ago. Since then, she has struggled greatly to control the chronic flashbacks and cannot function. She has tried therapy and medications, and they only seem to make her feel worse.

She hadn't remembered much of her childhood until the incident a year ago, and then it all came flooding back. Her earliest memory of father's abuse is in a home that they moved out of when she was 4 years old.

Carol's mother is angry at her for making "false" accusations against her father and she hasn't spoken with her mother for a year. Carol has threatened to call the police on her if he ever shows up again. Her older brother is a drug addict and she hasn't heard from him in a long time. Her husband is supportive but feels increasingly exhausted.

The rest of her story will unfold and, as with Elise, we'll learn whether EMDR therapy, in its standard protocol form, can meet Carol's needs.

Historical Overview and Origin of EMDR Therapy

In 1987, Francine Shapiro, PhD, discovered what grew to become what we know today as EMDR therapy during her now-famous 'walk in the park' (detailed in Shapiro, 2018, p. 7). During this walk, Shapiro observed her own experience of "spontaneous" eye movements while noticing "disturbing thoughts," and she experienced that those disturbing thoughts disappeared or were no longer disturbing when she called them back to mind. As a primarily behavioral psychologist who was already interested in research, she quickly worked to standardize the procedure and explored what seemed to work, and what didn't work; this procedure was termed "Eye Movement Desensitization," or EMD (Shapiro, 2018, p. 8). Soon after, she began recruiting volunteers for the first controlled study - 22 adults reporting histories of rape, molestation, or Vietnam combat - which was among the first published controlled studies assessing treatment of PTSD (Shapiro, 1989, 2018 p. 9-11). While Shapiro and others have understood EMDR therapy to be much more than simple behavioral desensitization, the procedure that we use to set up memories for reprocessing, including the Subjective Units of Disturbance (SUD) scale and Validity of Cognition (VoC) scale remains largely unchanged since 1989.

Timeline of Development: EMD ➔ EMDR ➔ EMDR Therapy

1987 Francine Shapiro's chance discovery
1989 Publication of EMD pilot study
1991-1995 With the addition of "Reprocessing," it is now EMDR
1995 EMDR International Association (EMDRIA) was formed
2012 EMDR *therapy* – A comprehensive psychotherapy approach undergirded by the Adaptive Information Processing (AIP) model
2018 – Publication of the 3rd Edition of Francine Shapiro's text on EMDR Therapy
2019 – Francine Shapiro dies

Originally termed, "EMD" (1987), Shapiro began adding the word "Reprocessing" (EMDR) in publications starting in 1991 and published the first version of her comprehensive textbook in 1995. This phrasing, *Eye Movement Desensitization and Reprocessing (EMDR),* reflected the idea that memories are not merely desensitized, and that desensitization alone (as understood in a behavioral sense) does not represent the multifaceted impact of reprocessing of all aspects of negative, maladaptive information to adaptive, healthy, and useful resolution that Shapiro and others were seeing. Clinicians witness and clients experience effects during EMDR therapy such as change in beliefs about self and the world, elicited and spontaneous insights, and changes in affects and physical sensations that far exceed the frame of simple desensitization. Generalization of the effects of EMDR therapy reached beyond the initial behavioral symptoms, and those classically identified as PTSD (Shapiro, 1994, 1995).

As EMDR became increasingly applied and studied as an effective treatment for presentations and diagnoses other than PTSD, the Adaptive Information Processing (AIP) model was developed. The AIP model articulated the principles of EMDR therapy in ways that translated to broader treatment applications, adapted procedures and protocols, and as a theoretical road map to guide conceptualization and treatment (Shapiro, 2002). The AIP model conceptualizes present symptoms as results of unprocessed or maladaptively processed information, which are accessed and reprocessed to allow incorporation of relevant adaptive information and experience. The previously disturbing or traumatic experience becomes incorporated into the client's overall life history, and treatment effects often generalize beyond the original memory and symptoms which were specifically targeted and reprocessed. See Shapiro (2018, p 350-351), and later sections of this manual for detailed explanations of the AIP model.

With the publication of *Getting past your past: Take control of your life with self-help techniques from EMDR therapy* (Shapiro, 2012), the phrase "EMDR therapy" was introduced to the public. This change in phrasing reflected an expanded understanding of EMDR as a continuum of treatment applications undergirded by the AIP model.

Adaptive Information Processing Model

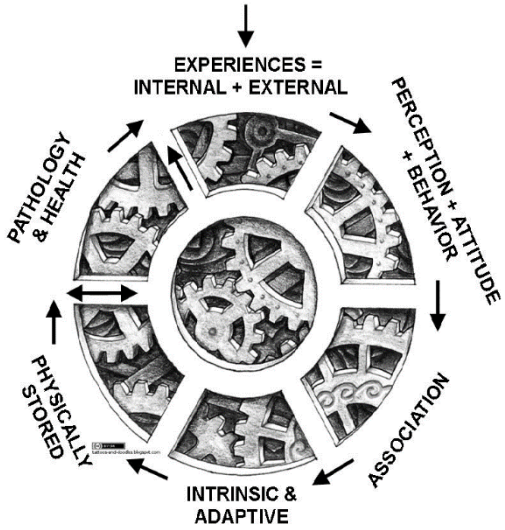
Basic Hypotheses

The Adaptive Information Processing (AIP) Model refers to the basic hypotheses and theoretical model which undergird EMDR therapy, and posits answers to questions such as "*Where do symptoms come from*?" and "*How does change (healing) happen?*"

Shapiro believed that the brain is oriented towards health and has the ability to achieve healing. The adaptive information processing (AIP) model postulates that there is an innate information processing system in the brain that "metabolizes" new experiences. Incoming sensory information is integrated and connected to related information that is already stored in memory networks, allowing us to make sense of our experience. This is "adaptive resolution." Normally, this information processing occurs during thinking, talking, or dreaming (Shapiro, 2001). For example, a conflict with a playmate ("me first") and its resolution ("we can share") is accommodated and assimilated into memory networks having to do with relationships and conflict resolution (Solomon & Shapiro, 2008).

Premises of the AIP Model

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



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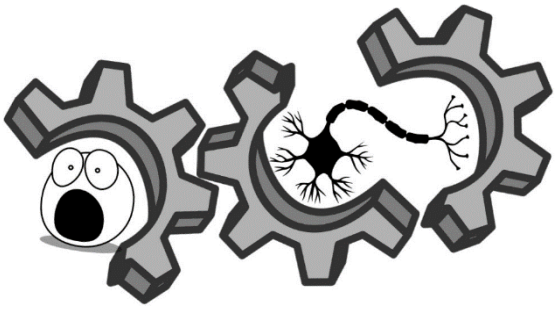
Traumatization has been described as a disruption of the inherent information processing system that normally leads to integration and adaptive resolution following upsetting experiences (Van der Kolk & Fisler, 1995). In trauma, because of the strong emotions involved, the memory is "frozen" in its state-specific form and its neurophysiologic network is isolated. This traumatic network is unable to connect with memory networks that hold adaptive information. When activated, the traumatic network may continue to function as if the trauma is still occurring in the present. In other words, the natural information processing system has malfunctioned.

AIP Model + Trauma

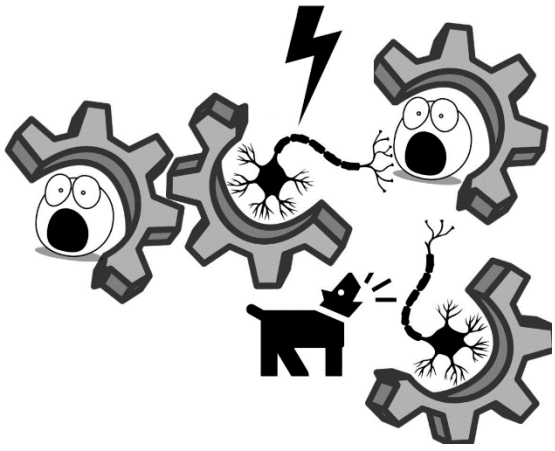
- Trauma causes a disruption of normal adaptive information processing which results in unprocessed information being dysfunctionally held in memory networks.
- Trauma can include DSM-5 Criterion A events and/or the experiences of neglect or abuse that undermine an individual's sense of self-worth, safety, ability to assume appropriate responsibility for self or other, or limits one's sense of control or choices



The AIP model postulates that dysfunctionally-stored traumatic memories lead to symptoms such as persistent intrusive thoughts, nightmares, negative emotions, negative beliefs about self, unpleasant body sensations, and maladaptive responses. According to the AIP model, conditioned responses and negative self-beliefs are not the cause of present dysfunction; they are seen as symptoms of an unprocessed earlier life experience. Past events retain their power because they have not been assimilated over time into adaptive networks (Solomon & Shapiro, 2008). For example, a conditioned response such as a fear of dogs might be related to a memory from age 2 when a big dog growled and barked at the toddler who mistook its bone for a toy. Unprocessed, the fear felt by that toddler became stored in an isolated memory network, and the child may demonstrate fear of dogs (rather than learning that bones are not toys). Later, when the same child feels afraid when awakened by a loud thunderstorm, this emotionally similar experience may become linked with the previous unprocessed experience related to the dog; the loud thunder is a reminder of the dog's growl. Again, if these experiences go unprocessed or maladaptively processed, generalization of the fear response could expand into daily symptoms of anxiety and the negative belief that "I am not safe" whenever a loud noise occurs.

AIP Model + New Experiences

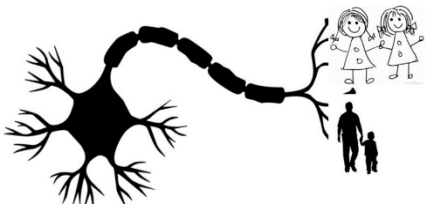
- New experiences link into previously stored memories which are the basis of interpretations, feelings, and behaviors
- If experiences are accompanied by high levels of disturbance, they may be stored in the implicit/nondeclarative (nonverbal) memory system. These memory networks contain the perspectives, affects, and sensations of the disturbing event and are stored in a way that does not allow them to connect with adaptive information networks
- When similar experiences occur (internally or externally), they link into the unprocessed memory networks and the negative perspective, affect, and/or sensations arise
- This expanding network reinforces the previous experiences



Adaptive and positive information and experiences are also stored… but may not be linked to the memory networks that hold disturbing experiences. For example, the same child may have also experienced noisy environments when playing with friends, known dogs who were always friendly, or may have a fond memory of walking in the rain with a grandparent while thunder rumbled in the distance.

AIP Model + Adaptive information

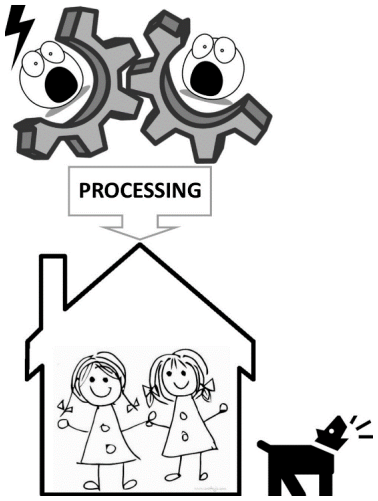
- Adaptive (positive) information, resources, and memories are also stored in memory networks



According to the AIP model, EMDR exerts its therapeutic effects in a number of steps. First traumatic material is specifically targeted in the EMDR protocol. Then this "frozen" material is processed in a focused manner. EMDR also activates neurophysiologic networks in which appropriate and positive information is stored. This allows connection of the traumatic material to positive networks, leading to the resolution of the traumatic memories.

AIP Model + Reprocessing

- Direct processing of the unprocessed information facilitates linkage to the adaptive memory networks and a transformation of all aspects of the memory.
- Non-adaptive perceptions, affects, and sensations are discarded
- As processing occurs, there is a posited shift from implicit/nondeclarative memory to explicit/declarative memory and from episodic to semantic memory systems (Stickgold, 2002 & 2008)
- Processing of the memory causes an adaptive shift in all components of the memory, including sense of time and age, symptoms, reactive behaviors, and sense of self



Within this example, processing the earliest memory associated with fear of loud noises and the negative belief "I am not safe" will facilitate linkage between the unprocessed (or maladaptively processed) fear related to dogs and thunderstorms, and the adaptive information that noise and thunder can occur without fear. As a result of reprocessing the disturbing experiences, the (now adult) client may report a shift in their responses to loud noises, and a remission of their startle response to dogs barking - having the present realization that they can now keep themselves safe, and that a dog barking may or may not indicate a present threat. Thus, the traumatic memory network has been resolved.

Clinical Implications

The AIP guides case conceptualization, treatment planning, intervention, and predicts treatment outcome.

Essentially, the AIP model posits that dysfunction in the present time is a result of maladaptively processed (or unprocessed) experience. Symptoms of maladaptively processed experience can include negative or irrational beliefs about self, disproportionate emotional or physical responses, behavioral patterns, relational patterns, etc. These can look like flashbacks and other 'ordinary' PTSD symptoms, or not. Now, something being 'maladaptively processed' may not be a big deal or it may be relevant to our clients' lives in a huge way—like boxes that are poorly packed and placed in storage—except for how these memories can remain active. They can influence functioning in the present when the world view dictated by the maladaptively processed experience generalizes. Subsequent experiences are then interpreted and stored according to the dysfunctional worldview

As we discussed above, many experiences may qualify as trauma, that is, the experience exceeds our Window of Tolerance, our ability to cope, and/or the resources available to us around the time of the experience. Thus, any experience (input to our brain) can become maladaptively processed and stored that way - waiting for its chance to be reprocessed with EMDR therapy! This is not to diminish the enormous gravity of objectively horrific and traumatic events, but rather to emphasize the universal potential for application of this model.

> *A Word About "Maladaptive"*
>
> Sometimes, the brain and body can process experience in ways that *are* adaptive to the time and place in which it occurred, but *not* adaptive to life—or the world—in general. It is the *generalization* of the trauma beyond the initial, traumatizing experience that indicates maladaptation.

Present Triggers, Past Wounding, and Imagined Future

When listening to clients describe their symptoms and struggles, you will learn to ask yourself questions such as "What experience got left unprocessed such that this is happening now?" or "Clearly, this client knows how to cope well with so much, but is somehow unable to in this situation. I wonder what maladaptively stored experience is derailing them. What has to be done to allow the future to be different for them?" This is the practical essence of the 3-Prong approach, to be discussed in detail later on.

At this point, a basic example of describing the AIP Model, suitable for use with clients and in less technical language, may be useful. While all metaphors fall short of complete accuracy, the metaphor of digesting or metabolizing is also used by EMDR originator Francine Shapiro (2018).

T: We've learned that our brains and our digestive systems have some things in common regarding how they take material in, process it, absorb what they can, store what they think needs storing, and let go what they don't think we need. So, have you or someone you know ever ate so much of something that your body lets you know it was having a hard time processing it?
C: Yeah, when I was in college, I took a box of doughnuts home from work and ate them for dinner. That wasn't so good. Ugh.

T: Sounds like it. So how did your body let you know that it was having a hard time processing those doughnuts?
C: I had heartburn for the first time - and the worst time - ever! I was bloated for days. I still can't tolerate sprinkles on anything - even the sight of them makes me nauseous.

T: Right! Well, I will leave it up to you whether you want to work on the doughnut issue or not, but that's a good example of how our input can exceed our processing system's capacity at the time. Sometimes experiences are too much for our brains to process effectively, so we end up with a "brain ache" or "brain burn," or aversion to "sprinkles" that affects us long after the initial experience. We have learned that the memory - or the experience - that was too much for us to process adaptively at the time it occurred can be re-accessed and digested—reprocessed—so that your brain can keep anything you need to know or remember and let the rest go. Does that make sense to you?
C: I think so. Translating back to the doughnut example, the result could look like me learning the lesson about eating doughnuts for dinner, but I could see sprinkles on doughnuts at the supermarket and not feel nauseous?

T: Exactly. Memories are a bit more sophisticated than most doughnuts, but the Adaptive Information Processing model suggests that if we access and reprocess the memory (or memories) where things got left unprocessed, the symptoms resulting from them will settle.

In all likelihood, the idea that present symptoms are a result of something related to past experiences is not new to your memory bank of theories of psychotherapy. However, application of the AIP Model and EMDR therapy for treatment of disorders like Schizophrenia - and subsequent reduction of psychotic symptoms - might be surprising (Miller, 2016). The reaches of the broadness of the application of the AIP model and which symptoms might be alleviated by memory reprocessing are still being determined by ongoing research, some of which will be discussed below.

Adaptive Information Processing - The Foundation of the Rail System

One might think of our AIP as the ground upon which the entire rail system is built (and rebuilt in processing). Since Francine Shapiro's discovery of what we now know as EMDR therapy, the basic components of the original 'recipe' and present-day version have been pieced out and explored to discover *why and how* this process works. These components include the hypothesized mechanisms, chief of which is bilateral/dual attention stimulus, and how they relate to what we know about the brain and information processing (see next section).

Summary and Implications of the AIP Model

The AIP model guides case conceptualization, treatment planning, intervention, and predicts treatment outcome:

View of pathology

Presenting issues and symptoms are viewed as stemming from unprocessed and/or maladaptively stored and unprocessed information, which has been unable to link with more adaptive information. This includes issues and symptoms that are unresponsive to medication or remain unexplained by medical examination and tests.

Adaptive information may be available but unlinked (e.g. a child who knows most dogs are safe, and experiences protection and care by a caregiver, but whose fear persists), or adaptive information may be unavailable or insufficient (e.g. A child who has only known mean dogs, or who experienced neglect by their caregiver).

Exception may be made for symptoms that are organically based, can be attributed to a medical condition, and respond to medical/pharmaceutical treatment.

Effects of unprocessed trauma are cumulative

Earlier memories that are maladaptively stored increase vulnerability to pathology including anxiety, depression, PTSD, and physical symptoms of stress. Further, they may interfere with healthy development of an individual's sense of self-worth, safety, ability to assume appropriate responsibility for self or others, or limits one's sense of control or choices. Once the memories are processed and linked to adaptive material, healthy development can resume.

Memories are the focus of treatment

Targeted memories must be accessed as currently stored so the appropriate associative connections are made throughout the relevant networks. The information processing system and stored associative/related memories are a primary focus of treatment, and essential for remission of symptoms.

Significance of procedures

EMDR procedures and protocols are geared to access and process dysfunctional memories and incorporate adaptive information.

Clinician, stay out of the way

The intrinsic information processing system and the client's own associative memory networks are the most effective and efficient means to achieve optimal clinical effects. Unimpeded processing allows the full range of associations to be made throughout the targeted memory and the larger integrated networks.

- Interventions to assist blocked processing should mimic spontaneous processing.
- All interventions change the natural course of processing and potentially close some associated pathways.
- Following any intervention, the target memory needs to be re-accessed and fully processed in the original form.

Map to adaptive resolution/healing

Processing of the memory and linkage to adaptive material shifts all elements of a memory to adaptive resolution. This leads to resolution of symptoms and healing/change of previous (maladaptive) patterns.

EMDR Therapy Research

Hypothesized Mechanisms of Action of EMDR Therapy

As with many functions of the brain and body, to date, it is not irrefutably clear *how* EMDR therapy works. Shapiro (2018, pp. 352-365) discussed some of the procedural elements of EMDR that may contribute to its effectiveness:

- Brief interrupted exposures (that alternate with metacommunication; Boudewyns and Hyer, 1996);
- A sense of perceived mastery by the creation and dismissal of traumatic memory imagery (Hyer & Brandsma, 1997);
- attention to physical sensation;
- Cognitive reframing when formulating positive cognitions and consolidating insights in the installation phase;
- Alignment of memory components (image, negative cognition, and physical sensations);
- Free association (Rogers & Silver, 2002);
- Mindfulness;
- Eye movements and alternative bilateral stimuli;
- Orienting response (a curious response to a new stimulus followed by a relaxation response if there is no threat; Stickgold, 2002);
- The taxing of working memory leading to reduced vividness of imagery (Van den Hout, Eidhof, Verboom, Littel, & Engelhard, 2014);
- Neural network changes (as the intensity of the emotion is reduced, the associations with positive networks are strengthened);
- REM sleep-like effects on brain state and brain processing (Stickgold, 2002);
- Parasympathetic relaxation response (Schubert, Lee & Drummond, 2011); and,
- An integrative effect

Regarding the neuropsychological mechanism of EMDR, Andrew Leeds (2016) proposes that rather than searching for the one, best theory of the mechanism of action of EMDR therapy, that the six mechanisms in the literature "together yield multiplex effects" (p. 35). These mechanisms "sometimes converge and sometimes diverge, leading to various outcomes in different clinical contexts and in different EMDR procedures" (ibid). The six hypothesized mechanisms are:

1. Working memory;
2. Orienting response;
3. REM (sleep) analogue;
4. Inter- and intra-hemispheric activation (Farina et al., 2015);
5. Prefrontal attentional flexibility (Lyle & Edlin, 2014) assisted by mindfulness (Kuiken, Chudleigh, & Racher, 2010), and metacognitive awareness; and,
6. Temporal binding via the thalamus (Lanius and Bergmann, 2014).

We will describe the first 3 mechanisms in more detail since there is the most scientific evidence and clinical support for these mechanisms.

1. EMDR taxes working memory

It is theorized that working memory has a limited capacity, so that when two tasks make simultaneous demands on the working memory, performance on one of the tasks deteriorates. In EMDR, the competing tasks are internal attention to the traumatic memory and external attention to the bilateral stimulation (BLS, now referred to as BL-DAS, or DAS). Specifically, the attentional demands of the BLS overload the working memory capacity, causing the traumatic

imagery to become less vivid and disturbing. Numerous studies have described reduced vividness and emotionality of negative memories with eye movements (EMs). The competing tasks theory has been substantiated in several randomized controlled studies (RCTs; Engelhard, Van Uijen & Van den Hout, 2010; Van den Hout et al., 2014; Van den Hout, Muris, Salemink, & Kindt, 2001; Van Veen et al., 2015). Two RCTs found EMs superior to audio tones in reducing vividness of images (Homer, Deeprose, & Andrade, 2016; Van den Hout et al., 2011).

2. EMDR stimulates the orienting reflex and associated parasympathetic response

The orienting reflex is a "what is it?" response to a new stimulus. Initially, this is evident with an increased sympathetic tone, but when it is evident that there is no danger, the reflex is followed by a physiological de-arousal relaxation response mediated by the parasympathetic nervous system. This relaxation response is evident within 10 seconds of the start of EMs and may be the main mechanism for the desensitization of the traumatic emotion. MacCulloch and Feldman (1996) and Armstrong and Vaughn (1996) both theorized that the orienting response elicited by the EMs in EMDR creates a positive state that can be paired with exposure to traumatic memories to reduce the anxiety and distress of the traumatic memory. Research has consistently shown that EMs produce a physiological de-arousal state that is evidenced by increased heart rate variability, decreased heart rate, and skin conductance (Barrowcliff, Gray, MacCulloch, Freeman, MacCulloch, 2003; Elofsson, von Schèele, Theorell, & Söndergaard, 2008; Sack, Lempa, Steinmetz, Lamprecht, & Hofmann, 2008; Schubert, Lee & Drummond, 2011).

3. EMDR elicits similar processes that characterize rapid eye movement (REM) sleep

REM sleep - and dreams in particular - have fascinated humans for centuries. People have been "sleeping on it" before making an important decision, finding inspiration during their dreams, observing people and animals in dream states with saccadic movement of the eyes underneath closed lids, and scientifically studying REM sleep. Not surprisingly, when Francine Shapiro noticed saccadic eye movements during the original walk in the park, REM sleep was a logical association (Shapiro, 1989). Several studies in recent decades have confirmed connections between REM sleep and processes related to activation and processing of memory (including traumatic memory).

Stickgold (2002, 2008) proposes that the shifting of attention across the midline at the same time as the inducing of the orienting response leads to activation of brainstem circuits involved in initiating REM sleep. The EMs shift the brain into a memory processing mode similar to that of REM sleep. Stickgold posits that it is this shift in the brain's state that is a key component in the activation and strengthening of weak associations (i.e., positive episodic memories) during EMDR therapy.

It is known that REM sleep facilitates the processing of information, the consolidation of memories and the activation of weak associations. This REM-like effect allows more distant, unexpected and potentially creative associations to come forward. Stickgold theorizes that in PTSD, the strength of the negative affect of the traumatic memory makes it difficult for the dysfunctional network to link with adaptive information. But the shift in brain state in EMDR allows a leveling of associations related to the memory, allowing new information to come forward, and the transformed memory is integrated into cortical semantic memory.

Also, saccadic eye movements have been shown to improve memory retrieval (Lyle & Edlin, 2014). While Stickgold (2002) tested neurobiological correlations between EMDR- and REM-state functions, direct evidence that EMDR induces the same processing that occurs during REM sleep is lacking. Instead, recent speculative theories associate the EM in EMDR to EM during slow-wave sleep, in terms of both the smooth pursuit and frequency (Pagani, Amann, Landin-Romero & Carletto, 2017).

EMDR Therapy Hypothesized Mechanisms of Action

In summary, “it is currently hypothesized that the bilateral stimulation during EMDR therapy processing sessions (1) tax working memory, (2) stimulate the orienting reflex and associated parasympathetic response, and (3) elicit the same or similar processes that characterize rapid eye movement (REM) sleep” (Shapiro, 2018, p 27).

These mechanisms are understood to work in concert, or in tandem, particularly in Desensitization - Phase 4, to account for the observable therapeutic effects of EMDR therapy (Shapiro, 2018).

For a more detailed exploration of this and other neurobiological correlates to EMDR, see Shapiro (2018, p 352-375), the Francine Shapiro Library (see below), and a recent review (Landin-Romero, Moreno-Alcazar, Pagani, & Amann, 2018).

Neurobiological Studies

Numerous neuroimaging studies have been done to investigate the effect of EMDR on the brain, more so than with any other PTSD therapy. In general terms, EMDR normalizes the classic PTSD picture of reduced medial prefrontal and anterior cingulated cortical control over a hyperreactive amygdala. Magnetic Resonance Imaging (MRI) research demonstrated that successful EMDR treatment led to amygdala volume increases, reversing the atrophy found in PTSD, in a pre-post design (Bossini et al., 2011; Laugharne et al., 2016) and compared to those who did not improve with EMDR (Nardo et al., 2010). One study found that frontal lobe volume increased in the subjects who improved following EMDR compared to the control group (Boukezzi et al., 2017). Another MRI study found significant EMDR effects on global brain networks, possibly indicating increased communication between subcortical and cortical structures (Jung, Chang, & Kim, 2016). A functional MRI study during EMDR found a significant increase in ventromedial regions of the prefrontal cortex, associated with heightened information processing (Richardson et al., 2009).

Imaging taken before and after effective EMDR therapy with single-photon emission tomography (SPECT) and near-infrared spectroscopy (NIRS) have identified normalization in regional blood flow (RBF) in prefrontal areas when subjects are asked to attend to their standardized trauma scripts (Lansing, Amen, Hanks, & Rudy et al., 2005; Levin, Lazrove, & Van der Kolk, 1999; Oh & Choi, 2004; Ohta, Matsuo, Kasai, Kato, & Kato, 2009; Pagani et al., 2007). This implies increased cortical control over the amygdala, an increase in logical over emotional reasoning, and improved perspective on the memory. “The significant normalization of these activations after the trauma processing can be interpreted as the neurobiological correlate of clinical recovery” (Pagani, Hogberg, Fernandez, & Siracusano, 2013, p. 35).

Some very interesting results have been coming out of electroencephalogram (EEG) research recently where subjects can be studied during EMDR. Four studies measuring EEGs during successful EMDR therapy demonstrated similar results to the neuroimaging studies, namely, there is a shift of activation from cortical and subcortical regions with high emotional valence to cortical regions in which cognitive and associative functions are processed (Pagani et al., 2011, 2012, 2015; Trentini et al., 2015). Furthermore, Pagani (in the above studies) and Harper, Rasolkhani- Kalhorn, and Drozd (2009) have found that EMDR elicits 1-2 Hz slow (delta) waves similar to the EEG recorded during slow wave sleep (SWS).Slow-wave sleep has a key role in memory consolidation and in the reorganization of distant functional networks. It is known that in SWS, the emotions and information from memories are transferred from the subcortical areas to

the neocortical areas where they are strengthened in REM sleep. It is also known that in animal models, slow wave stimulation of the amygdala causes extinction of fear memories (Lin et al., 2003). This low-frequency rhythm generated by EMDR in memory areas of the brain may be "binding these areas together and causing receptors on the synapses of fear memory traces to be disabled [i.e. depotentiation]. This mechanical change in the memory trace enables it to be incorporated into the normal memory system without the extreme emotions previously associated with it" (Harper et al., 2009, p. 81).

For a more detailed exploration of neurobiological research in EMDR, see Shapiro (2018, p 365-369) and a recent review (Pagani, Hogberg, Fernandez & Siracusano, 2013).

Leading Edge Research

Baek, et al. (2019) successfully induced a lasting reduction of fear in mice by pairing visual alternating bilateral sensory (ABS) stimulation with a conditioned stimulus.

They traced the neural pathways from the superior colliculus (SC; portion of midbrain involved in visual-attentional processing) to the mediodorsal thalamus (MD; relay station to the prefrontal cortex and amygdala) to the basolateral complex of the amygdala (BLA; involved in encoding fear and fear extinction).

The ABS stimulation paired with the conditioned stimulus suppressed the fear cells in the BLA during extinction and at a week follow-up. The SC-MD circuit was necessary to prevent the return of fear.

Are Eye Movements Necessary?

A recent meta-analysis of 26 RCTs demonstrates a moderate average effect size (Cohen's *d* = 0.41) in clinical settings and a large effect size (Cohen's *d* = 0.74) in laboratory settings for eye movements. The strongest effect size difference was for reduction of vividness of disturbing memories in the laboratory studies (Cohen's *d* = .91; Lee & Cuijpers, 2013).

Leeds (2016) summarizes the literature on the effects of bilateral eye movements as follows:

1. Consistent psychophysiological effects - de-arousal – a shift from sympathetic to parasympathetic activation

2. Paradoxical cognitive effects:
    - Decreased vividness and emotionality of disturbing memories
    - Enhanced memory processing
    - Enhanced episodic memory retrieval
    - Increased accuracy of memory
    - Improved attentional, cognitive and semantic flexibility
    - Enhanced executive control processes, and increased metacognitive awareness

Clinical Outcome Studies

EMDR's efficacy in the treatment of PTSD is established in 30 well-designed randomized, controlled studies (RCTs) and 22 nonrandomized studies in PTSD (Shapiro & Solomon, 2017). The effect sizes for PTSD are generally moderate to large compared to wait-list (e.g., Chemtob, Nakashima, & Carlson, 2002; Wilson, Becker & Tinker, 1995) and other non-trauma treatments (e.g., Carlson, Chemtob, Rusnak, Hedlund, & Muraoka, 1998; Scheck, Schaeffer, & Gillette, 1998). EMDR, CBT or exposure treatments (all focused on the traumatic memory) were comparable in effectiveness for PTSD (Bradley, Greene, Russ, Dutra, & Westen, 2005; see below, Research Comparing EMDR to CBT/PE for PTSD). Standards for gold standard studies (e.g. diagnosis, measures, blind assessors, manualized treatment, randomization, treatment fidelity, and adequate number of sessions) were delineated because early research suffered from methodological problems. The more rigorous the EMDR study, the larger the treatment effect size (Maxfield & Hyer, 2002).

> ***How Many Hours of Therapy?***
>
> Shapiro (2018) made the point that it requires approximately 5 hours of EMDR therapy for an 84-100% remission of civilian adult PTSD (Shapiro, 2018, pp. 384-395), whereas military populations require 12 sessions for a 78% remission of PTSD (pp. 389-390), and complex PTSD clients require an extensive preparation phase (pp.391-394).

Van der Kolk et al. (2007) compared EMDR to the antidepressant, fluoxetine, and to placebo for 8 weeks in PTSD patients. EMDR was significantly more successful in achieving sustained reductions in PTSD and depression symptoms than either fluoxetine or placebo. At 6-month follow-up, 88% of the EMDR group compared to 73% of the fluoxetine group no longer met criteria for PTSD. However, 75% of the adult-onset trauma EMDR group, 33% of the child-onset trauma EMDR group and 0% of the fluoxetine group achieved asymptomatic end-state functioning. Results for EMDR were not only maintained at 6-month follow-up, but subjects' level of functioning increased (Van der Kolk et al., 2007).

EMDR therapy for children was reviewed in Shapiro, Wesselmann and Mevissen (2017). In 9 randomized, controlled trials (RCTs) it was an effective treatment in traumatized children and in four of these studies, it was at least as effective as Cognitive Behavior Therapy (CBT). A meta-analysis found that EMDR compared to no treatment or treatment as usual significantly reduced PTSD symptoms in children aged 4-18 (Rodenburg, Benjamin, de Roos, Meijer, & Stams, 2009). EMDR has also been effective in children with conduct problems, other anxiety disorders, intellectual disabilities, mood disorders and complex trauma, but more research is needed in these areas.

The Inclusion of EMDR Therapy in Recognized Treatment Guidelines

The following organizations have recognized EMDR as an efficacious treatment for PTSD:

- American Psychological Association (1998)
- International Society for Traumatic Stress Studies (2009)
- American Psychiatric Association Practice Guidelines (2004)
- Substance Abuse and Mental Health Services Administration (2010)
- Cochrane Database of Systematic Reviews (2007)
- World Health Organization (2013)
- U.S. Department of Veterans Affairs and Department of Defense (2017)

The following international government agencies have accepted EMDR as an effective treatment for PTSD:

- French National Institute of Health and Medical Research (2001)
- United Kingdom Department of Health (2001)
- Israeli National Council for Mental Health (2002)
- Dutch National Guidelines Mental Health Care (2003)
- Australian Centre for Posttraumatic Mental Health (Department of Veterans Affairs) (2007).

EMDR Therapy is Effective in Conditions Other than PTSD

Building on EMDR therapy's success in treating PTSD, clinicians and researchers have expanded their investigation into its effectiveness in treating other conditions. Much of what has been published are case reports or case series, however a number of randomized, controlled trials (RCTs) have been published, especially in the last decade.

RCTs have shown effectiveness in the treatment of:

- Phobias, especially specific phobias
    - Dental (Doering, Ohlmeier, de Jongh, Hofmann, & Bisping, 2013)
    - Flying (Triscari, Faraci, D'Angelo, Urso, & Catalisano, 2015)
- Panic disorder (Horst, et al., 2017)
- Obsessive Compulsive Disorder (Nazari, Momeni, Jariani, & Tarrahi, 2011)
- Bipolar Disorder (Novo, et al., 2014)
- Depression (Gauhar, 2016)
- Complicated Mourning (Sprang, 2001)
- Addictions (Hase, Schallmayer, & Sack, 2008)
- Schizophrenia and schizoaffective disorder (Van den Berg, et al., 2015)
- Pain (Gerhardt, et al., 2016; Rostaminejad, Behnammoghadam, Rostaminejad, Behnammoghadam, & Bashti, 2017)
- Post myocardial infarction anxiety (Moradi, Zeighami, Moghadam, Javadi, & Alipor, 2016) and depression (Behnam Moghadam, Alamdari, Behnam Moghadam, & Darban, 2015)
- PTSD in Cancer patients (Capezzani, et al., 2013)
- PTSD in Multiple Sclerosis (Carletto, et al., 2016)

Case reports or case series show effectiveness in complicated grief, body dysmorphic disorder, fibromyalgia, migraine, musculoskeletal pain, trigeminal neuralgia, neuropathy, olfactory reference syndrome, and chronic fatigue. The subject of EMDR for conditions other than PTSD has been recently reviewed in Valiente-Gomez et al. (2017) and Shapiro (2018).

What Sets the AIP Model and EMDR Therapy Apart?

EMDR Therapy was built upon many layers of psychological theory and practice and matured over the past decades alongside other trauma-focused treatment models. Francine Shapiro recognized that EMDR therapy is both a synthesis of, and in clinical practice, a bridge between several major psychological models.

While this manual and training will focus specifically on the protocols, procedures, and application of EMDR therapy and the AIP Model, you may note similarities to other general and trauma-focused models of psychotherapy. Psychodynamically trained clinicians will notice attention to etiological patterns and events that include family-of-origin. Those clinicians trained in Cognitive and Behavioral models will note the attention to beliefs, conditioned responses, and measures of cognitions and responses. Somatically trained clinicians will note the identification

of and attention to body sensations. Clinicians trained in clinical hypnosis will recognize the attention to imagery and scripting of language. And so on… The following chart may aid in your intellectual differentiation between EMDR therapy/the AIP Model and other major models of therapeutic change.

Table 2: Comparative Models of Therapeutic Change

Model/Theory	**View of Pathology**	**How Change Happens**
Cognitive*	Irrational thoughts are the basis of pathology.	Cognitions are changed through reframing, self-monitoring, and homework exercises
Behavioral*	Cannot see within the "black box" (the mind/brain).	Learned behavior is changed through conditioning, exposure, modeling, etc. (learning processes)
"Third wave" Cognitive-Behavioral (DBT, ACT, FAP)	Suffering is inevitable.	Change comes through acceptance, commitment to change, and mindfulness exercises.
Psychoanalytic/ Psychodynamic	Impact of family of origin, object relations, ego defenses.	Change is created by insight or "working through." Goal is to make the subconscious and unconscious conscious.
Family Therapy	Problems and solutions are interactional.	Exploration and evaluation of family dynamics. Change comes through education and role realignment.
Experiential	Awareness and impulses are alienated from experience. Seek safety rather than growth.	Affect and body are central. Uses relationship, "two-chair," "meaning bridge."
Adaptive Information Processing / EMDR therapy	Maladaptively or unprocessed experience leads to development of pathology.	Reprocessing of maladaptively processed experience and linkage to adaptive information facilitates healing.

*Trauma-focused Cognitive-Behavioral Therapy (TF-CBT) is a more advanced descendant of the cognitive and behavioral conceptualizations, and far more nuanced. Refer to Ehlers and Clark (2008) for a comprehensive discussion. A more thorough, comparative survey of some of the approaches noted above is discussed by Ehlers, et al. (2010).

For further reading on EMDR therapy and the AIP Model in relation to other theoretical models, look to Shapiro (2018), pages 20-24 and 349-359.

Is EMDR Therapy Essentially Hypnosis?

This is a common question posed by clients when they learn about EMDR therapy, and bears clarification here. Hypnotic tradition does inform EMDR therapy, and work with dissociation tends to be highly hypnotic in nature, but EMDR is not hypnosis. Nicosia (1995), studied electroencephalograms (EEGs) taken during EMDR, and found that brain activity of subjects was within the normal range, and did not differ from waking state EEGs. This study indicated that EMDR therapy did not appear to produce the altered consciousness state associated with hypnosis. Pagani, et al. (2012) also confirm that EEG readings during EMDR do not demonstrate the patterns found in hypnosis.

Dissociation-savvy EMDR therapists who are trained in clinical hypnosis may intentionally induce hypnotic trance with more complex clients in conjunction with EMDR (Coy, 2020; Fine & Berkowitz, 2001) to enhance trauma reprocessing. However, complex clients who are highly hypnotizable may *spontaneously* enter trance in response to a variety of EMDR therapy interventions that push them outside their Window of Tolerance. In any case, these effects are incidental, rather than integral, to the practice of EMDR therapy.

Is EMDR an Exposure Therapy?

Contrary to the theory behind flooding (which involves prolonged, sequential, directive, and anxiety-focused exposure), EMDR involves very brief (20-30 second) 'exposures.' Clients are first asked to focus on the most distressing picture, and then they are allowed to free associate within the memory or between memories. The client's attention is split between the feared stimulus and a motor task; they are allowed to use cognitive avoidance (skipping elements and image distortion). The focus can be on any distressing emotion. Importantly, EMDR is effective for the emotion of guilt (Cerone, 2000), whereas guilt is a variable that reduces the effectiveness of Prolonged Exposure (Meadows & Foa, 1998). Also, in EMDR, corrective information can come from the client, not only the habituation effect or the therapeutic situation. In contrast to systematic desensitization, EMDR is ineffective when paired with relaxation procedures (Rogers & Silver, 2002).

Reconsolidation of memory is a neurobiological process hypothesized to underlie EMDR's effects. The process of reconsolidation includes both assimilation (new information is integrated into existing cognitive schemas) and accommodation (existing cognitive structures are modified to accommodate the new experience). In EMDR desensitization is postulated to be the result of information processing, and not a result of habituation (Rogers & Silver, 2002). During EMDR, changes in cognition, affect and sensation appear to occur concurrently (Shapiro, 2001). In conclusion, the evidence classifies EMDR as an information processing therapy rather than an exposure therapy (Rogers & Silver, 2002).

It is important to clarify that while "cognitions" are a large part of the *Assessment* and *Installation* Phases, EMDR therapy does not work through efforts to change the cognitions from Negative to Positive. Instead, the *Negative Cognition* represents the cognitive aspect of the dysfunctional, maladaptively processed (or unprocessed) material; then, as the memory is processed, adaptive connections are made and the eventual felt-sense of the *Validity of the Positive Cognition* is simply viewed as the natural product of the old material being fully metabolized.

Research Comparing EMDR to CBT/PE for PTSD

Ten RCT studies have directly compared EMDR to cognitive behavioral therapy (CBT) or prolonged exposure (PE) PTSD treatment protocols. Eight of the studies found that both treatments were equally effective for treating traumatic memories. Taylor et al., (2003) reported that both treatments were effective, but PE produced superior effects while Moghadam, Kazemi & Taklavi (2020) reported that the effectiveness of EMDR method was greater than the CBT method with respect to the effect size. In 8 of 10 studies, EMDR was found to be more efficient than CBT/PE. EMDR either required fewer sessions, less homework, or the magnitude

of the treatment effects were greater at follow up (Ironson, Freund, Strauss, & Williams, 2002; Jaberghaderi, Greenwald, Rubin, Dolatabadim, & Zand, 2004; Lee, Gavriel, Drummond, Richards, & Greenwald, 2002; McGuire Stanbury et al., 2020, Nijdam, Gersons, Reitsma, de Jongh, & Olff, 2012; Power et al., 2002, Rothbaum, Astin & Marsteller, 2005).

Meta-analyses of PTSD treatments have concluded that EMDR is equivalent to exposure and CBT (Seidler & Wagner, 2006; Bradley et al., 2005), there is a lower dropout rate with EMDR (Swift & Greenberg; 2014) and EMDR requires far less homework - a course of CBT requires 23 hours of homework and EMDR uses 2.7 hours (Ho & Lee, 2012).

Francine Shapiro Library

Applications of EMDR therapy beyond PTSD will be discussed later on. Those of you interested in reading or conducting research studies on EMDR therapy may find the Francine Shapiro Library to be invaluable: https://emdria.omeka.net/.

EMDR Therapy Meets Dissociation: A Brief History

The story is well known. On a walk, Francine Shapiro noticed that she moved her eyes back and forth and felt the distress she was experiencing leave. Curious, she wondered if this was something that might be helpful to others. Wanting to find a group where she could experiment with this, she approached Stu Brown, the Clinical Director of the San Jose Vet Center, an outpatient clinic for Vietnam Veterans. Stu asked her to present the technique to the staff. She explained to the staff group how she came to notice the eye movements that were helping her. She then asked for someone who had a 'stuck place' they would be willing to share. The person she refers to as 'Doug' shared a traumatic scene from Vietnam, when helicopters were unloading the wounded, and an officer was yelling at him. He had worked on this event, knew, and resolved the issues that had felt traumatizing to him. However, the scene was stuck, a frozen picture of the field full of the wounded, the aircraft, and the pervasive chaos. He couldn't see the field as it usually appeared. Shapiro focused on him, guiding him through a series of eye movements in a gentle, deeply attuned manner. When she was done, Doug could see the field, clear of the chaos, and once again as it usually was, green and peaceful. The staff were impressed and agreed to allow Shapiro to work with the Vets in the Center. She asked that vets be referred to her who had worked through issues and had similar 'stuck' places. She continued to get positive results, and after leaving the Vet center, tried what she had learned on rape victims, whose trauma tended to be more current and personal.

Over the next several years, she worked, researched, and shared what she learned with others. EMDR became a local phenomenon. That's when some unforeseen consequences began to emerge. Clinicians trained in EMDR began to use it with their trauma survivors. In most cases, it worked well. However, in some cases, it seemed to have the effect of opening Pandora's Box, and clients became flooded with deeply disturbing traumatic memories. These were the clients who were dissociative. In fact, Paulsen (1995) said that "EMDR seems to act like a divining rod for dissociation" (p. 35). In 1993, Paulsen, Vogelmann-Sine, Lazrove and Young first presented on EMDR in Dissociative Disorders (DDs) at the ISSMPD (later known as ISSTD) conference. Then in 1995, Shapiro's EMDR Dissociative Disorder Task Force (Fine, Luber, Paulsen, Puk, Rouanzoin and Young) published their report (Shapiro, 1995, p. 365-369). Shapiro and Fine subsequently presented at the 1996 ISSD (ISSTD before the addition of the T) Annual Conference. The presentation was titled: "EMDR and Its Uses in the Treatment of Dissociative Disorders."

The first publication on the use of EMDR in DDs was in 1994 by Young, where he described its use only in circumscribed phobias. This was followed by the Task Force report, published as an appendix in Francine Shapiro's first EMDR book (1995). ***This report, which has been reprinted in the 3rd edition (see Shapiro, 2018, pp. 499-503), should be read by all participants in this training course.*** It discusses the need for screening all patients for DDs, clarifying a DD diagnosis, assessing for therapist and patient readiness factors, embedding EMDR in a total DD treatment plan, and gives suggestions for the use of EMDR in each stage of a 3 stage trauma treatment. They specifically list "red flags" which argue against the use of EMDR: on-going self-mutilation, active suicidal or homicidal intent, uncontrolled flashbacks, rapid switching, extreme age or physical frailty, terminal illness, need for adjustment of medication, ongoing abusive relationships, alter personalities that are strongly opposed, extreme character pathology, and serious comorbid disorders. They also warn that "the use of eye movements too early in treatment risks premature penetration of dissociative barriers. This could produce such results as: flooding of the system, uncontrolled destabilization and increased suicidal or homicidal risk" (ibid, p. 501).

This was followed by articles by Paulsen in 1995, Lazrove and Fine in 1996, Twombly in 2000, and Gelinas in 2003, that provided a lot of detail on the effect of EMDR on dissociation, gave case examples and procedural guides. Other recommended articles include Van der Hart, Nijenhuis and Solomon (2010), and Van der Hart et al., (2014), and books by Forgash and Copeley (2008), Paulsen (2009), Gonzalez and Mosquera (2012), and Knipe (2014).

Twenty-six years later, the challenges of using EMDR with dissociative clients continues. One of the continuing issues is the lack of training in assessing and working with dissociative issues in clients. This is the most common cause of negative experiences of EMDR. As Philip Kinsler once said, "If you don't know your client, any intervention can be risky." Discovering that a client is dissociative is one part of the solution. The next part is to learn how to work with dissociation, and that particular person's experience of dissociation. When that knowledge, and a strong therapeutic bond is present, EMDR becomes a very powerful tool for change

Stages, Prongs & Phases - Keeping Them All Straight

Before delving further into the complexities of EMDR therapy, it may be helpful to illustrate how the Stages of Treatment relate to the temporal prongs and phases of EMDR therapy. They are listed here and illustrated below. As you see, we will use Arabic numbers for 'Stages' and Roman Numerals for 'Phases.'

Table 3: States, Phases, and Prongs

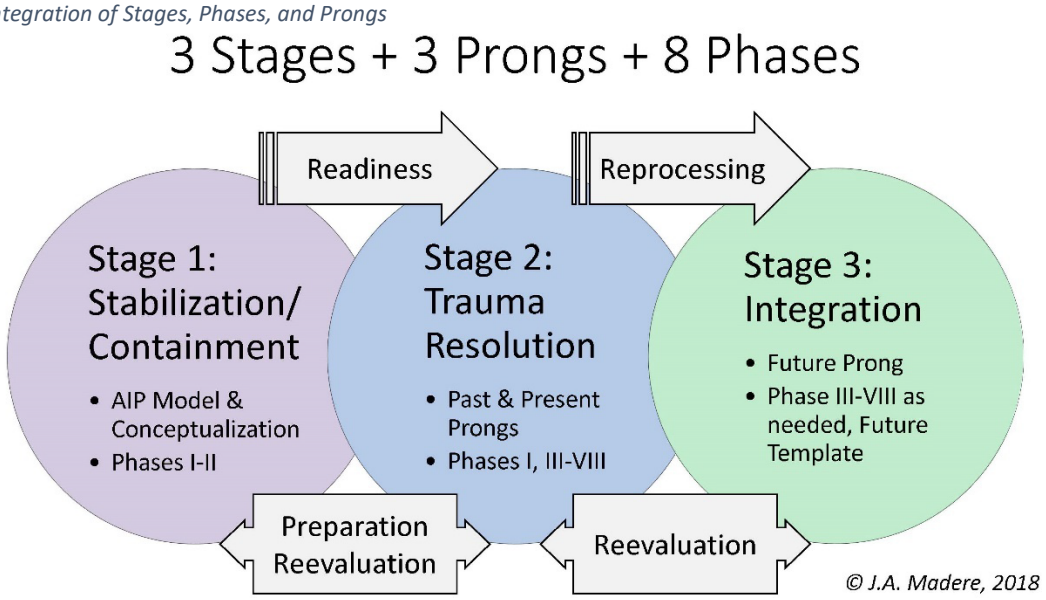
3 Stages of Complex Trauma Treatment
- Stage 1: Stabilization/Containment
- Stage 2: Trauma Resolution
- Stage 3: Integration

3 Temporal Prongs of EMDR Therapy
- Past
- Present
- Future

8 Phases of EMDR Therapy
- Phase I: History Taking
- Phase II: Preparation
- Phase III: Assessment
- Phase IV: Desensitization
- Phase V: Installation
- Phase VI: Body Scan
- Phase VII: Closure
- Phase VIII: Reevaluation

Together, direct case conceptualization and treatment planning work together in a cyclical yet forward movement, as illustrated here:

Figure 8: Integration of Stages, Phases, and Prongs



What's the Frame: Starting Therapy Safely (Stage 1, Phase I)

You might think of the three circles above as representing a pair of '3D glasses' that will aid you in discerning the pace and focus of treatment with clients who present trauma-related issues and symptoms. The following nuggets represent key elements to identifying and implementing a safe and effective therapeutic frame.

Boundaries, 'Safety,' and Power Imbalances

From the very first session, the trauma is already in the room. Actually, it was likely present in the relationship before the first contact between you and the client. Maintaining this knowledge and the awareness that reenactments are inevitable will motivate and guide you to be careful and thorough as you get to know your client and their history.

Screening for dissociation before you screen for dissociation

Formal screening and assessment for pathological dissociation will be discussed in detail below, however, hints of dissociative features can often be detected in initial contacts and interactions. For example, what might it tell you if a client calls to confirm their appointment multiple times within the week prior? Or presents in your lobby area hours prior to their appointment for no logistical reason? Or doesn't remember why they were referred to you by their psychiatrist of 15 years?

Paramount Importance of Accurate Client Reporting

The accuracy and context of the information that is gathered during initial and later sessions, both explicitly and implicitly, depends on adequate therapeutic rapport, the client's sense of safety in the relationship, and the therapist knowing when the client is near the edge of their Window of Tolerance. The point here is not to assume that clients will be deliberately dishonest, but rather, it is more likely that avoidance or trauma-related phobias will lead to disclosure of incomplete information. It really is all about the relationship. This issue will be discussed again in later sections regarding Phase II/Preparation.

Informed Consent as an Ongoing Factor in Treatment

When treating clients presenting with complex trauma or dissociative disorders, the issue of informed consent can pertain to every session - and conceivably to every intervention in each session. If it is not already embedded in your practice, consider adopting the tone of 'ask rather than tell,' and erring on the side of honoring avoidance as the potential articulation of a boundary. Unless acute safety factors prevail, seeking consent of the entire known self-system to the fullest extent possible is essential, particularly if it involves accessing traumatic memory.

Practicing within One's Area(s) of Knowledge and Experience

Codes of ethics, ISSTD and ISTSS treatment guidelines, and graduate programs in mental health fields are all clear that practicing within one's areas of knowledge and experience is essential to avoid harm to clients. This training is designed to provide a basic foundation in recognizing and understanding pathological dissociation, and basic training in the practice of EMDR therapy. If you don't have or pursue training in treatment of specific populations and issues, this training will not sufficiently equip you to apply EMDR therapy to treat those populations or issues.

When is it appropriate to access trauma, and how does the therapist figure that out?

We are so glad you asked! This is exactly what we hope to help you learn to discern throughout this training and is a sure sign that your '3D glasses' are properly perched. Specific sections, marked 'Red Flags' and 'Decision Trees,' will address this question in multiple places throughout this manual.

Example Client: A Brief History & Presenting Symptoms

Now, it is time to hear more information about our first example client, Pablo. We will keep this information in mind, along with his initial presentation, throughout the sections introducing and illustrating the 8 Phases of the standard EMDR protocol.

Pablo (PTSD)

Pablo is a 29-year-old, married father of two, who sought counseling because his wife is concerned about his angry outbursts and withdrawal from the family and life in general. Two years ago, he was involved in a car accident, and he says he "hasn't been the same since." His knee had to be reconstructed, causing chronic pain. He experiences disturbing flashbacks and mood-related difficulties.

He was driving down a country road and the driver of another vehicle collided head-on with the driver's side corner of Pablo's car. The other driver was texting at the time. Pablo recovered from the whiplash, but his left knee was shattered. Doctors reconstructed the kneecap, but Pablo still can't fully bend his left leg. Additionally, he experiences significant pain the next day if he "overdoes it," and sometimes it feels as if that leg, from knee to foot, is disconnected from the rest of his body. Pablo says he is very confused by that, saying, "it's weird".

After the knee surgery, he experienced a depressive episode, during which he had thoughts of hanging himself. He says that's better now with antidepressants, but "it's still tough". The pain and the insomnia are making him irritable. He 'blows up' at his family sometimes. He feels like he is letting his family down and does not want to "burden them" with his problems, leading to a feeling of emotional isolation. He has been able to return to work as a mechanic, but he takes a lot of days off due to trauma-related flashbacks and memory problems.

Pablo experiences brief flashbacks when driving, which are more like waves of panic now. Most troubling for him are nightmares where he wakes up as a car is about to hit him. He struggled to

get behind the wheel after the accident but now he can drive in town short distances. He used to love to go on long drives. He mostly avoids driving now, especially on country roads.

While driving, he is hypervigilant about cars staying between the lines. Inside his home he is aware of the sound of traffic outside. He jumps with loud noises. His heart pounds for 20 minutes after he hears tires squeal, which is a somewhat frequent occurrence where he lives. He has resorted to wearing earplugs to drown out the traffic noise at night.

He feels distant and cut off from others and tends to isolate. He doesn't think he will ever have a normal future, which makes him extremely angry--sometimes out of nowhere. He feels really conflicted about this, but also feels like no one 'gets' it. He tells himself he should 'move on' from all of this, but he just can't. The car accident shattered his belief in himself and the world. "It's like I have something wrong with me that can never be fixed." Pablo feels ashamed that even his faith in God has been shaken by this experience. He felt helpless for a long time after the accident, but that is improving.

Eight Phases of EMDR Therapy

While the Phases are not exactly linear (rather a parallel to how the Three Stages of Treatment flow), Phases I and II must be at least initially completed before proceeding to Phases III-VI. In order to give you an idea of how the sequence of EMDR therapy looks, the eight Phases are listed below briefly, then each is comprehensively described in subsequent sections.

Phase I: History Taking (including diagnostic evaluation and treatment planning)
Phase II: Preparation (for Trauma Resolution)
Phase III: Assessment (of Target Memory)
Phase IV: Desensitization (of Target Memory and Associated Channels)
Phase V: Installation (of Positive Cognition)
Phase VI: Body Scan (to Discern and Reprocess Latent Disturbance)
Phase VII: Closure (of Session)
Phase VIII: Reevaluation (of Previous Session's Target and 3 Prongs)

In This Section

For each Phase of EMDR therapy, you'll see the following sections:

- Overview
- Comprehensive exploration of each element of the phase
- Decision Tree (when applicable)
- Discussion of example client(s)
- Red Flags
- Advanced Considerations - Information that will be covered in later sections, and/or pertains to implementing EMDR in more complex cases

Phase I: History Taking & Diagnostic Evaluation

Overview

As with any therapeutic modality, building rapport within the therapeutic relationship and getting to know your client's symptoms, life history, and history of symptoms are included in the essential first steps. Diagnostic evaluation will also inform when and how you apply each Phase

of EMDR therapy. Screening for pathological dissociative symptoms is an essential part of evaluating your client's trauma-related symptoms. Keeping in mind your client's Window of Tolerance and general level of stability will help guide the speed, timing, depth, and breadth of how you facilitate History Taking. Many clients may benefit from inclusion of Phase II (Preparation) or Stage 1 (Stabilization) interventions prior to full completion of this phase. Informed consent is a continual process, and may be revisited several times in Phases I and II as client readiness is determined and their unique treatment plan is developed.

Phase I: History Taking

As an EMDR trained clinician, you can conduct an ordinary bio/psycho/social/spiritual intake with your AIP glasses on, so to speak. Some clinicians think of this as looking for and noting 'smoke trails,' indicating 'fires' that may be signs of unprocessed or maladaptively processed information *or* signs of obstacles such as pathological dissociation. This angle of History Taking will aid in determining readiness and appropriate Preparation strategies, so that potential fires can be addressed intentionally when you and the client are ready to do so, and sought out and reprocessed if/when appropriate. As a new EMDR clinician, you can begin by reviewing the information given, and conducting a clinical interview with questions such as these in mind:

Conceptualization	**Family of Origin/Attachment**
• When did the presenting issue begin? • Was there a time that the client's overall functioning changed towards better or worse? • How does the client's reported general functioning compare/contrast to the symptoms and issues presented? • Does the client iterate negative self-referencing beliefs about self, others, or life in general? • How has the client reportedly responded to prior therapy or medication for the presenting issues? • Is there a clear timeline or list of traumatic events, or do events span multiple developmental timeframes or decades?	• What are/were family of origin dynamics? • What is their history of attachment? Does it include experiences of abuse and/or neglect? • What kinds of attachment bonds and/or patterns are evident? • What is the family history of issues related to mental health, including trauma and dissociation? • How do family or traumatic events coincide with developmental gaps or milestones? • If history of abuse by attachment figures is present, what is the current level and quality of contact? • How might current attachment relationships affect or be affected by treatment/change in the client's symptoms?
Affect Tolerance/Regulation	**Socio-Enviro-Cultural-Spiritual Factors**
• Does the client present acute or persistent emotional or physical distress in response to a life event? • Does the client seem to avoid traumatic material, giving only vague information, or appear alexithymic (lacking words for emotions/moods)? • Does the client seem to re-live, flood, give extensive detail, or become otherwise not-presently-oriented when presenting information? • Does the client report receiving comfort or soothing, present the ability to self-regulate, or describe/present dangerous ways of coping?	• What is the quality of their peer and romantic relationships? • Has there been any exposure to natural disasters, violence, or stigma? • What is their spiritual history? Evidence of harm? Possible adaptive or resource material? • What adaptive material (potential resources) might be held in the strengths, relationships, and experiences described by the client? • How do the client's personal values relate to present symptoms and/or future change and healing?

Clients who present the following factors are generally suitable for direct application of the standard EMDR protocol and procedures:

1. Good affect tolerance, for both pleasant and unpleasant experience
2. A stable life environment
3. Willingness to experience temporary discomfort for long-term relief
4. Good ego strength
5. Adequate social support and other resources
6. A history of treatment compliance

These and other factors can be found in Shapiro's 2018 text, pp. 500-501. Comprehensive history taking can also include a genogram-guided interview (Kitchur, 2005), assessments, and methods from other treatment models employed through an AIP-informed lens.

The standard EMDR therapy approach is predicated upon the assumption that you and your client can clearly identify which memories to target, and in what order. What if you don't? What if you can't? For clients with severe dissociative presentations, memories may be revealed to your (and their) awareness in layers. This consideration and the above AIP-informed questions will guide treatment planning to the appropriate pace and, if necessary, specialized adapted protocols.

Shapiro (2018) text recommended reading:

Therapist Factors & Patient Factors, Appendix E on Client safety, pp. 498-503.

Closure & Containment

Practicing titration of traumatic material during, and containing it near the end of, a session is an important part of treatment, and applies even during the *History Taking* phase. It is not unusual at all, in talk-based therapies, for a client to discuss their trauma in-depth during a session and leave feeling, at best, raw or, at worst, destabilized without the therapist ever knowing it. Employing various containment strategies at the beginning, during, and at the end of your initial sessions with a client can establish a pattern of predictable activation and regulation of the nervous system, which will support therapeutic accessing and containment of traumatic memory material in later phases. EMDR and dissociation pioneer Sandra Paulsen (2009) calls this the 'resource sandwich.' Alternatively, attempts to contain and titrate can yield information indicating that extended preparation/stabilization may be necessary before traumatic memory can be accessed safely and therapeutically.

Continued History Taking

Once initial history taking has concluded, new information regarding history and current symptoms and experiences may continue to be gathered throughout the duration of therapy. Memories which were previously occluded or judged insignificant may emerge. As unprocessed or maladaptive material is reprocessed, symptom patterns will likely change. Keeping a log of present symptoms and triggers can be useful to identify these - see Trigger, Image, Cognition, Emotion, Sensation (TICES) log in Appendix B.

Client Selection and Readiness Criteria for EMDR Therapy

Client selection and readiness is multifaceted, and you will find case examples and decision trees throughout the following sections of this manual to illustrate examples of readiness and non-readiness. Basic factors of readiness include:

- ☑ Adequate rapport: To allow for accurate reporting of experience within and outside of session
- ☑ Window of Tolerance: Can tolerate both significant disturbance and positive affect and sensation to allow for activation and reprocessing of memories
- ☑ Ability to sustain dual attention: Can maintain awareness of the present moment while at the same time dipping into past traumatic material
- ☑ Calm/Safe Place: Successfully completed and utilized by client, among other self-regulation techniques
- ☑ Screening for pathological dissociation: DES and/or MID completed without red flags
- ☑ Physical health: Can tolerate emotional activation without serious, physical side effects

State Shifting Strategies: The Basics

Phases I and II of EMDR therapy are about setting the stage for effective resolution of traumatic material. This includes setting a precedent, from the first contact (whenever possible), of experiencing a tolerable level of distress at some point during the session, then containing and regulating back to baseline (or better) by the end of the session. The methods within these Phases are set up to facilitate establishment of this pattern and to promote safety when the traumatic material is finally accessed for reprocessing.

Initial interactions and sessions with a client often provide clues regarding their tolerance of affect, and how/if they are able to reliably shift in/out of different affective states. The below examples and verbiage are largely adapted from the work of Pat Ogden (Ogden, Minton & Pain, 2006). Examples of these clues might be:

- Client states, “Oh, I can’t talk about that or I’ll never stop crying/relapse, etc.…”
- While recounting severe experience of abuse, client appears emotionally numb or detached, is dismissive of themselves, or “falls in” to the memory and shares explicit detail.
- Client experiences an abreaction, panic, or flooding in response to thinking or speaking about traumatic experiences.
- Client reports potentially dangerous coping (such as substances, or self-abuse) as the “only way” they can feel better or “get my mind on something else.”

Containment, containerization, grounding, and orienting strategies are skills to bring a client back into or keep them within their Window of Tolerance. The developers of this training note that there is often different meaning applied to the same words (e.g., ‘grounding’) across disciplines, so it is important for the clinician and client to be clear between themselves about what words mean to them. If you are familiar with different verbiage, please notice that three different intentions are present in the strategies described below. These skills need to be introduced and tested for effectiveness with each client. Distinguishing between and amongst these three types of intentions is important.

Containment

A strategy used to increase subjective distance (or boundary) between the client and the traumatic material, and to slow or reduce activation after distress has occurred. This can include containerization. Containerization is a strategy whereby traumatic material (but not ego states) are imaginally "set aside" in a container (Kluft, 2012; Murray, 2011; Omaha, 2004). (See script here).

Use: When the client is at, or near, the upper or lower edge of their Window of Tolerance; when they are in distress; or, when you are nearing the end of a session in which traumatic material was accessed.

Intention: To decrease activation, helping the person to re-regulate when needed.

Examples: Limiting the scope of material discussed by directing the client to set aside material in a container, breathing, relaxation, or imagery exercises to facilitate down-regulation, TICES (triggers, images, cognitions/thoughts, emotions, sensations) log after experiencing a trigger.

Grounding

A strategy used to either aid a client in staying in their Window of Tolerance, ('in the room' or 'on the train') or bring them back 'into the room' when needed. A person is grounded when they are somatically in the room (i.e., they feel their body and it feels like it is in the room) *and* their attention is anchored in the present time and situation (i.e., they are oriented).

Dual attention, by definition, involves the person's attention being simultaneously on the past and the present. Grounding skills are the strategies that maintain the "in the present" aspect.

Use: When the client is within their Window of Tolerance, to help them 'anchor' prior to turning attention to traumatic material. Whenever a client has become dissociated and is not responding to the therapist in the present, either partially or completely. *This can occur seemingly out of the blue, when discussing a memory, or during EMDR.*

Intention: To engage and sustain the client's connection to the present moment.

Attentional grounding examples: A relational, social engagement practice at the beginning of session or prior to turning attention to traumatic material; or, while processing, a reminder to an activated client that they are 'on the train,' working on trauma material in your office.

Somatic grounding examples: a 'fidget' or sensory object, alerting scents in the office, ask the client to feel their feet on the ground, wiggle their toes or take a sip of cool water. Toss a ball back and forth with the client.

Orienting

A grounding strategy used to facilitate connection with the present moment/reality.

Use: When the client has shown signs of disconnection from present moment/reality, such as disproportionate distress or dissociation. In reprocessing terms: use orienting if the client has 'jumped off the train' (out of their Window of Tolerance) and is reliving, rather than noticing, the past experience.

Intention: To (re)establish connection to and focus their attention on the present moment/reality.

Examples: Naming 5 things they can see in the office, naming things they can hear, touch, or smell. Asking questions such as "Does your whole person know that you're here in my office? Do you know how old you are? What is your shoe size? How tall are you? Do you know the date?" Asking the client what they plan to do after session. "Chat" about present day events.

Client's ability to sustain Dual Attention Awareness

Dual attention to the past and present simultaneously is an essential posture for therapeutic processing of traumatic material. Dual attention is sustained when a client is noticing the past material and experiencing thoughts/emotions/body sensations related to the past, *without re-living* the past event. Using the train metaphor, this looks like the client riding on the train, noticing the scenery passing by (past material) and their *present* thoughts/emotions/body sensations in response to that scenery. This posture is essential to teach and assess in History Taking, and to monitor in Desensitization.

Selecting the target memory

There are a number of different approaches to identifying target memories for reprocessing. Regardless of the selection approach, identifying traumatic memory/memories for reprocessing is meant to be done in a cursory, surface-level manner rather than in a 'digging down in the dirt' kind of way. Whenever possible, going into extensive detail/narrative and over-activating memory networks (and possibly knocking the client out of their Window of Tolerance) is still to be avoided when identifying target memories. If your client skids into detailed narrative, you can remind them that you will ask for information in further depth once you choose which memory to target and reprocess. Standard target memory selection approaches include:

- Single incident/event
- Timeline
- 10 worst incidents
- Cluster of related experiences
- Selection based on intrusive symptoms
- Selection based on present issues or symptoms
- Kitchur's Strategic Developmental Model (2005)

These methods, in addition to approaches to identify earliest associated memories related to present/recent experience, will be described in detailed later in the training, in Phase III, Assessment.

Why titrating, even at this point, is important in EMDR Therapy

Limiting the amount and type and intensity of the information the client has to process increases the success of adaptive information processing. This applies during History Taking and Preparation, as well as later phases of EMDR therapy, and stabilizes or expands the Window of Tolerance.

Diagnostic Evaluation

Screening for Pathological Dissociation: The Dissociative Experiences Scale

Screening and assessing for the presence of pathological dissociation is often viewed by EMDR clinicians as a 'formality,' a mundane (and inconvenient) prelude to digging into trauma material. Shapiro (2018) stated very clearly, however, that, owing to the prevalence of undetected dissociative disorders in the general clinical population, "the clinician intending to initiate EMDR should first administer the Dissociative Experiences Scale (Bernstein & Putnam, 1986; Carlson & Putnam, 1993) and do a thorough clinical assessment with every client" (p.273-274). Screening for pathological dissociation prior to using Bilateral Dual-Attention Stimulation (BL-DAS or just DAS) is not an option: It is a necessity. Period.

The Dissociative Experiences Scale, 2nd Edition (DES-II) is composed of 28 self-scored items and is designed to screen for the following phenomena: Depersonalization/derealization, amnesia, absorption, and imaginative involvement. The DES is intended to help guide the clinician's decision-making to determine whether further, more comprehensive diagnostic assessment is needed prior to moving forward with trauma accessing--or even certain forms of resourcing. The adult version of the DES was written at a high school reading level. (For your convenience, we have included the DES in Appendix B.)

Administering the DES

Typically, you'll administer the DES in your office, either before or during a session with your client. You can either ask the client to complete the DES on their own, or you can complete it with them by reading the questions and collecting their responses. (The latter can be especially valuable for reasons we'll discuss further on.)

The directions for completing the DES are:

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

Each item is scored on a 0 to 100 scale: '0' means the client has never had that experience, and '100' means that the client is constantly experiencing it. The experiences described in the DES are not 'time limited' (i.e., past month, past year) and the client should take into account whether they have ever had that experience, even as far back as childhood.

The amount of time required to complete the DES may vary greatly depending on the client, but typically can be completed in about 5-10 minutes, if the client is completing it on their own. It typically takes more time if you are administering it with the client in-session, owing to the heightened level of interaction.

Though the DES is no replacement for the discerning eye that one develops through training and experience in working with complex trauma and dissociation, it can be a valuable tool in screening for dissociative phenomena during Phase 1 of EMDR therapy.

Scoring the DES

Scoring the DES is pretty straightforward: Add up the client's responses from the 28 items, then divide by 28. This simple calculation gives you the client's 'mean,' or average, score for all 28 items.

Originally, research suggested that the cutoff score for clinical significance--the minimum mean score suggesting that the client may have a dissociative disorder--should be 30 (Carlson, et al., 1993). Mueller-Pfeiffer et al. (2013) actually used a DES cutoff score of 12 for *any* dissociative disorder and 20 for DID/DDNOS (now OSDD).

You should always clarify notably high item scores (20 or greater) to ensure that your client understood what the item described, and to get clear examples of how the client experiences that phenomenon.

The DES sub-scales (depersonalization/ derealization, amnesia, absorption, and imaginative involvement) yield their own scores (Carlson, Putnam, Ross & Anderson, 1991), but it is debatable whether they yield information that is any more useful than the overall DES. There is also a "DES Taxon" (Waller, Putnam & Carlson, 1996) essentially a boiled-down score comprised of the eight items on the DES considered to be most indicative of pathological dissociation (items 3, 5, 7, 8, 12, 13, 22, 27). The score sheet includes all of these sub-scales and may be found in Appendix B of this manual.

DES Mean Scores (Carlson & Putnam, 1993)			
General Population (Adults)	7.2	Schizophrenia	16.6
Anxiety Disorders	8.7	Borderline Personality Disorder	19.3
Affective Disorders	11.9	PTSD	30.6
Eating Disorders	15.9	DDNOS	32.6
Late adolescence	19.8	DID	45.0

Interpreting the DES: Before, During, and After

Because an overall score close to either '0' or '100' is statistically unusual, it is worth considering that, if your client scores many or most items at or very near '0' or '100,' there may be more going on inside than they are either able or willing to consciously report. This *may* be a sign that more formal diagnostic evaluation of dissociative symptoms is necessary--but it *may not* be, as well. This information must be considered in the context of what you know about the client, and even what you sense or feel as a trained clinician sitting with the client.

Earlier, we noted the option of asking your client to complete the DES on their own or with you asking the questions aloud. There is one, very valuable reason to consider administering the DES with your client while they are sitting in the room with you: Visual evidence.

For example, if you notice your client becoming visibly disturbed, 'zoning out,' forgetting the question, appearing puzzled, displaying changes in voice, speech, mood or mannerisms, or taking either no time at all or a significant amount of time to respond to an item, then it's worth being curious about what is happening for them. These sorts of occurrences can themselves be diagnostically significant. Long-time EMDR practitioner and dissociative disorders specialist Joanne Twombly (2012) suggests that, "Remaining curious and open to the possibility that there

might be more going on beneath the surface of an answer provides the space for information to be eventually revealed" (p. 3). We would add to this that contradictions in a client's responses on different items on the DES can also be a window into previously undiscovered dissociation.

The DES is not, per se, a red light/green light tool to tell you whether to proceed with trauma accessing, though it's often viewed that way. It is no replacement for a critical eye and can be very useful for initial case conceptualization.

Availability of the DES in Other Formats

Non-English Versions

The DES was written in American English and is also available in dialect non-specific Spanish. Although the DES has been translated into other languages, there is, unfortunately, no consolidated source from which to access all of them. The International Society for the Study of Trauma and Dissociation (ISSTD) does, however, offer translations in Spanish, Hebrew, and Turkish to members, on the Member Resources page of its website (login required).

Child and Adolescent Versions

There are two versions of the DES suitable for use with children. We mention both here because they appeal to slightly different age ranges and offer up somewhat different information.

The first is the Children's Dissociative Experiences Scale and Posttraumatic Symptom Inventory (CDES/PTSI; Stolbach, 1997) adapted from Bernstein & Putnam, 1986). It is a 37-item, multiple-choice, self-report screening tool written specifically for girls aged 7 to 17. This version of the DES has also been adapted by Arianne Struik (2014) for use with indigenous children, and is available on her website (http://www.ariannestruik.com). The length of this version of the DES is owing to the combination of both the CDES and the PTSI into a single instrument.

The second version of the DES suitable for younger persons is the Brief DES (DES-B), developed by Dalenberg and Carlson (2010), and subsequently modified to fit DSM-5 diagnostic criteria by the same authors (APA, 2013). The DES-B is an 8-item, multiple-choice, self-report screening tool that, unlike the CDES, is not gender specific. It also has the benefit of being much shorter than the CDES, though it will yield less information about your young client's experience.

There is also a version of the DES geared more toward adolescents, called the A-DES (Armstrong, Putnam, Carlson, Libero, & Smith, 1997), which is available in English. It is similar in its language, and the same in structure, to the adult version of the DES.

Screening Tools for Parents, Teachers, and Other Carers

The Dissociative Experiences Scale is a self-report measure. However, particularly when working with children and younger adolescents, it is imperative to obtain observational data and feedback from adults in order to come up with a clear diagnostic picture. A valuable screening tool for this purpose is the Child Dissociative Checklist, Version 3 (CDC; Putnam, 1997).

Diagnosing Pathological Dissociation: The Multidimensional Inventory of Dissociation (MID)

The Multidimensional Inventory of Dissociation (Dell, 2006) is a 218-item, self-report inventory that assesses the whole domain of pathological dissociation and distinguishes between and amongst PTSD, DID, and OSDD/DDNOS, based on a statistically-derived diagnostic algorithm. It assesses the following symptoms for clinical significance:

- Criterion A: memory problems, depersonalization, derealization, flashbacks, somatoform symptoms, and trance;
- Criterion B: child and persecutory voices, voices/internal struggle, speech and thought insertion, made/intrusive emotions, impulses, and actions, temporary loss of knowledge, experiences of self-alteration and puzzlement about oneself;
- Criterion C: time loss, coming to, fugues, being told of disremembered actions, finding objects among possessions and finding evidence of one's recent actions.

The MID also contextualizes the criteria above in terms of emotional and characterological factors, including: Defensiveness, Rare Symptoms, Emotional Suffering, Attention-Seeking, Factitious Behavior, and Manipulativeness. There are many other useful scales such as the Borderline Personality Disorder (BPD) Index, Psychosis Screen, Schneiderian First-rank Symptoms Scales, and Self-state or Alter Activity Scales (child, helper, angry, persecutor, and opposite gender; (Dell, 2006). Because the MID can be extremely useful in the context of EMDR therapy, we will go into significantly more detail regarding the MID during didactic portions of the training.

All documents necessary to administer, score and begin to interpret the MID are available at www.mid-assessment.com. Note: Appendix IV of the *Interpretive Manual for the MID, 3 Edition,* addresses issues specific to EMDR therapy (Coy, Madere & Dell, 2020).

Additional Tools for Diagnostic Evaluation

Many screening and assessment tools are available. The following are suggestions most known by the authors, and most recommended by EMDR therapy trainers, authors, and clinicians. Even clinicians who are not psychologists, or who do not usually use screenings or assessments, may find that these tools are helpful in putting symptoms into context in the client's life in a manner that promises to be robust, valid, and reliable. A more comprehensive list of tools may be found at www.isst-d.org.

Recommended Screening Tools	
Trauma-Focused Screening	*Dissociation-Specific Screening*
Impact of Event Scale (IES) Assesses subjective distress caused by traumatic events during the previous seven days (Weiss, 2007). Adverse Childhood Experiences Scale (ACES) Measures categories of traumatic experience prior to age 18 (Felitti & Anda, 2014). Found in Appendix A (Shapiro, 2018, p 429-432).	Dissociative Experiences Scale, II (DES) Described in detail above. This is the bare minimum of screening necessary prior to resourcing and trauma accessing Phase III. (Carlson, & Putnam, 1993). Available in 16 different languages at www.sidran.org Somatoform Dissociation Questionnaire (SDQ- 5 (Nijenhuis, Spinhoven, van Dyck, van der Hart, & Vanderlinden, 1997), and SDQ-20 (Nijenhuis, Spinhoven, Van Dyck, Van der Hart, & Vanderlinden, 1996).

Trauma Experience Checklist (TEC) Addressing potentially traumatizing events in client's history (Nijenhuis, Van der Hart & Kruger, 2002). Traumatic Events Screening Inventory (TESI) TESI-C - Assesses a child's experience of a variety of potential traumatic events including current and previous injuries (Ribbe, 1996). Also Parent version (Ippen et al., 2002). Life Events Checklist 5 (LEC-5) Measures direct and indirect experience of stressful events (Weathers et al., 2013).	Difficulties in Emotion Regulation Scale Helpful for assessing readiness, affect awareness (Gratz & Roemer, 2004). Scale of Body Connection Measures readiness, Window of Tolerance as relates to body/somatic elements (Price & Thompson, 2007). MID 60 An abbreviated version of the Multidimensional Inventory of Dissociation that functions as a screening (Kate et al., 2020) *Adolescent/Child Dissociation Measures* Adolescent DES English, Spanish and Japanese (Armstrong, Putnam, Carlson, Libero,& Smith, 1997). Child Dissociative Experience Scale and Post-Traumatic Stress Inventory (CDES/PTSI) (Stolbach, 1997) Child Dissociative Checklist (Putnam & Peterson, 1994)

Phase I: History Taking Decision Tree

Single/Discrete Event History	Complex Trauma History (No dissociative disorder)	Complex/Unknown Trauma History (dissociative disorder)
• Evidence of adaptive material, skills, and resources • Symptoms and issues localized or specific time of onset • DES screening completed • WoT allows for discussion of history and symptoms with appropriate affect • Able to contain/shift affect in and between sessions	• Some adaptive material, some utilization of skills and resources • DES/MID no/low Amnesia and less acute self-state activity • Symptoms and issues chronic or complex • WOT allows for some discussion of history and symptoms, occasional hyper-/hypo-arousal • Some avoidance or dismissal of history, symptoms, and/or traumatic experiences - Some ability to contain/shift affect in and between sessions, or growing in this ability	• No/unknown adaptive material, absence or non-utilization of skills • DES/MID w/Amnesia or DD • Symptoms and issues chronic and complex • WOT rarely allows for discussion of history or symptoms without hyper/hypoarousal • Frequent avoidance or dismissal of history, symptoms and/or traumatic experiences - Difficulty containing/shifting affect in and between sessions without switching or maladaptive coping
Proceed to standard Phase II: Preparation	Employ Stabilization strategies, titrate History Taking, and expect extended Preparation. Wait to proceed at least until after therapist completes full training and client demonstrates readiness.	Employ Stabilization strategies. Refer to Stabilization and 3 Stage model of treatment. Do not intentionally access traumatic material or employ BL-DAS until therapist is more experienced and the client demonstrates readiness.

Discussion of Example Clients - History Taking

Pablo

Additional History

Pablo denied any experience of mental health symptoms before the accident. He did have trouble in the past with drinking too much but he was able to cut back to 1 to 2 drinks a day without treatment after getting a warning at work. In terms of history, Mother had depression, father struggled with alcoholism and rage attacks, and oldest brother drinks too much.

Pablo is the youngest in sibling of 5. His father would fly into rages when drinking and call his wife and his children names and hit them with whatever object was handy. Mother took care of them physically but never talked about feelings. Pablo learned it was 'not ok' to ask for things, especially emotional support or guidance. His parents are still together and live in another city. Pablo rarely talks to them.

Pablo finished high school and did the mechanic apprentice course. He had a wild period in adolescence where he hung out with the wrong crowd, drank too much, got into some fights and destroyed some property. He has no criminal record.

He has been working at the same garage for 5 years. The boss is very tolerant. When Pablo was drinking too much and missing work, he gave him a warning. Pablo was able to cut way down 3 years ago. He doesn't want to end up like his father.

He met his wife at a bar. They have been married 6 years. She helped him turn his life around by supporting Pablo's reconnection with his Catholic faith and "just being there for me—pushing me to get my act together—she's amazing". He finds his wife's family much more supportive than his own. They have 2 boys aged 5 and 3. He was always a very sociable guy. He used to enjoy playing baseball with his friends. Now he hardly sees his friends and can't play sports.

Pablo's Dissociative Experiences Scale (DES-II) Results

Initial Scores (0 – 100 metric)
DES Mean Score: 11.43
DES Taxon: 6.25
Depersonalization/Derealization Scale: 6.67
Amnesia Scale: 0
Absorption Scale: 23.75

Following up on the DES, Pablo was able to offer supporting evidence for most of the items he endorsed. There was a small number that he appears to have misunderstood, and these scores changed post-interview:

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

Pablo responded with a 10 initially. At follow-up, Pablo explained that "just feels like a different person than I used to be—I feel like I don't really know who I am anymore". What the item asks about is a literal experience; Pablo described a more existential, metaphorical experience. ***RESULT: Revised from 10 to 0.***

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

Pablo responded with a 10 initially. At follow-up, Pablo again was thinking of broader experience—essentially, feeling betrayed by his body after the accident. What the item asks about is a literal experience; Pablo described a more existential, metaphorical experience. ***RESULT: Revised from 10 to 0.***

Item 14. Some people have the experience of sometimes remembering a past event so vividly that they feel as if they were reliving that event.

Pablo responded with a 60 initially. At follow-up, Pablo found himself thinking more critically about the wording of the item, and realized he was thinking more about his experiences of flashbacks, and decided he experienced what was described by this item far less. ***RESULT: Revised from 60 to 20.***

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

Pablo responded with a 10 initially. At follow-up, Pablo was able to understand he had read the question differently than it was written. He was thinking about physical movement being more difficult since the accident. ***RESULT: Revised from 10 to 0.***

Post-interview Scores (0 – 100 metric)
DES Mean Score: 8.93
DES Taxon: 5
Depersonalization/Derealization Scale: 3.33
Amnesia Scale: 0
Absorption Scale: 17.5

Based on scoring for the Absorption Scale, which overlaps to some degree with trance-related phenomena, as well as the previously reported posttraumatic symptoms, the therapist opted to proceed with formal diagnostic evaluation for posttraumatic and dissociative symptoms, in this case employing the Multidimensional Inventory of Dissociation. Pablo was open to proceeding.

Pablo's Multidimensional Inventory of Dissociation (MID) Results

Diagnostic Impressions

Explicit Post-Traumatic Stress:	Posttraumatic Stress Disorder
Pathological Dissociation:	Dissociative diagnosis deferred; closely evaluate Criterion A and B symptomology
Somatization:	Clinically sub-elevated, but possibly therapeutically relevant, somatization reported

Mean MID Score is 8.6, which is similar to Pablo's DES Mean Score of 8.93. The Defensiveness Scale score, at 60, is roughly in line with therapy clients with PTSD who took the MID. Other validity scales suggest some under-reporting, which may point to Pablo's attachment history—but this a matter to be clarified by further history taking.

Criterion A Symptoms
Pablo's Mean Scores on Criterion A symptoms largely overlap with the norms for persons with PTSD, with the exception of Memory Problems, which seems notably lower. His mean score for Trance is curiously lower than his Absorption Scale score on the DES, though the phrasing of

items differs between the two instruments, so this could account for the variance. (Notably, Pablo only endorsed one Trance Scale item that specifically names ‘trance’, so it may be that he did not identify with that term. This may be something to explore in follow-up.) He met clinical significance for two symptoms here: Memory Problems and Flashbacks. Referring to the MID Diagnostic Graph, it appears that persons with PTSD are most likely to meet clinical significance for these two Criterion A symptoms.

Criterion B Symptoms
Again, Pablo’s Mean Scores on Criterion B symptoms align surprisingly closely to those of the ‘average’ therapy client with PTSD, per the MID Dissociation Scales Graph. Higher means cluster around Thought Insertion, Intrusive Emotions, and Intrusive Impulses. Looking at symptoms through the lens of clinical significance, Pablo ‘passed’ for one symptom: Self-puzzlement. The ‘dissociative diagnosis deferred’ indication is likely due to Pablo having met clinical significance for three symptoms across Criterion A and B, though all three are consistent with the MID profile of a person with PTSD.

Criterion C Symptoms
Pablo endorsed two items and ‘passed’ one item for Time Loss, but nothing else. It would be important to explore this in the follow-up interview.

Follow-up Interview
The follow-up interview largely validated the experiences that Pablo had endorsed. He reported that he found the items of the MID phrased in a way that made sense to him, though he felt a bit uncomfortable with the word ‘trance’ to describe his experience, as it made him think of a creepy stage hypnotist he’d seen on television years ago. Pablo noted feeling relieved that the experience he has where his lower leg feels disconnected from the rest of his body (Item #164) is actually a ‘thing’, because it makes him feel ‘crazy’ when it happens. Pablo’s responses, particularly on the more highly elevated Criterion B items, were contextualized in terms of his disillusionment and anger resulting from the accident, though further history taking would reveal that the ‘seeds’ for these experiences were likely planted much earlier in his life, only coming to fruition with this recent crisis. This is not uncommon. The items Pablo endorsed for Time Loss (specifically #23 and #141) were also related to his post-accident experience.

Pablo’s Readiness Criteria

Pablo seems to have fairly good rapport with his therapist, as indicated by his willingness to discuss his vulnerabilities during the history taking process. He can generally sustain dual attention when describing the accident, at least when he feels engaged with an attentive listener. He is financially stable and his physical health is adequate. He has solid connections to his wife and her family, who serve as supports for him. Although he has not been in contact with friends recently, they are not distant and could be re-engaged to enhance Pablo’s social support network. His connection to his Catholic faith can be a valuable resource in his healing process. Of concern is his history of reliance on alcohol to manage his emotional states, and this may need to be addressed by helping Pablo deepen his reliance on alternative self-soothing strategies. Pablo is not actively suicidal, and denies any suicidal ideation at all for quite some time. Pablo does have a number of post-traumatic symptom features, and at times ‘trances out’, but he has responded well to containment strategies and breathing techniques introduced by his therapist early in the work.

Elise

History

Elise has come for therapy for help with her anger. She says it really started at age 15 when her boyfriend raped her on their third date. In fact, she had a complete personality change after that. She started drinking ("it helped me forget"), hanging out with a rough crowd, not caring about school, in fact not caring about much. "I developed an attitude." She had a series of boyfriends that didn't treat her well and she married her husband because he made "lots of promises" and she was pregnant with their daughter. Although he was controlling and hit her a few times before the marriage, the abuse got really bad after her daughter was born. She finally managed to get away with her daughter after going to shelters 5 times.

She tried hard to keep it together for her daughter, working, going to school to become a nursing assistant, and drinking socially, "but I still dated losers and I had anger issues." When her daughter was in her late teens, Elise started drinking heavily. After the last relationship fell apart due to her angry outbursts two years ago, she overdosed, and she finally went to rehab. She has been sober for a year. "I'm starting to come to terms with my issues."

She admits she has been having flashbacks, panic attacks in response to reminders, nightmares and insomnia since age 15. She blames herself for the assault because she went on the date voluntarily. When asked about it, she cries and says she can't talk about it. When the topic is changed, she quickly regains her composure. She avoids her home town because it reminds her of the age 15 assault. She can only go home if someone drives her and she doesn't look out the window. She can't watch any TV programs about sexual assault. She was always a daydreamer and a bit forgetful, spending a lot of time at school "zoned out." But since the age 15 assault, she has the experience approximately weekly of watching herself, as if from outside her body, doing everyday things. It is not necessarily related to stress or during a panic attack, and occurs when she is sober. She also frequently feels as if she were looking at the world through a fog.

In terms of her childhood, she doesn't remember anything from before she was adopted at age 3. Her adoptive parents "tried hard" to include her in the family, but they weren't good at talking about feelings. She was always afraid they would reject her like her birth mother did. She was especially afraid they would send her away at age 6 when her sister, Jessica, was born. She has a good relationship with Jessica, but she indicates there is too big an age gap for them to be really close.

Elise's DES Results

On the DES, Elise scores 22.5, scoring on the absorption and imaginative involvement scale at 33, on the depersonalization-derealization scale at 22 and on the amnesia scale at 11. The DES is less than the cutoff of 25 and seems to be mostly about "normal" absorption and imaginative involvement. Her DES-taxon score is 15.

Elise's Multidimensional Inventory of Dissociation (MID) Results

Elise's MID Report indicates a lot of amnesia, trance states, angry voices, dangerously toxic PTSD symptoms, abandonment and rejection issues and a diagnosis of "Dissociative Diagnosis Deferred."
You diagnose her with PTSD with dissociative features.

Elise's Readiness Criteria

In terms of readiness criteria, she has heard about EMDR and really wants to work on the memories fueling her anger, she is likeable with a good sense of humor, her physical health is good, and she works really hard at all the skills she is taught. She wishes she had been taught skills years ago.

Carol

Carol's DES Results

Mean DES is 49.6 and probability of pathological taxon is 100%.

Carol's Multidimensional Inventory of Dissociation (MID) Results

Carol's Mean MID Score is 48.6 and the diagnostic indicators are DID and PTSD. She endorses 5/6 General Dissociative Symptoms, 10/11 Partially Dissociated Intrusions symptoms and all 6 Fully Dissociated Actions (Amnesia) at a clinically significant level. She strongly endorses child, angry and persecutory self-states and endorses "I have DID." She also had dangerous persecutory voices, toxic PTSD and dissociated self-harm behavior.

Carol's Readiness Criteria

Carol will not be ready for EMDR therapy for a long time. Later in this manual we will outline some concepts and interventions that may be helpful toward extended Stabilization and Preparation with Carol.

Phase II: Preparation (for trauma resolution)

Overview

As the title indicates, *Preparation* encompasses clinical pieces that aid the clinician in determining client readiness for later phases involving accessing traumatic memory. Simple application of Phase II involves orientation to the EMDR therapy process, setting up EMs or other BL-DAS, and enhancing a positive memory via the Calm/Safe Place or Resource Development and Installation (RDI) protocol.

Additional resourcing is recommended depending on your client's existing self-regulation skills, tolerance of and access to both positive and negative affect, and presenting history and symptoms. Prior to approaching Phase III or IV, it is essential that both you and your client know that they can predictably and reliably turn attention to disturbing material, and then contain that material and re-regulate prior to the end of session.

Educating the Client: Explaining the Procedures and Effects in EMDR therapy

Educating the client about certain procedural nuts and bolts in EMDR therapy is an important factor in successful reprocessing, and requires that you, yourself, understand them on your own terms. Additionally, learning how to explain these complex ideas in a succinct way will make it much easier for your client to weigh the benefits, ask thoughtful questions, and offer informed consent to proceed. The primary tasks in educating the client are:

1. Describe the AIP Model

The client should have some sense of what makes EMDR therapy effective. EMDR clinicians often make information about EMDR therapy available on their website, and in their office lobby. At this juncture, with data gathered in Phase I in mind, you can describe the AIP model (perhaps again) to the client in a more personalized way, for example:

> *"When we met for your initial session, you described to me how your fear of driving had grown to interfere with your ability to maintain the life and relationships you want. From what I've learned about you, it seems there may be some 'old stuff' that hasn't been fully processed, which may be feeding the fear and the thought that "I'm going to die!" while driving to work. We've completed the preparatory steps which tell me that it's okay to move forward to assess those present fears and let your brain guide us to where the distress is coming from. It seems to pre-date the minor accident you had last year, although you report that fear related to driving definitely worsened after that. Based on how the last few sessions have gone, would you still like to proceed in this direction?"*

2. Obtain Informed Consent

It's ideal if the client understands what they're getting into before they 'hop on the train.' Ensuring that client has the capacity and information they need to grant Informed Consent is an *ongoing* process throughout the course of therapy. Reaffirming their consent before beginning Phase III of EMDR is necessary. Here's why: Because of the reputation EMDR therapy has developed for bringing effective and rapid resolution to symptoms of post-traumatic stress, some clients may eagerly request EMDR without knowing or understanding what it looks like, and definitely without understanding what it is like for them. It is not unusual for clients to be surprised at how rapidly deep reprocessing goes, especially if they're working on a particularly charged memory.

3. Ensure that Communication Lines Are Open and Active

The 'Stop' Signal

The 'stop' signal is the 'brake' that stops the train with "no ifs, ands, or buts." The client is informed that, if they are overwhelmed or go outside their Window of Tolerance and feel as though they need to stop to re-ground or re-orient, then they can tell you to STOP, or hold up their hand to express the same thing, to pause the DAS.

More profoundly traumatized or attachment injured clients may be unable to do this, instead reflexively resorting to freezing, becoming sleepy/faint, or just shutting down in some way or another. As we noted earlier, this may actually be a red flag that your client is not ready to delve into reprocessing safely, owing to their incapacity to discern and articulate the boundaries of their Window of Tolerance.

Thus, although you're going to inform the client (and any aspects of self that are involved in that session's work) that they can stop processing at any time, you'll still need to carefully attune to how your client is presenting, and watch closely for any energetic or non-verbal shifts you notice that are saying 'stop' even when the client isn't saying so explicitly. For some clients, this may in itself become a major focus of History Taking, Preparation, and Trauma Reprocessing. Because of the importance of this, we recommend engaging the client in a 'dress rehearsal' of the 'stop' signal, employing a very brief experience with an agreed-upon signal. After the 'test run,' check in with the client and make any adjustments that enhance your client's capacity to put the brakes on.

Pausing DAS and re-grounding/re-orienting if a client exits their WoT is critical. Once they are outside their WoT, new learning stops. 'Pushing through' with more DAS becomes pointless at best, and re-traumatizing at worst. So, listen to and watch your client. If they look like they're 'gone,' then pause and check-in.

Most importantly, if you got this far along in the process without evaluating the client for dissociative symptoms beyond the level of PTSD, and you're seeing chronic freezing, sleepiness, shutting down, or something else that seems unusual, then please PAUSE. Step back from what you're doing. Re-evaluate your client's symptoms in terms of dissociation before considering accessing trauma material. Consider doing additional, deeper resourcing.

Setting the Stage for Accurate Client Feedback

Both in the course of helping the client widen their Window of Tolerance during Phase II: Preparation, and in subsequent trauma reprocessing, it is absolutely critical that the therapist trust that the feedback they receive from a client accurately represents their subjective experience. Without this, it is impossible to know whether reprocessing is occurring, and whether the move toward adaptive resolution of the traumatic memory is proceeding. It will also make it very difficult to know whether intervention may be needed to help reprocessing move along.

If this is the client's first time reprocessing, they will have no idea what to expect during the course of reprocessing. Because of this, it is necessary to help the client understand that any questions you ask about what they are noticing between sets of DAS are simply meant to track the course of processing. You can explain that you'll be checking in, briefly, between sets of DAS for "whatever is there" - a thought, a memory, a body sensation, an emotion. Shapiro's (2018, p.122) language is a good starting place:

> *"As we process the information and digest the old events, pictures, sensations, or emotions may arise, but your job is just to notice them, just to let them happen. Imagine that you are on a train and the scenery is passing by. Just notice the scenery without trying to grab hold of it or make it significant. Remember, if you need to take a rest, just hold up your hand.*
>
> *"We will start by asking you to focus on a target. Then I will ask you to follow my fingers with your eyes. After we do that for a while, we will stop and talk about anything that comes up. You can't keep a picture steady while the eye movements are going on, so don't try. When we talk, you just need to give me feedback on what is happening. Sometimes things will change and sometimes they won't. I may ask if something else comes up; sometimes it will and sometimes it won't. There are no 'supposed to's' in this process. So just tell me what is happening, without judging whether it should be happening or not. Just let whatever happens, happen. Any questions?"*

For clients who do not resonate with that metaphor, we can see about finding another. The best metaphors often come from the client, but if you're trying to find something and the 'train' just isn't making sense, then other metaphors might be:

- Moving down a river in a speedboat, as we notice the scenery changing along the shore
- Noticing the shifts and changes as the 'hard drive' of their computer defragments
- Looking to the sky and noticing, without judging, as the clouds pass by

For clients whose difficulties are less entwined with attachment wounding, a simple metaphor that emphasizes mindful, non-judgmental awareness may be enough to allay their anxiety.

Other clients, however, may have learned from an early age that sharing what's really going on inside is frowned upon, shameful, or even punishable. From a more attachment-injured client, you might hear things like:

- "I just want to get it [the reprocessing] right."
- "What if I'm doing it [reprocessing] wrong? What will happen?"
- "I'm afraid of saying the wrong thing."
- "I might get in trouble if I say how I'm really feeling (what's really going on inside)."

These questions may invite your curiosity, because they may reflect a childhood where remaining silent (or only telling a parent what the child believed they wanted to hear) has been a reliable source of safety. These childhood memories may even be formulated as reprocessing targets of their own, prior to returning to the previously chosen trauma memory.

4. Answer the Client's Questions and Address Their Concerns

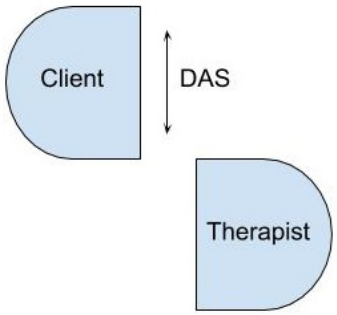
Clients may present with all sorts of questions about the process of EMDR therapy. Here are a few examples:

> How long will EMDR therapy take?
> Once you have determined the readiness of the client for EMDR therapy, and the intended course of treatment, an estimate of number of sessions or when progress will be evaluated may be given. Of course, answers to this question will vary and will only be estimates.
>
> Generally, for clients presenting with a single event or history of discrete traumatic events, estimating 1-5 reprocessing sessions per target, plus completion of Present and Future prongs will bring that treatment plan to the point of reevaluating present symptoms and determining whether to end or continue therapy. In the experience of the authors, clients in this grouping may complete such a treatment plan in 8-15 one-hour sessions.
>
> What can I expect to happen after EMDR therapy sessions?
> Refer to the script and content within Phase VII: Closure.
>
> Clarifications of the AIP model and EMDR therapy process.
> Most questions can be addressed by referring to and explaining the 8 Phases and 3 Prongs of EMDR Therapy. Clients who are motivated to read may be referred to *Getting Past Your Past* (Shapiro, 2012), for a client-friendly in-depth explanation.

5. Familiarize the Client with the Procedures in EMDR Therapy

Seating Arrangement

Since the default form of DAS is eye movements (EMs), it's best for you, as the clinician providing the stimulus for the EMs, to remain outside the client's field of vision, as much as your arm length can comfortably accommodate. This can help to avoid distracting the client from paying attention to what's most important. To achieve this, it's helpful to describe to the client the two "ships [passing] in the night" analogy (Shapiro, 2018, p. 468), with client and therapist sitting facing, but offset in relation to, one another, as so:



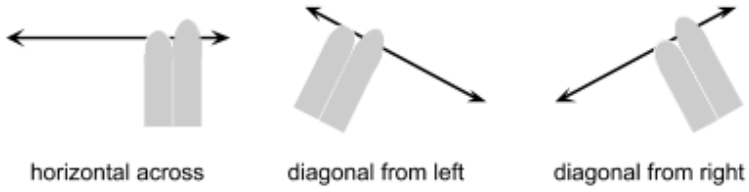
Your hand should be about 12 - 14 inches from the client's face.

This sort of seating arrangement has an additional, hidden benefit: If your client has a tendency to over-attune to another person in close proximity, then you are helping to counter that by creating just enough emotional and physical space for them to attune to themselves - which is ideal during reprocessing.

Preferred Form(s) of Bilateral Dual Attention Stimulation

Introducing the client to the forms of dual-attention stimulus (or *DAS*) helps determine which will best work for them prior to reprocessing. Shapiro (2018) described three distinct forms of DAS: Eye movements; tactile/taps; and, auditory/tones. Let's briefly look at each of these:

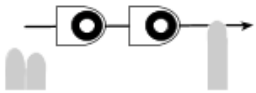
Eye Movements
The earliest form of dual attention stimulation (or *DAS*) discovered by Shapiro (2018) as having an impact in reducing emotional disturbance was eye movement. Eye movements are the most thoroughly researched and validated (Leeds, 2016), and are the 'go to' form of DAS when reprocessing. Importantly, eye movements are particularly helpful if a client experiences visual flashbacks, owing to the element of distraction from internal stimulus that eye movements offer. The rule of thumb is to employ eye movements unless the client is unable, owing to eye injury, discomfort, or a trauma-related concern (Shapiro, 2018, p. 61). Shapiro (2018, p. 61-64) illustrated three different eye movement directions the therapist may employ:
The default is horizontal, across the client's full field of vision, making certain to cross the midline of the brain. In addition, it's important to establish which of the two 'diagonals' feels more comfortable for the client (Shapiro, 2018, p. 60-61). The reasons for shifting to 'diagonal from left' or 'diagonal from right' in the course of reprocessing will be discussed below, in *Phase IV: Desensitization*. Just remember to make a note for yourself of which of the diagonals feels more comfortable for your client!



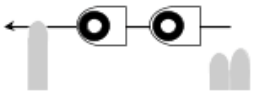
Hold your index and middle fingers up together,
with your thumb, and 'ring' and 'pinky' fingers, folded in.

Tracking eye movements will likely not be possible with clients who experience significant sight impairment or have an eye injury; thus, tactile or auditory tones will serve as the primary form of DAS.

For clinicians who intend to introduce EMDR therapy into their work with younger clients, it is important to recognize that, because younger children experience difficulty tracking across the midline of the brain, modifications in the typical use of eye movements may be necessary to accommodate this limitation, such as variations on the two-handed method (Shapiro, 2018, p. 64) such as this, where the right and left index fingers are alternated in the 'up' position, so that the client's focus alternates back-and-forth without having to continuously track the finger across the mid-line:



1. Left fingers folded down, right index finger up



2. Left index finger up, right fingers folded down

Speed, Distance, and Motion of Eye Movements

The speed of the eye movements should be fast, but not so fast that it causes discomfort or dizziness for the client. Eye movements should cross the midline and span the client's field of vision from right to left, then left to right. Your fingers (or other focusing object) should be roughly 12 to 14 inches from the client's face, and the movement should be straight across the client's sight-line. (Your hand movement should *not* look like that of a windshield wiper.) Some therapists find it helpful at first to follow a horizontal visual anchor, such as a bookshelf or a window frame, to keep their movement steady and consistent. It may take some experimenting to determine what works best for the client.

*The hand should move **straight across** the client's sight-line. Making like a 'windshield wiper' or drifting across at a slight angle is incorrect.*

Factors to Consider in Facilitating Eye Movements, with Alternatives

Some therapists find that they struggle to sustain using their hand, arm, and/or shoulder for extended reprocessing, owing to fatigue or discomfort. As such, some have found it helpful to use a wand, or even a bright pencil, to facilitate the bilateral stimulation needed.

However, some clients--particularly those who have experienced physical aggression or other harm--may trigger at the cue of a waving hand, arm, or other implement such as a wand. In these instances, there are alternatives:

- An app (on a tablet) that facilitates bilateral eye movements (they exist, inexpensively)
- A "light bar" or tabletop device designed for EMDR therapy (no small investment)
- The 'two hand" method (see previous page)

The "two hand" option yields the same 'forth and back, back and forth' motion as waving the hand from side to side, but may mitigate the fear factor for your client.

Tactile Stimulation
Tactile DAS is considered, and has been shown in most research, to be roughly equivalent to eye movements in effectiveness (Leeds, 2016). Recent findings (Paulsen & Serin, 2018) suggest the possibility that tactile DAS, on its own, may not fully access all memory networks to ensure full, adaptive resolution of a target memory. Many EMDR therapy practitioners use the eye movements and taps interchangeably, however, with *seemingly* similar effects. As we noted above, if a client's symptoms include flashbacks with a pronounced visual component, then, assuming the client has no difficulties with eye movements, they are the preferred form of DAS.

Types of Tactile Stimulation
Tactile DAS itself comes in a number of forms, which we'll describe here, from least (physically) intrusive to most intrusive:

The 'Butterfly Hug'
Developed by Lucina Artigas in 1998 as a means for more effectively employing EMDR therapy with survivors of a natural disaster in a group treatment setting (Artigas & Jarero, 2013), the effectiveness of the Butterfly Hug has since been validated in controlled research. The directions offered by Jarero, Artigas, Uribe & Garcia (2016) are as follows:

> *"Please watch me and do what I am doing. Cross your arms over your chest, so that the tip of the middle finger from each hand is placed below the clavicle or the collarbone and the other fingers and hands cover the area that is located under the connection between the collarbone and the shoulder and the collarbone and sternum or breastbone. Hands and fingers must be as vertical as possible so that the fingers point toward the neck and not toward the arms.*
>
> *If you wish, you can interlock your thumbs to form the butterfly's body and the extension of your other fingers outward will form the Butterfly's wings.*
>
> *Your eyes can be closed, or partially closed, looking toward the tip of your nose. Next, you alternate the movement of your hands, like the flapping wings of a butterfly. Let your hands move freely. You can breathe slowly and deeply* (abdominal breathing), *while you observe what is going through your mind and body such as thoughts, images, sounds, odors, feelings, and physical sensation without changing, pushing your thoughts away, or judging. You can pretend as though what you are observing is like clouds passing by."*

Electronic Tappers/Pulsers
Over the years, a handful of producers have developed gadgets that produce alternating bilateral taps, in the form of a gentle vibration or pulse, for use in EMDR therapy. All of these involve the client holding small 'tappers' or 'paddles,' one in each hand (or under the feet, etc.), while the clinician manages the (adjustable) duration, speed, and intensity of the taps. However, regardless of the maker, they cost a bit of money.

One caveat on using the tappers with clients who have been severely traumatized: Be very mindful of using any sort of electronic tapper/pulser if you know that your client has any history of being harmed with shocks, as the gentle vibration could be experienced as overwhelming for some (or all) aspects of the self.

Manual Tapping
This is the most intimate, and intrusive, form of tactile DAS because it requires the therapist to be the in the closest physical proximity to the client. There are three common ways of employing manual, tactile DAS:

- Tapping on the backs of the client's hands resting, palms-down, on their legs/knees
- Tapping on the sides of the client's knees (with therapist and client knee-to-knee)
- Using a soft-bristled paintbrush on the backs of the client's hands resting, palms-down, on their knees (Gomez, 2013)

Taps of any form may be used while the client's eyes are open or closed. It's best to assess with your client whether they have a preference. Some clients' eyes have been observed to naturally track the alternating tactile stimulation while their eyelids are closed. If it happens, that's fine--but it's also fine if it doesn't happen.

There have been isolated, anecdotal reports from clients who have a difficult time accessing sensation and emotion, that it is easier for them to get into their 'felt sense' if they close their eyes while engaging in reprocessing using taps (rather than eye movements).

Speed and Distance of Tactile Stimulation

The speed of the tactile stimulation is going to be dependent on the form you employ. The "fast, but not too fast" guideline doesn't so much apply here, although faster taps are certainly preferable. Again, it may take a bit of experimenting to determine what works best for each client.

Distance becomes a factor particularly when employing physical taps, as physical contact and/or close proximity can potentially trigger all kinds of responses for a client. Power dynamics, both actual and perceived, between the therapist and the client--as well as the restrictions imposed on touch by legislation, professional codes of ethics, and institutional codes of conduct--should thus be taken into account when deciding whether, and when, it is appropriate to employ physical taps.

Auditory Stimulation

Shapiro (2018, p. 51) stated that "[a]lternative bilateral stimulation such as auditory and tactile stimuli have been found to have a clinical effect similar to that of the eye movements." That said, the effectiveness/impact of auditory tones in EMDR therapy is supported by the least research of the three established forms of DAS (Leeds, 2016).

Some of the same producers of tappers/pulsers also offer devices that produce alternating bilateral tones, sometimes integrated with eye movements and taps! However, there are also a number of Smartphone apps that offer precisely the same thing, in conjunction with headphones. Just be certain that the app produces a bilateral, alternating auditory tone that can be adjusted to your and your client's preference.

Shapiro (2018, p. 64) mentioned using alternating bilateral finger snaps on either side of the client's head, but adds that "this [form of DAS] should only be used in isolated situations, when no other option is viable and the clinician is able to determine that the physical proximity required will not be experienced by the client as intrusive or possibly threatening." When working with a client who presents as chronically hyper- or hypo-aroused, or who has been victimized using hypnotic techniques, this option should be avoided. Notably, there is some limited evidence supporting the preferential use of auditory DAS when addressing chronic pain as occurs in carpal tunnel syndrome (Grant, 2014a) and fibromyalgia (Grant, 2014b, citing Friedberg, 2004).

Speed and Distance of Auditory Stimulation

As with tactile stimulation, the "fast, but not too fast" guideline isn't particularly relevant, although faster, alternating tones are certainly preferable. It may take a bit of experimenting to learn how different clients respond to different speeds of alternating tone.

Combining Forms of DAS

Although the idea (and practice) of combining forms of DAS (e.g., eye movements and taps in tandem) has been around for a long time, there has not been much in the way of empirical research to support its value. More recently, however, there has been isolated research (Paulsen & Serin, 2018) indicating that the effects of DAS are more comprehensive if eye movements and taps, in particular, are combined, and working in tandem. de Jongh (2019) has offered further support for these findings. There remains little, if any, support for such a heightened impact if auditory tones are one of the forms of DAS. For now, though, we will conclude that eye movements are best, with tactile stimulation coming a close second.

Evaluating and Widening the Window of Tolerance (WoT)

Calm/Safe Place

As the standard EMDR Preparation procedure, Calm/Safe Place serves a number of purposes as described below. Stepwise instructions may be found in Shapiro, 2018, pp 117-119, or via your practicum worksheet.

- Orients the client to DAS and allows the clinician to observe how the client responds to DAS while focused on (presumably) positive material;
- Gauges the client's tolerance of positive affect and sensation;
- Gauges the client's access to adaptive material;
- Tests the client's emotional flexibility and ability to 'shift state' by concentrating first on a positive resource experience, then cueing disturbance, then pivoting back to the resource. *(State shifting is normal--it's what happens naturally, unless it cannot. Here, we are looking at indicators that the state shifting does not happen in a way that will allow us to move from calm to distress to calm again.);*
- If the client has a positive experience, reports experiencing deepening of pleasant affect and sensation, is able to self-cue, tolerates cueing disturbance, and is able to shift back to the resourced state, this is an indication toward readiness for trauma accessing;
- Any seemingly innocuous word can be potentially triggering to a client. If a client presents low tolerance to the words "calm" and/or "safe," this may be a potential red flag for more complex traumatization. This is an exercise of finding a place of neutrality, or baseline that is free from disturbance; and,
- Gonzalez and Mosquera (2012) state that "safe place installation could be proposed as a dissociative screening test" (p. 3).

Additional Preparation and Containment Methods

Four Elements (E. Shapiro, 2009) is an additional resource protocol that incorporates grounding, breathing, and salivary activation before identifying and enhancing a positive memory resource. This resource protocol can be used instead of or in addition to Calm/Safe Place and is often particularly effective for clients who present with symptoms of anxiety and/or hyperarousal.

Lightstream is a visualization exercise focused on identifying and reducing disturbing material manifesting in body sensations. After the disturbing sensation is visualized and objectified (shape, size, color, etc.) a healing color is identified. Then, the clinician offers a guided visualization of the healing color directed at the objectified disturbance in the client's body. Some clients prefer to imagine colored water (instead of light) washing over them - a re-scripting of this exercise by the name *Emotional Shower* (Madere, 2014) may be found in Appendix C. This exercise can be used on its own for clients who experience muscle tension or other somatic disturbance, and in conjunction with or following containment at the end of session. It is important to note that this exercise is not strictly scripted and may be modified to fit the imagery

that feels most comfortable for your client. **Note:** Some clients may become triggered by the idea of 'taking a shower,' so it's best to ask first whether this language is acceptable to them.

Containment procedures should be introduced as early as possible in the therapeutic process, and practiced near the end of every session in which traumatic material has been accessed in any way. In EMDR therapy this is also known as Phase VII: Closure. Essentially, any accessed or unresolved maladaptive material is set aside using visualization or symbolic actions, after which the therapist prompts the client toward relaxation (using one of the above exercises or resources), grounding, containment, and/or orientation to present time. Many containerization scripts and methods exist, and this process is open to the influence of your prior training, creativity, and the needs of your client. A few specific procedures will be outlined within Phase VII: Closure.

Phase II: Preparation Decision Tree

Single/Discrete Event History	Complex Trauma History (No dissociative disorder)	Complex/Unknown Trauma History (dissociative disorder)
• Evidence of adaptive material, skills, and resources • DES screening completed • 'Container' is effective • Calm/Safe Place is effective • General life functioning is stable	• Some adaptive material, some utilization of skills and resources • DES/MID no/low Amnesia and less acute self-state activity • Able to contain traumatic material with assistance • General life functioning is adequately stable	• No/unknown adaptive material, absence or non-utilization of skills • DES/MID w/Amnesia or DD • Symptoms and issues chronic and complex • Difficulty containing/shifting affect in and between sessions without switching or maladaptive coping • General life functioning is impaired
Proceed to Phase III: Assessment	Extended Preparation. Wait to proceed to Phase III: Assessment and Reprocessing at least until after therapist completes training Module III and client demonstrates readiness.	Employ Stabilization strategies. Refer to Stabilization and 3 Stage model of treatment. Do not intentionally access traumatic material or employ BL-DAS until therapist is more experienced and the client demonstrates readiness.

Discussion of Example Clients

Pablo

Pablo had no problem with EMs. He had some difficulty imagining a calm place because of his chronic anxiety. The therapist also directed him through the Lightstream imagery. He pictured his anxiety as a red-hot blob in his chest. Eventually he was able to picture the heat and the redness melt away. He did better at the Calm/Safe place exercise. He recalled his favorite beach and was able to really get into the imagery and forget about his anxiety.

Elise

Elise has been working really hard to turn her life around, seems to be functioning well, and is insightful. She seems well resourced with all the new skills she is successfully using and she has a sponsor she can call. The assault at age 15 seems like it is a huge source of trauma, so you decide to stay clear of it for now. Perhaps you can start EMDR with one of the more recent memories of arguments with an ex-boyfriend or the ex-husband.

Just in case, you decide to teach her the calm/safe place, light stream, the container and the four elements skills. She can vividly imagine a wood paneled living room with comfortable sofas and a big fireplace as her safe place. She was able to picture a memory of getting angry at her daughter and using her calm/safe place to calm down. Lightstream on an angry incident with a coworker worked really well, as did the Four Elements. For her container she chose to send a memory of her last boyfriend to the moon in a rocket and could picture it vividly.

Carol

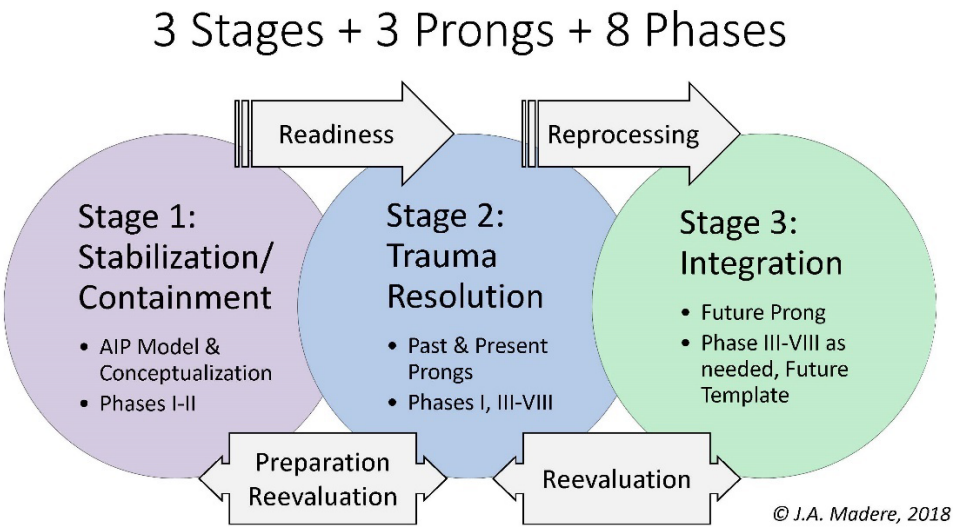
Carol will not be ready for memory processing with EMDR for a long time. After some ego state therapy, she might be able to engage in resource development and do some Progressive EMDR work on reducing phobias of inner parts and symptoms.

"Hallmark" Red Flags in Phase I: History Taking & Phase II: Preparation
What if adaptive information is absent, inadequate, or blocked?

- **Limited capacity to experience (tolerate) emotional disturbance**
- **Internal conflict:** in thought, perception, and behaviors such as drug/alcohol abuse, compulsions, disordered eating behavior, and other severe behavioral issues
- **Chronic inability to move forward in life**: 'Terminal ambivalence,' inability to complete major tasks for unknown reasons
- **Chronic memory problems:** Significant amnesia (on DES or MID, especially Criterion C of MID)
- **Somatic symptoms and other symptoms posing as medical issues**: High pain tolerance, eye flutters/rolls, distracted/narrowed gaze, rapid-onset headaches, narcoleptic-type symptoms, unusual/non-response to medications.
- **Integration failures**: Disparate event recall, noticeable shifts in perception of the same event at different times, subjective affective experience at odds with outward presentation, childlike body language/positioning.
- **Secondary Gains and Systems Impact:** Phobia of life change (loss of benefits, etc.) which can manifest as 'secondary gain' issues
- **Dissociative Phobias** *(refer back to pp. 49-53 of this manual for more detail)***:**
  - **Phobia of attachment:** To the self, to others, to the therapist. Look for issues with rapport, honesty, being seen, expressing emotion, abandonment issues, taking care of others in service of self-preservation.
  - **Phobia of trauma-derived mental actions:** These include the intrusive symptoms of a dissociative disorder such as voices, intrusive thoughts, emotions, impulses and actions, identity alteration, and amnesia symptoms. This will slow everything down, because it suggests there is a front part/s that does not want to know (and/or parts in the back that do not want the front part/s to know) what is going on inside and why.
  - **Phobia of dissociative aspects of oneself:** 'They're not there, they're not me'; fear of particular parts or kinds of parts; conflict between parts; fluctuating consent.
  - **Phobia of traumatic memory or aspects of the memory:** Which manifests as avoidance of reminders of the memory, affects, sensations, thoughts, fantasies, needs and leads to avoidant behaviors, and an increasingly narrow Window of Tolerance.
  - **Phobias of attachment related to a perpetrator:** What was the relationship with the perpetrator? (e.g., loyalty/double-bind thinking: 'You can hurt me as much as you want as long as you protect me')

Advanced Considerations

Let's review our trauma treatment model:



'Preparation' here can be thought of both as EMDR Phase II *and* a recurring task any time it seems that your client may benefit from additional resourcing (see next section below) prior to further trauma accessing. Some clients may require more ongoing resourcing than others, depending on their continuing capacity to remain within their Window of Tolerance. The Preparation Phase must be customized to the client's needs and ability to stay present, to shift state from distressed to calm, tolerate positive and negative affect, and do so without risk of decompensation (Shapiro, 2018, p 290).

Indications and Precautions in the Style, Speed, and Depth of Preparation

Sometimes Calm/Safe Place is either not what your client needs, or it is too big of a step. Here we will discuss three presentations which may require adjustment to standard Phase II: Preparation procedures and may co-occur: pathological dissociation, attachment trauma, and intolerance of positive and/or negative affect.

Pathological Dissociation: In Phase I, you screened and/or assessed your client for pathological dissociation using the DES, MID, and/or comparable screening or assessment tools. If high internal conflict among self-states was evident, a longer Preparation/Stabilization period is likely warranted and necessary. Additionally, in the MID, if there are higher mean scores in Criterion A: Depersonalization, Derealization, and Trance; significant self-state/parts activity reflected in MID Criterion B, Schneiderian First-rank Symptoms, or the Self-State/Alter Activity scales; or, amnesia symptoms are apparent under Criterion C—or, if other indications of secondary dissociation (Steele, Boon, & Van der Hart, 2017) are in evidence—the following skills/interventions (among others) will be imperative for moving forward with your client:

- Dissociative Table (Fraser, 2003; Martin, 2012)
- Parts mapping (Fine, 1991/1993; ISSTD, 2011)
- Targeting/resolving of defenses (Knipe, 2015; Gonzalez & Mosquera, 2012)
- Identifying and addressing trauma-related phobias (Steele et al., 2005, Gelinas, 2011)

Attachment Trauma: Individuals who have experienced emotional abuse, neglect, or other attachment-oriented trauma may require nuanced and extended Preparation due to lack of adaptive memory networks. Within the AIP Model, if adaptive memory networks are lacking, resolution of maladaptive material is much more difficult. Resourcing is the process of finding

positive memories, attributes, images, etc. and then strengthening them to build adaptive memory networks. Resourcing is done prior to attempting to reprocess events having to do with self, and self in relation to others. Several approaches are listed here:

- Resourcing parent figures (ideal or repaired) - (Parnell, 2013; Paulsen, 2009)
- Attachment-focused resourcing (Parnell, 2013)
- Preparation / Resourcing particularly for children and adolescents who have been adopted and/or in foster care (Adler-Tapia, 2012; Gomez, 2013; Wesselman, Schweitzer & Armstrong, 2014)
- Resource Development and Installation (RDI) of Mastery, Relational and /or Symbolic resources (Beere, 2010; Fisher, 2001; Korn, 2009; Korn & Leeds, 2002; Shapiro, 2018, pp. 248-250)

Affect Intolerance: Individuals who have experienced trauma often develop a restricted Window of Tolerance (WoT) of both pleasant and unpleasant affect. Clients who present with traits of personality disorders (APA, 2022), with or without a known history of trauma, also commonly experience affect intolerance/phobia. Imagine that the limits of the WoT are muscles that have seized, atrophied, or otherwise lost pliability; clearly, those "muscles" need to be massaged, stretched, and exercised in order to walk the journey of trauma resolution without serious injury. Many of the approaches listed immediately above apply here, in addition to the following:

- Tapping in positive experiences (Parnell, 2008, 2013; R. Shapiro, 2013)
- Positive affect tolerance protocol (Leeds, 2006)
- Affect Tolerance Protocol (York & Leeds, 2001)
- RDI, particularly the protocol as adapted by Beere (2010) and Fisher (2001). See also Shapiro (2018, pp. 249-250).
- Loving Eyes Technique (Knipe, 2015)
- Resetting Affective Circuits (Paulsen, 2017; Paulsen, O'Shea, & Lanius, 2014)

Preparation strategies such as those listed above, in combination with consistent practice of regulation skills in session, and rehearsal of containment practices will aid in stabilizing the client for (re)entry into the EMDR phases of accessing and reprocessing traumatic material. Occasionally, Preparation / Stabilization interventions are sufficiently effective in resolving acute/presenting issues such that clients may choose not to proceed to trauma resolution; this is not to reduce the significance of reprocessing or resolving trauma, but rather to underscore the profound importance and effects of this phase/stage.

Controversy: DAS or No DAS in Phase II?

According to a study conducted by Hornsveld, et al. (2011) evaluating the positive impact of horizontal eye movements, vertical eye movements, and no eye movements during RDI,

> "…eye movements (horizontal and vertical) decrease the experienced strength of positive and resourceful autobiographic (sic) memories, the effectiveness of eye movements in RDI is questionable. It may even be counterproductive."

This article set in motion a heated debate between RDI developers Andrew Leeds and Deborah Korn and Dutch EMDR therapy practitioners and researchers on the validity and efficacy of DAS (in general, and eye movements in particular) in Phase II: Preparation (see Leeds & Korn, 2012; Hornsveld, et al., 2011).This is an issue that has not yet found resolution in the EMDR therapy world.

Phase III: Assessment (Activation of Trauma Memory)

Overview

The tasks in *Phase III: Assessment* include: Selecting the Target Memory and Assessing the Target Memory for Reprocessing, (which includes 7 components).

After all necessary *Phase II: Preparation* has been completed, an issue, memory, or sequence of memories is selected. You, as the therapist, then “set up the target” by assessing seven components of one selected memory: Image/Picture, Negative Cognition, Positive Cognition, Validity of Positive Cognition, Emotion, Subjective Units of Disturbance, and Body Sensation. Hereafter this memory is referred to as the “Target.”

Within *Phase III: Assessment*, your goal is to identify and activate the components of the memory (or experience) in preparation for reprocessing. Targeting activates the neural network you have chosen to process. Identifying all of the components of the assessment ensures you are "hitting the target.” The more accurately you target the memory, the more effective EMDR therapy will be. The order of the components and corresponding questions are important and intentional - some say that the information these components access may alternate between Left and Right hemispheres, thereby beginning processing of the memory before external DAS is applied. The languaging of the questions (script below) is very intentional and important and not to be ad-libbed (unless you are trained in an advanced or adapted protocol that indicates different verbiage, and understand when and why to employ such modifications).

Each client is different and may report that certain components are easier or more difficult to access. Some clients may find that assessment and activation of the traumatic memory exceeds their Window of Tolerance. Thus, it is important that you have oriented the client to several regulation strategies to shift state and modulate the intensity of activation, and that you have facilitated or guided the client in using these successfully prior to beginning Phase III. These strategies include:

- Container, Lightstream, Calm/Safe Place, RDI, Four Elements
- Visual distancing and titration strategies such as viewing the memory through the wrong end of a telescope, broadcasting the memory onto a screen with volume/brightness/channel controls, making the picture black & white, pulling the shade on the train window, etc.
- Body-oriented and multisensory grounding and orienting strategies

When treating simple/single incident trauma, you may be able to proceed to Assessment with only completing the basic steps of DES screening, containment, and Calm/Safe Place. If you are addressing complex trauma, more strategies will need to be exercised before Assessment, and during the process of setting up the target memory as needed. Clients presenting with significant levels of pathological dissociation will require other preparatory and alternative strategies.

Selecting the Target Memory

In this phase of your treatment plan with your client, you determine how and where to apply Phases IV-VIII to traumatic memories identified thus far. Your decisions with regard to target selection and sequencing will be guided by this question: is the current goal of therapy symptom reduction, or more comprehensive treatment of an issue, pattern or disorder? We will discuss methods to organize and prioritize the events and symptoms gathered in Phases I-II.

Single Incident

If a client presents with a specific memory that they want to resolve, or one incident stands out above the rest as clearly unprocessed or maladaptively processed, a single-incident approach may be indicated. Selecting this treatment planning strategy means you intend to focus on one Past Memory through completion of Phase VIII, then reevaluate or end EMDR therapy.

Timeline

Sometimes clients present with a series of relatively discrete events which can be organized in a chronological timeline. This can be an issue-specific timeline (e.g., times client was bullied by siblings), or a broad timeline of disturbing events throughout the client's life. Such an approach usually requires client tolerance of organizing a lot of traumatic material, and commitment to a full 'house cleaning' approach to EMDR therapy.

Here, and in other target selection approaches, starting with the first/earliest or worst memory is generally recommended. Beginning with the earliest identified traumatic memory allows the greatest potential generalization and stabilization of memory networks by resolving the related symptoms at their foundation. Starting early also minimizes the risk of flooding by association and accessing of earlier related memories, called 'Feeder Memories.' Beginning with processing of the worst identified memory can be indicated when clients have difficulty seeing past an event as they look backward in time. Some clinicians argue that starting with the worst incident can be relieving to the client and client's nervous system, making all subsequent work relatively less daunting. Caveats for this position are described below.

10 Worst Incidents

Identifying the 10 worst incidents in a client's history is one of the original approaches to target selection in EMDR therapy. Essentially, this is a distilled timeline which prioritizes the worst, most disturbing, or most pivotal (in a negative or maladaptive way) events in a client's history. When clients present with dozens or hundreds of traumatic memories, identifying the 10 worst can be less daunting, and identify the incidents most likely to yield relief when reprocessed. The number 10 is somewhat arbitrary - if 8 or 12 incidents are identified, that is okay.

Similar to the timeline approach, you then proceed to assess and reprocess the first or worst memory, with the same considerations. Sometimes when clients present with generalized depression or anxiety, and a history of traumatic events, this method can allow reduction of the overall burden on the nervous system. Methods outside of EMDR therapy may provide other options to guide target selection in these presentations. **Note:** This approach is best used only with your least-traumatized clients

Cluster of Related Experiences

When a client presents symptoms or an issue related to "all the times ____" happened, identifying and selecting a target from a cluster of related experiences can be indicated. These may be addressed similarly to a Single Incident, with one memory representing the cluster. This approach tends to be more appropriate when the cluster of experiences occurs within a couple of years or one developmental stage. If the 'cluster' spans several years or developmental stages, identifying the first and the worst related experiences, and targeting them accordingly, may be indicated.

Selection Based on Intrusive Symptoms

Basing target selection on intrusive symptoms may be indicated if a client presents with flashbacks, nightmares, or other intrusive symptoms that clearly point to an event or series of events as their genesis. This may overlap with a Single Incident (if the intrusive symptoms point to a discrete incident), Cluster or Timeline approach. Organization and selection of memories within the Cluster or Timeline should be according to those approaches, with the scope restricted to incidents relating to the intrusive symptoms.

NOTE: If the intrusive symptoms appear to extend beyond general, post-traumatic symptoms in complexity, then it will likely be necessary to integrate other forms of therapy (such as a 'parts' therapy) to ensure that adequate preparation occurs prior to accessing trauma material.

Selection Based on Present Issues or Symptoms

Many clients present to therapy saying they want to work on certain issues or symptoms, rather than specific traumatic memories. After History Taking, you and your client may be aware of multiple traumatic memories, but unsure which are most closely connected to the memory networks involved in perpetuating maladaptive symptoms, issues, and patterns in the present. The affect scan and floatback techniques (below) can help lead to the key memories behind these issues.

Affect Scan and Floatback: Finding the Touchstone

When earlier related experiences are not readily known or accessible, or there are many which may link and you want to identify an earlier memory network most closely associated with a more recent incident or symptom, EMDR clinicians commonly employ one of two similar procedures: Affect Scan or Floatback. The scripts for each are as follows:

Affect Scan

1. Ask the client to bring to mind the disturbing experience (or the issue or symptom)
2. Ask the client to focus on the experience, emotions and sensations that arise when they focus on this disturbing experience
3. Instruct the client:
   "Hold the experience in mind, notice the emotions you're having right now, and notice what you're feeling in your body. Now let your mind scan back to an earlier time when you may have felt this way before and just notice what comes to mind." (Shapiro, 1995; Shapiro, 2018, p. 445).

Floatback Technique

1. Ask the client to bring to mind the disturbing experience
2. Identify the negative cognition held with that experience, and notice the associated physical sensations that arise when they focus on this experience
3. Instruct the client:
   "Now hold the image and negative belief in mind, and notice the sensations in your body, and just let your mind float back to an earlier time and tell me the first scene that comes to mind where you felt this way before." (Young, Zangwill, & Behary, 2002, in Shapiro, 2018, p 445).

While modified in their application, these techniques often used within EMDR therapy to identify past memories related to current symptoms are not new. Ernst Kris (1952, p. 60), a disciple of Freud, called these techniques regression in service to the ego. He used movements back in time to help the person in the present, understanding that preconscious and unconscious material occur in an individual's present experience and functioning.

The client may mention several experiences. Note all of them in temporal (time order) sequence, specifically identifying the earliest experience reported. This earliest experience is what is referred to as the 'Touchstone Event.' You will then proceed to assess this earliest memory, complete target setup, and fully reprocess it through Phase VIII. Any related intermediate events are then targeted and reprocessed (if disturbing), in temporal sequence. After all Past incidents within this selection have been reprocessed, proceed to address Present and Future prongs.

Note: Use of Floatback or Affect Scan is also practiced when implementing other target-selection approaches, especially when an emotional state doesn't shift on its own with BL/DAS, and/or when there is difficulty reaching a 0 SUD during Phase IV / Desensitization, to be discussed below. The AIP Model indicates and many experienced EMDR clinicians agree that targeting the earliest related experience yields the most effective and efficient processing and generalization of adaptive linkages.

Caveats & Target Selection Consideration

As mentioned above, there are pros and cons to beginning with the first or the worst memory. Beginning with the earliest known/related traumatic memory provides most opportunity for generalization across subsequently developed memory networks, and least opportunity for encountering Feeder Memories which can cause flooding. However, the client may report a low disturbance level related to the earliest/first memory, and may more easily attend to a later, more disturbing memory. Starting with the worst related traumatic memory may provide quickest relief to the client's symptoms, provided that they can tolerate accessing and processing the higher level of disturbance.

A third option can also be considered, which is starting with a memory that the client considers less disturbing, as a sort of "dress rehearsal" of reprocessing a memory. Times when this may be appropriate include: when the client is uncertain about trauma accessing and reprocessing; the clinician discerns the client's WoT may not yet be able to accommodate processing the first or worst incident; and/or the client appears to need increased efficacy provided by successful reprocessing of a less disturbing incident. Cons of this approach include potential activation of Feeder Memories or related events, and delayed processing of traumatic memories that are more likely to bring greater relief or generalization. (E.g., Hofmann, 2010).

7 Components in Assessing a Target Memory for Reprocessing

The components of Assessment are described here, along with suggestions for common situations that may require some troubleshooting. In practicum, and in your use with clients, you will use a worksheet with the scripted questions printed on it. While this may seem clumsy at first, use of EMDR scripts and worksheets is essential to the process, and fidelity is shown to correlate with more robust and consistent outcomes. If you feel it necessary to explain your use of a worksheet to clients, they may appreciate that the worksheet will allow you to follow the protocol, and free up your attention and memory for attuning to their needs during subsequent phases.

You may notice the words "experience," "memory" and "incident" being used. Originally, EMDR therapists used the word "incident" exclusively. Shapiro's final text (2018) used all three terms interchangeably. The point is to refer to the memory in a way that is intentionally vague and neutral.

Picture or Worst Aspect of the Memory

After asking the client to turn their attention to the selected memory, and re-regulating if necessary, you ask "***What picture best represents this experience to you?***" or, "***What picture best represents the worst part of the experience as you think about it now?***"

This picture/worst aspect is only obtained for purposes of activating the traumatic memory. Once the target memory is set up, and the first set of reprocessing begun, we assume that the picture may have changed and henceforth refer to the memory as "the incident."

Troubleshooting

If the client has difficulty identifying a picture, or the memory lacks a clear visual element, you may instruct the client to "***think of the incident***" or ask "***What represents this incident for you now?***" The client does not need to have a memory-based visualization of the incident.

Negative Cognition (NC)

Next, the cognitive component is elicited when you ask "***What words go best with the picture that express your negative belief about yourself now?***" (emphasis added). If the client struggles to find a belief, or seems hesitant to voice it, you may offer clarifiers such as "***What do you think of yourself even if you know it isn't true?***"

A NC must be negative, self-referencing, generalized, stated in present tense, and untrue as an absolute statement. Negative Cognitions generally fall into one of three categories:

1. Responsibility (Defectiveness or Action)
2. Safety / Vulnerability
3. Power / Control / Choices

Some clinicians and clients find the sheet of compiled Negative Cognitions (found in Appendix C), or flashcards with NCs written on them, to be helpful.

Example: Incident: A car accident in which the car the client was driving was hit by a driver who failed to yield to a red light.
Picture: The deployed airbags and disorientation after impact, before emergency vehicles arrived.
Negative Cognition: I'm not safe

In this example, the NC is negative, an "I" statement, generalized beyond the time when it was objectively true, and an absolute statement which feels true even though they know it isn't. If the client had struggled to identify a NC, or offered one that did not meet all criteria such as "I can't control other drivers," you may guide the client by asking questions such as:
"***What does it feel like the picture or incident says about you as a person?***" or "***How does that make you feel about yourself?***"

An effective NC is stated in the client's own words, and evokes an emotional response within the client. You may find yourself tempted to add finesse to the words of the NC offered by the client - unless what the client said is specific to details of the incident (rather than generalized), objectively and/or generally true, or fails to meet other criteria, resist this urge.

Sometimes a NC which refers to self in the world as opposed to "I" can be suitable, especially when the NC fits with how the unprocessed/maladaptively processed material of the incident has affected their life; for example, "It's not safe to trust anyone."

Troubleshooting

When an attempt has been made to identify a NC, and "the thoughts, emotions, or situation appear to be too confusing or complex," it can be appropriate to proceed without choosing a NC (Shapiro, 2018, p 126). This should only be an occasional exception, as the NC is an essential component to treatment planning and activation of maladaptive material for processing. Emotional over-activation, defensive refusal to identify a NC, and initial discomfort (of the client) speaking a negative statement about self may indicate lack of readiness for reprocessing, and are not usually reasons to bypass choosing a NC.

Highly defended clients may tend to select cognitions related to Power/Control/Choices when the core maladaptation is shame or fear. For example, if the incident involves being tricked into a situation that resulted in abuse, choosing the NC of "I'm not in control." This NC may have also been true at the time of the incident. If you sense this kind of gut-level mismatch between the incident/picture and the NC, and other yellow or red flags are present, consider consultation before proceeding into Phase IV/ Desensitization. Also consider titrating the memory, and make a mental note to track when channels of responsibility, shame, and safety emerge to ensure thorough processing of the memory.

Positive Cognition

The next component refers to what statement will be true (instead of the NC) once the memory is no longer disturbing. You ask, ***"When you bring up that picture, what would you <u>prefer</u> to believe about yourself <u>now</u>?"***

Similarly to the NC, the PC must be self-referencing, present tense, generalized, able to be objectively true, but this time positive in valence. The PC should be in the same domain category as the NC (Responsibility/Worth, Safety/Vulnerability, Power/Control/Choices), and roughly opposite the NC. If the client offers a statement with the word "not" you may clarify by asking ***"So, if you're not in danger now, what does that say about you?"*** The client may answer with a statement such as "I'm safe now." It is essential that the PC be in the client's own words, or at least words familiar to the client.

In sum, the PC states "even though this incident did happen, I am worthy/safe/able to make good choices now." It must, however, be realistic and congruent in context - for example "I'm in control" as the PC for an incident of childhood harm is more in-line with a defensive coping style than a potential adaptive resolution.

Troubleshooting

Identifying a PC is often challenging for major trauma survivors and they may feel as if they are setting themselves up for failure. You may need to teach your client to imagine positive outcomes, or even describe what they would be if they were possible. For example, ask them to imagine a small step forward in the direction they desire - one that seems actually possible - such as “I can learn to trust myself.”

The PC is important because it is like the destination for the train ride. Processing goes more smoothly, if the brain has a goal to aim towards. The PC will be rechecked after the incident has been reprocessed and the client reports no disturbance when thinking of the incident. So, a tentative statement that does not yet feel true is acceptable at this juncture.

Validity of Positive Cognition (VoC)

As another baseline measure, the perceived validity or “trueness” of the PC is measured by asking, ***“When you think of the incident, how do the words (****repeat the PC****) feel to you now, on a scale from 1 to 7, where 1 feels completely false and 7 feels completely true?”***

Here, “trueness” is measured on a felt-sense or gut-level basis - thus your client may know that they are safe now, but they may not feel safe now. Before reprocessing, we expect that the VOC will be less than 7.

Troubleshooting

If the initial VOC is reported to be 1 or 2, and the present environment does not contribute additional rationale for this low rating, you may consider questioning the suitability of the PC. Perhaps a PC selected from the cognition list does not fit the client’s own words, or the client has never experienced that PC to be true.

Similarly, if the client rates the initial VOC to be a 7, the client may be rating the VOC based on rational/cognitive truth rather than *feeling* true, or the PC may not be a good fit (see troubleshooting for PC).

Emotion(s)

As you progress through the steps of setting up the target memory for reprocessing, we expect the emotional content of the memory network will become activated. Some clients may need assistance to modulate activation throughout this process, while others may remain relatively unactivated, hypo-aroused, or unaware. We presume that you have already tested their ability to “shift state” during a normal or extended *Preparation* phase.

You gather the emotional component(s) of the activated memory network by asking ***“When you think of the incident, and the words (****repeat NC****), what emotions do you feel now?”*** The client then names the specific emotion(s) they are feeling presently pertaining to the target memory. As implied by the preponderance of parentheses in this section, identification of multiple emotions is not necessary.

Troubleshooting

If the client doesn't know what they are feeling, they can guess (with help from the therapist) and clarify as they go on, *assuming they actually experience a felt sense in their body*. Words or phrases which are not technically "emotions" such as "like I just can't do anything right" are acceptable, as long as they connote an emotional felt sense.

Subjective Units of Disturbance (SUD) measure

Thus far, you may have witnessed activation of the traumatic memory, but unless the client has exceeded their window of tolerance (requiring intervention or detour) you don't know exactly how activated they feel. This information is gathered by asking, ***"On as scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does it feel now?"***

Notice, the script is intentionally vague, and does not specifically name the incident/memory, picture, NC, or emotion. Here, you are asking for the client's subjective rating of the disturbance as a whole, as it relates to the present experience of the incident/memory being assessed for reprocessing.

Location(s) of Disturbance (in the body)

Next, as soon as you write the SUD level on your worksheet, ask ***"Where do you feel it (****the disturbance****) in your body?*** A simple identification of "in my chest*"* is an adequate response.

In this final component, you are asking the client to activate meta-awareness, an essential aspect of safe and productive reprocessing, and connect with the experience of the disturbing memory in their body. If the client is unable to immediately answer, you may say ***"You reported an 8 on the SUD scale. Where do you feel the 8 in your body?"*** This final question of target setup is often activating, which is why it's important to set up BL-DAS prior to target setup, and ideal to plan for sufficient time to begin Desensitization immediately after target setup.

Troubleshooting

Major trauma survivors may have learned to separate themselves from their bodies - this question assumes they are subjectively in their body and can feel it. Again, presuming *Preparation* phase work indicated your client was able to access and tolerate body sensation, the following instruction may be applied:

"Close or relax your eyes and notice how your body feels. Now I will ask you to think of something, and when I do, just notice what changes in your body. Now, think of the memory, bring up the picture if it's okay to do that. Tell me what changes in your body. Now add the words (state the NC). Tell me what changes in your body.

Discussion of Example Clients and Summary of Components

Pablo

Setting up for *Assessmen*t: Pablo (the example client) and his therapist are seated, they have set up positioning for EMs and an alternate form of DAS. They have agreed to begin working on the memory of the car accident at this session. Both worksheet and writing utensil are ready! (T = Therapist, C = Client/Pablo)

Picture

T - "*So, what picture best represents the worst part of the incident as you think about it now?"*
C - The car is about to hit me, just like in the nightmares I've had so many times.

Negative Cognition

T - "*What words go best with the picture that express your negative belief about yourself now?*"
C - I'm going to die, I can't drive anywhere because it's just not safe. You know that I've also been stuck on the thought that something is wrong with me, but that's more about my knee.
T - *"Which fits best, I'm going to die, I'm not safe, or something's wrong with me?"*
C – I'm not safe

Positive Cognition

T - "When you bring up that picture, what would you prefer to believe about yourself now?"
C - I'm safe now, I know I'm safe, it just doesn't feel like it sometimes.

Validity of Cognition (VOC)

T - *"Right! So, when you think of the incident, how to do the words "I'm safe now" feel to you now, on a scale from 1 to 7, where 1 feels completely false and 7 feels completely true?"*
C - About a 3.

Emotion(s)

T - *"Okay. When you think of the incident, and the words "I'm not safe," what emotions do you feel now?"*
C - The fear is creeping up, not quite panic.

SUD

T - *"Mm-hmm. On a scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the highest or most intense disturbance you can imagine, how disturbing does it feel now?"*
C - Oh, it's up to a 6 or so.

Location of Body Sensation

T - ***"**Where do you feel the disturbance in your body?"*
C - In my arms, chest and legs. Oh, and my stomach. And my heart is beating faster.

Elise

Setting up for *Assessmen*t: Elise and her therapist have set up positioning for EMs and have already used tapping in the calm/safe place exercise. Together, they have agreed to begin working on the memory of the breakup with her last boyfriend, Roger. She says she has had a lot of therapy on it and it is only moderately upsetting at this point. (T = Therapist, C = Client/Elise)

Picture

T - "*So, what picture best represents the worst part of the incident as you think about it now?"*
C – "I'm screaming at the top of my lungs at Roger for coming home 2 hours late from work and not answering his cell phone."

Negative Cognition

T - "*What words go best with the picture that express your negative belief about yourself now?*"
C –I'm a total loser.

Positive Cognition

T - "When you bring up that picture, what would you prefer to believe about yourself now?"
C –I can beat this anger problem.

Validity of Cognition (VOC)

T - *"Right! So, when you think of the incident, how to do the words "I can beat this anger problem" feel to you now, on a scale from 1 to 7, where 1 feels completely false and 7 feels completely true?"*
C - About a 2.

Emotion(s)

T - *"Okay. When you think of the incident, and the words "I'm a total loser," what emotions do you feel now?"*
C – (Quiet for a moment, tearful). I guess it is shame.

SUD

T - *"Mm-hmm. On a scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the highest or most intense disturbance you can imagine, how disturbing does it feel now?"*
C –I thought I was over him, but when I focus on the shame, it seems like an 8.

Location of Body Sensation

T - ***"**Where do you feel the disturbance in your body?"*
C - In the pit of my stomach.

The purpose of Assessment is to activate the components of the memory for processing. Thus, when session time allows, it is preferable to proceed immediately into Phase IV: Desensitization after a brief reminder to orient the client to dual attention (script to follow).

Phase III: Assessment Decision Tree

Single/Discrete Event History	Complex/Recent Trauma History (No dissociative disorder)	Complex Trauma History (no dissociative disorder)
• Evidence of adaptive material, skills, and resources • DES screening completed • 'Container' is effective • Calm/Safe Place is effective • General life functioning is stable • Able to clearly identify all elements of target setup	• Some adaptive material, some utilization of skills and resources • DES/MID no/low Amnesia and less acute self-state activity • Able to contain traumatic material with assistance • General life functioning is adequately stable, or was prior to recent traumatic event • Able to clearly identify all elements of experience, once the appropriate scope is identified	• Some adaptive material, some utilization of skills and resources • DES/MID no/low Amnesia and less acute self-state activity • Able to contain traumatic material with assistance • General life functioning is adequately stable, with lapses in response to discrete 'triggers' • Able to clearly identify all elements of experience in target setup, including Body Sensation.
Proceed to trauma processing using EMDR Standard Protocol	Consider utilizing the Recent Traumatic Event protocol, or EMD.	Consider EMD for initial target, but wait to proceed to Desensitization until completing this training and client is ready.

"Hallmark" Red Flags in Phase III: Assessment

Given that Assessment is the first time in an EMDR therapy treatment plan that you ask the client to intentionally access a traumatic memory network, each step of setting up the target is a test of their Window of Tolerance. Common Red Flags for each:

- Picture/Worst part: Hypo-arousal could look like inability to access (avoidance or numbing), hyperarousal could look like flooding or other reliving of the incident.

- NC: A bit of pre-frontal cortex (PFC) functioning is required to access and verbalize an effective Negative Cognition. Hypo-arousal could look like identification of cognitions in the domain of Control/Choices (see advanced considerations in Phase IV: Desensitization) when that is not appropriate to the incident or having no thoughts. Hyper-arousal could look like stating that “all” of the cognitions on the sample list apply, and/or other signs of flooding or reliving of the event. If your client cannot distinguish between *then* and *now*, especially after being reminded, they may be outside their Window of Tolerance without either of you realizing it. One way of getting past this can be to ask the client, ‘What would a child say about their self in this situation?’

- PC: Here the test is whether the client can tolerate/access a positive, self-referencing statement. If they can’t come up with one, or offer up a PC in the domain of Control/Choices when it doesn’t really seem to ‘fit’ with the target memory, this could indicate either internal conflict or a problem with tolerating pleasant emotions due to hyper- or hypo-arousal. Again, if your client cannot distinguish between *then* and *now*, they could be outside their WoT.

- VOC: The numerical rating of the VOC requires the client’s PFC to be ‘online’ and that the client has the capacity to sense the ‘trueness’ in the here-and-now. If your client is more emotionally ‘flexible’ this will be easier for them. But, if the client is more activated or less emotionally flexible, this may be quite challenging.

- Emotions: During this step of setting up a target, you might again see the client being hyper- or hypo-aroused, and not having full access to their experience. Hyper-arousal or over-accessing could mean they feel like they’re being pulled “back there” and losing dual attention. This might look like intellectualizing (or using abstract language to describe their emotions), emotional distancing/withdrawal, numbing, or even denial.

- Sensation: If you and your client have done an adequate job of stabilizing during Preparation, you already know whether they run into difficulty accessing their felt sense or tolerating body awareness. Again, look for signs that your client is in hyper- or hypo-arousal, and evaluate where they are in relation to their WoT.

If any aspects of the basic target setup are missing or intolerable for your client, put a pause on trauma-accessing for now. Gently return to Preparation/Stabilization, thank your client and their brain for letting you know what was needed, and wait until completing this entire training and obtaining consultation and/or advanced training before returning to trauma accessing.

Advanced Considerations

In addition to the many nuances described above within the 'Troubleshooting' sections, several other potential challenges are outlined here.

The Subtleties of Setting Up Targets

Clients and clinicians new to EMDR therapy most often struggle with identifying appropriate and accurate NCs and PCs. Identifying a negative belief that feels true but is objectively false in some way, and a positive belief that is objectively true but feels less than fully true is understandably awkward, especially for clients who are accustomed to avoiding cognitive distortions, the practice of positive self-affirmations, etc. Taking some time to identify accurate cognitions, as well as activating all aspects of the target assessment, set the stage for the most efficient processing of the maladaptive material related to the target memory.

In the 3 Stages of Complex Trauma Treatment

As illustrated above, Phase III: Assessment falls within Stage 2 of complex trauma treatment. For simple trauma (single event, or a handful of discrete events), the process through Stages 1, 2, and 3 is fairly linear. Once the client demonstrates adequate stabilization and readiness, incidents can be targeted and reprocessed sequentially, pausing only for reevaluation and to attend to Present and Future prongs when appropriate.

For complex trauma, where there are a multitude of events, developmental or attachment trauma, dissociation, or other confounding factors, it may be necessary to toggle back and forth between Stages 1 and 2 to facilitate processing of one target memory, or between target memories. For example, if a lack in adaptive connections is evident, reprocessing may be paused to complete additional resourcing or RDI; or, if a conflict between parts of self is identified, some work on stabilizing the relationship among parts may be necessary as a brief intervention, or for several sessions.

Processing trauma with clients who meet criteria for a dissociative disorder almost always requires some fractionation or titration of the traumatic material, meaning that one incident may be split into multiple mini-targets for reprocessing. Models within the field of treating dissociative disorders include the BASK model (Fine, 1999) and the Fractionated Abreaction Technique (Kluft, 2013). Many adapted and advanced protocols have been promulgated within the EMDR community to fractionate and contain processing, and will be discussed in later sections. Perhaps it is needless to say that flow between Stages 1-3 is far less linear, and looks more like a Spirograph design as the client's needs and WoT are continually evaluated and addressed.

To be clear, listing the 10 worst events or developing a comprehensive timeline of traumatic experiences is often difficult to do and usually unwise for clients presenting with complex trauma and usually impossible to do and definitely unwise for dissociative clients. The memory networks of clients presenting with complex trauma and dissociative disorders seem to be highly interconnected, overlapping, and sometimes involve layers or connections which are not apparent at first. Naming the 10 worst events or viewing the entire timeline of events may be far more than their WoT can handle. A developmental timeline, or a genogram-focused approach (Kitchur, 2005) may be both more tolerable and more effective for these presentations.

Maureen Kitchur's Strategic Developmental Model for EMDR Therapy

1) A genogram is used to elicit the nodal events in the client's life
2) Targets are selected for processing in the following age group order:
   - middle childhood (4-11)
   - early childhood (0-3)
   - adolescent (11-17)
   - adult
3) Within each age group (except for early childhood), the memories are targeted as follows: most disturbing memory of parent's relationship, most disturbing memory of one parent then the other, and then known traumas in chronological order.
4) Early childhood memories are targeted if there is a memory, corroborated event or attachment wound.

Identifying Emotions and Body Sensations

Under-feeling/sensing
Not surprisingly, a significant percentage of clients presenting for psychotherapy have difficulty accessing or identifying their experience of emotions and body sensations. This percentage is perhaps higher for clients presenting for EMDR therapy, as some members of the public at large hold the perception that one does not have to "talk about their feelings" in EMDR therapy. That perception is somewhat true, but incomplete. Someone presenting with under-feeling/sensing may have arrived at that experience for a myriad of reasons, some of which are described here, along with suggestions for responding to them.

Alexithymia
The state of consistent difficulty or inability to recognize or describe emotion-related experiences or responses is called alexithymia. This may result from simple lack of practice (relationships and settings in the person's life didn't require or provide for it), family of origin constructs ("we didn't ever talk about feelings"), and/or exist as a facet of presentations such as Autism Spectrum Disorder.

Depersonalization
Disconnection from self, including internal emotional and physical experience, is a facet of about 70% of DSM diagnoses (Steele, 2012). Items 7, 11, 12, 13, 27, and 28 of the DES II describe experiences which represent depersonalization (some of which are coupled with experience of derealization). While a symptom of dissociation, depersonalization is often also a manner of coping common among those who meet criteria for PTSD - when someone disconnects from any internal experience, for sake of survival or another adaptive function, connection to other internal experiences may be diminished. Those who have PTSD and also experience depersonalization can be given a diagnosis of dissociative PTSD according to the DSM-5.

> What is important in EMDR therapy is that the client can access and tolerate pleasant/enjoyable affect, and access and tolerate unpleasant/disturbing affect in order to activate and reprocess neural networks associated with Resource and Target memories.

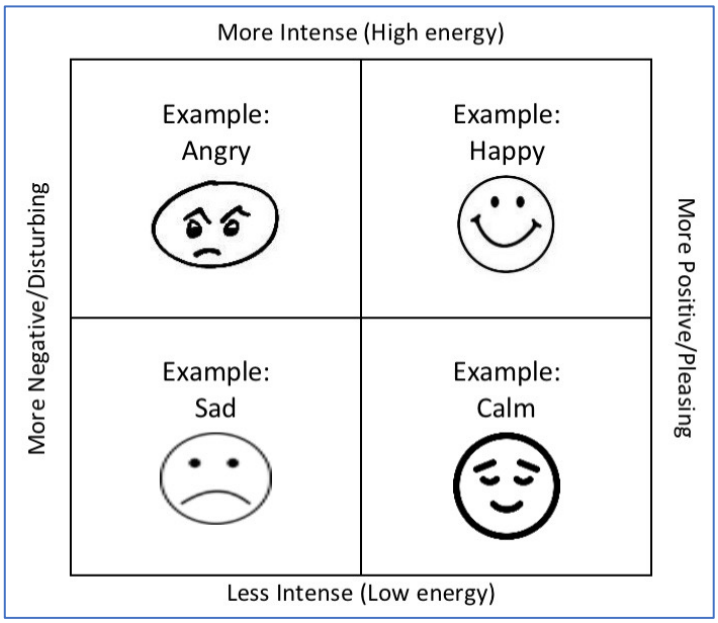
Often, within Calm/Safe Place, another Resourcing (Preparation) protocol, asking the client to "tell me a bit more about that" can allow them to light up the memory network for you to observe a smile, or signs of relaxation, and reflect those to the client. If they welcome that with a

response such as “Yeah, I guess so,” or “Sort of, it’s more like…,” that’s an encouraging sign! If the client argues, dismisses, or otherwise appears to guard against activating the associated affect or sensation, that may be an indication for caution.

Within Assessment, we are (usually) activating negative or disturbing material. If a client has not spoken much about the Target memory to anyone, and/or has avoided thinking or speaking about it, the memory network may be “cold”... or there may be conscious or unconscious avoidance of affect in an effort to stay within their Window of Tolerance. Instructing the client “if it’s okay, zoom in to the memory just enough to allow you to feel any clues of emotion, or until you notice you feel something” or asking “If you imagine seeing yourself at the time of the incident, what’s that like for you now?” can sometimes prompt activation.

Clients who experience alexithymia and/or depersonalization, have already been screened for pathological dissociation, and are familiar with plotting points on a graph using ‘x’ and ‘y’ axis may find the following table approachable. (A blank version of this graph is available in Appendix C.)

Figure 9: Plotting Emotion & Sensation by Quadrant (Madere, 2017)



Helping a Client Plot a Felt Experience of Emotion or Body Sensation

T: So, when you’re telling me about that experience, and notice any emotional response you’re having in this present moment, would you say those emotions are more Positive/ Pleasing or more Negative/Disturbing?
C: It’s definitely negative, but I’m not sure if it’s disturbing.

T: Okay, so it’s on the left side of the vertical axis, about how far?
C: About half way.

T: So, if this were on a 0-10 scale in each direction, about a ‘-5’?
C: Yeah.

T: About how intense does it feel right now? How far up or down on the vertical axis fits for you?

C: (shoulders slumped)

T: It looks like your energy is low, is that right?
C: Yeah… maybe about ¼ of the way down.

T: Okay. So, it would be in that lower left quadrant. Quite negative, and a bit low in energy. Does that feel about right?
C: Yeah that's pretty close.

T: Are there any words that come to mind with that emotional experience right now?
C: It's what I call "feeling down."

Over-feeling/sensing
Some clients present a predominant pattern of overfeeling/sensing, or accessing memories, emotion, and body sensation so easily and so strongly that you may wonder whether they are still within their Window of Tolerance. In contrast to those who underfeel/sense, clients who overfeel/sense may report a myriad of responses when asked to identify emotions and body sensations during the Assessment, or in any phase, for that matter.

To ensure effective reprocessing, be certain that…

1. The targeted memory network(s) are sufficiently activated;
2. Your client begins, and is able to stay, within their Window of Tolerance; and,
3. You are able to keep the 'train' moving down the track, rather than digressing into extended conversation between sets of DAS.

Gauging level of activation, the combined abilities of you and your client to moderate access to emotion and body sensation when needed and practicing both increasing and decreasing access to emotion and body sensation are essential prior to beginning Desensitization. If you assessed the client to be ready to move from Preparation to Assessment, and encounter difficulty setting up the Target memory due to over/underfeeling or over/undersensing, returning to Preparation (at least briefly) is indicated to ensure effective reprocessing in future sessions.

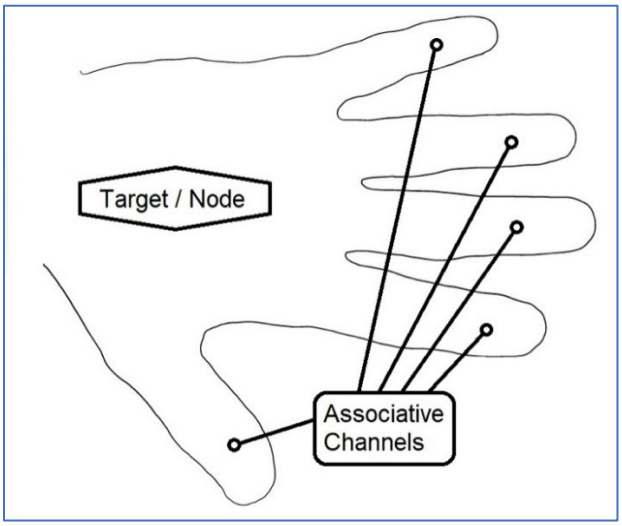
The Reprocessing Phases

Overview of Reprocessing: The Bird's Eye View

Before we get into the mechanics of moving the train along during reprocessing, let's look at its typical journey along the railway, from the point of Phase III: Assessment moving forward.

The Single Hand

Shapiro (2018, p. 30) offered up a helpful way of thinking about reprocessing a single memory, which we can imagine here as a hand:



The **Target / Node** is the target memory, in whole. When we are looking for an 'entry point' to the rail system to reprocess the target memory, we look for its most emotionally, cognitively, and physiologically charged aspects--represented by the seven components of the memory we collect during Phase III: Assessment.

The **Associative Channels** contain both maladaptively and adaptively stored information that we will link up during the reprocessing phases to achieve full, adaptive resolution of the disturbing memory. These channels may contain the raw, undigested aspects of the target memory; other, later memories connected via associative links, some (or all) of which may be accounted for within an established targeting sequence, and others that did not surface during initial evaluation; and, linkages to unconsciously held 'feeder' memories that are somehow connected to, but precede, the target memory.

In conceptualizing a full targeting sequence, we might imagine a small 'network' of hands, each representing a separate target memory, but with some interconnected or overlapping fingers that represent the associative links. Thus, we can see how we might be able to organize a targeting sequence around a Negative Cognition such as "It's not ok to have feelings," a disturbing body sensation, or even a powerful emotion. It is these overlaps that may help explain the generalizing impact on associated memories we see when full reprocessing of a single target memory occurs.

However, because some target memories--or parts of self that hold those memories--either may not share naturally overlapping linkages or else contain 'blocks'--as if there was a cow hanging

out on the tracks--we must at times create 'manual' connections to ensure that the train doesn't run out of track.

Only in Phase V: Installation do we reconnect with the Positive Cognition (PC) and the Validity of Cognition (VoC) scale.

Phase IV: Desensitization (of the selected memory)

Overview

After assessing the Target, sets of BL-DAS ('DAS') are administered to allow all maladaptively stored or unprocessed material related to the Incident to be reprocessed and cleared. After each set, the clinician instructs the client to *"take a deep breath, let it go…"* then asks, *"What do you notice now?"* Generally, after a brief report by the client, the clinician says, "go with that" and continues with sets unless the client's presentation indicates processing is stuck, processing is at the end of a channel, or unclear/no change is occurring. Desensitization continues until the SUD=0 and maintains at that level for at least 2 sets, or the session time is almost over, in which case Closure is facilitated. Ideally, the train moves down the track on its own and reprocessing takes place organically. Sometimes, though, the train encounters a barricade or requires a detour, and so we intervene to keep things moving along the track.

Phases IV, V, and VI are the reprocessing phases in Standard Protocol, and, although they do occur discretely and in sequential order, there may be times when you'll briefly return to desensitization if something surfaces in Phase V or VI that was unavailable during Phase IV. This fluidity makes it all the more important to have a clear sense of what you can do to ensure optimal reprocessing throughout.

Desensitization

To begin *Phase IV: Desensitization*, we focus in on the most charged information--the picture/image that represents the worst part, the Negative Cognition (NC), and the body location(s) of the disturbance these bring up.

Readiness: Before We Depart the Station, Make Sure You Have Everything!

Once you have 'set up' the target memory for reprocessing in Phase III, you will continue right on to Phase IV to begin reprocessing the memory. Let's be sure, though, that everything is in order before shifting into reprocessing.

Reprocessing Readiness Checklist

- ☑ Are significant risk factors manageable, or absent?
  e.g., active substance abuse, suicidal ideation with plan/means, current self-injury, unaddressed dissociative coping, etc.
- ☑ Have you obtained adequate Informed consent to proceed?
- ☑ Have you established which form(s) of DAS you're going to use?
  - Eye movements, taps, or tones?
  - Alternate eye movement direction (or form of DAS) identified?
- ☑ Have you agreed upon a comfortable physical distance during reprocessing?
- ☑ Have you ensured that the client knows their STOP signal and feels comfortable using it?
- ☑ Have you reminded yourself of all the skills and abilities you brought with you?

Beginning: Fueled by a Metaphor, Away We Go

Remember, it's important that the client has a sense that 'whatever comes up, comes up'--neither you nor they have a clue what might surface in the course of reprocessing, and so there are no expectations for what "should" come up--even, and especially--if the content has *no apparent connection to the target memory*. We return again to Shapiro's (2018, p. 122) helpful language, intended to help 'release the parking brake':

> *"As we process the information and digest the old events, pictures, sensations, or emotions may arise, but your job is just to notice them, just to let them happen. Imagine that you are on a train and the scenery is passing by. Just notice the scenery without trying to grab hold of it or make it significant. Remember, if you need to take a rest, just hold up your hand.*
>
> *"We will start by asking you to focus on a target. Then I will ask you to follow my fingers with your eyes. After we do that for a while, we will stop and talk about anything that comes up. You can't keep a picture steady while the eye movements are going on, so don't try. When we talk, you just need to give me feedback on what is happening. Sometimes things will change and sometimes they won't. I may ask if something else comes up; sometimes it will and sometimes it won't. There are no 'supposed to's' in this process. So just tell me what is happening, without judging whether it should be happening or not. Just let whatever happens, happen. Any questions?"*

Here's a brief look at how things might look from here on, picking up from the end of Phase III with Pablo, the example client who experienced a car accident:

T - "Now, hold in mind the picture (image) that represents the worst part of the car accident, along with those words "I'm not safe," and where you feel that in your body, and just notice."

[BL-DAS] .....[then PAUSE]

T - "And what are you noticing now?"
C - (with surprise) "Wow. My arms, hands, and legs are so *tense*!"
T - "Just noticing that."

[BL-DAS] .....[then PAUSE]

T - "OK...And what are you noticing now?"
C - (a sick look in his eyes, confused) "My stomach is churning."
T - "OK. Just notice the churning in your stomach."

[BL-DAS] .....[then PAUSE]

T - "OK...And what are you noticing now?"
C - (fearful, eyes wide)"I want to escape! I know what happens next...!"
T - "You still with me? Does it feel like it's ok to keep going?"
C - "Yeah - I just feel like I want to get out of the car!"
T - "Just noticing that."

[BL-DAS] ……..[then PAUSE]

T - "OK...And what are you noticing now?"
C - "That person driving the other car...they looked up from texting, and they were scared too!"
T - "Go with that."

[BL-DAS] ……..[then PAUSE]

T - "OK...And what are you picking up on now?"
C - (shaking head) "You know, that was such a terrible thing that happened to me."
T - "Just noticing that."

[BL-DAS] ……..[then PAUSE]

T - "OK...And what are you noticing now?"
C - (anger) "I wish that hadn't happened. I wish that other driver had paid more attention. The hell I've been through!"
T - "Just noticing that."

[BL-DAS] ……..[then PAUSE]

T - "OK...And what are you getting now?"
C - (tearful) "It's just--everything me and my family have been through the past two years."
T - "Yeah. Just noticing that."

[BL-DAS] ……..[then PAUSE]

T - "OK...And what are you noticing now?"
C - "It's weird. I feel calmer, now, for some reason."
T - "Just noticing that."

[BL-DAS] ……..[then PAUSE]

T - "OK...And what are you getting now?"
C - "I still feel calm."
T - "All right, then. Let's check back in with the original memory."

As a contrast, when the therapist is working with Elise, who has a much more complex trauma history, we see that reprocessing in Phase IV: Desensitization does not go as anticipated:

T - "Now, hold in mind the picture (image) that represents the worst part of the argument along with those words "I'm a total loser," and where you feel that in your body, and just notice."

[BL-DAS] .....[then PAUSE]

T - "And what are you noticing now?"
C - (Sobbing) "I am such an awful person. I deserved to be dumped."
T – "Elise, can you look at me? Do you know where you are?"

C – "Yes, I'm here with you doing EMDR" (looks at you and stops crying).
T – "Do you want to go on?"
C – "Yes."
T - "OK. Let's go back to the picture of you screaming at Roger, and go with that."

[BL-DAS] .....[then PAUSE]

[After about 15 passes, Elise begins screaming angrily while still following the therapist's fingers. The therapist continues on for about 5 more passes, but Elise's agitation further escalates and she veers into a shocking bout of swearing.]

T - "OK, let's take a break, blow it out."
C – (Continues swearing and is starting to raise fists.)

T – (Moving chair away, giving her space, trying to speak calmly) "Elise, Elise, you are safe here with me, your therapist, in my office. It's OK now. Take a big breath in and blow it out slowly. Remember your 4 elements and 'blue for water and calm'? That's it, a big breath in and a slow breath out. Picture the calm water. I have a glass of water here for you when you are ready."
C - (Calming down, drinks the water, then stares blankly)

T - "How are you doing?"
C – "I don't know."
T – "What is happening for you right now?"

C – "I'm floating, I'm watching my body."
T – (Shifts back to the Four Elements. When Elise reports feeling grounded again, the Therapist returns to inquiry)

T – "What just happened?"
C – "I don't know. I don't remember. The last thing I remember is being ashamed of my anger."
T – "Perhaps it would be best to set this memory material aside in the container until the time seems right to sort through it…"

Now, we'll take a closer look at specific elements of reprocessing that will ensure that the train reaches its destination.

Frequently Asked Questions: Keeping the Train Moving Down the Track

BL-DAS: How Many Passes, and How Fast?

In the course of reprocessing, sets of DAS may vary in length and speed. One ‘pass’ means that, if you start at the left side of the client’s field of vision and move your fingers to the right, once you return to where you started on the left, you’ve completed a pass. A pass is also known as a ‘saccade,’ which is literally a “rapid movement of the eyes between two fixed points.” (From here on, we will use ‘pass’ and ‘saccade’ interchangeably.)

The ‘rule of thumb’ is around 25 initial passes, starting slowly and graduating quickly to ‘full’ speed to allow the client’s eyes to acclimate to tracking your fingers. As we established in Phase II: Preparation, standard saccades should be ‘fast, but not too fast,’ with a typical set of eye movements being roughly 20 seconds in length. If you’re using taps or tones, the frequency should be as fast as the client can tolerate, with no ‘pauses’ between the felt/heard stimulus (e.g., Tap – Pause – Tap – Pause) (Paulsen & Serin, 2018). Regardless, it’s ideal to pay attention to your client’s feedback, and find a speed that can be both comfortable and effective.

The ‘rule of thumb’ number of saccades is simply a starting point, though, and it is always best to follow the client--if they seem to need more or less, then attune to that and adjust accordingly as the process unfolds. Some clients, for example, may only be ‘getting started’ at 25 saccades, depending on how long it takes them to access and deepen their contact with memory material, or how long it takes for highly charged emotional material to work its way through. There may be instances during the course of reprocessing when you will end a set of saccades and the client indicates, verbally or nonverbally, that they aren’t ‘done yet.’ You can check in about whether they would like you to continue the saccades.

With clients who are more apt to intellectualize or be ‘in their head’ (in a non-dissociative way), a longer, 25+ saccade set of fast *eye movements* tends to be better, as it is more likely to disrupt the client’s tendency to succumb to internal distraction and rumination and allow natural processing to occur.

Early in your training, you are learning to use EMDR therapy with clients with less complex issues. However, there is value in knowing, at this stage, that clients with more complex trauma *may* be able to cope better with a shorter number of saccades at a reduced speed--say, 6 to 10 slower passes at most--which can aid in controlling how much memory material comes through during each set, essentially reducing the possibility of ‘flooding’ or uncontrolled abreaction. With shorter, slower sets, reprocessing will occur more slowly, but it may be no less powerful. The greater the degree and complexity of wounding a client has experienced, the more likely you’ll need to slow and reduce the number of passes to avoid over-accessing or accessing too quickly.

So, standard saccades should be ‘fast, but not too fast,’ with a typical set of eye movements being just short of 20 seconds in length. With clients that are more apt to intellectualize or be ‘in their head,’ faster eye movements tend to be better, as they are more apt to disrupt the client’s internal distractedness. With more highly traumatized clients, slower eye movements may limit the possibility of ‘over-accessing.’ If you’re using taps or tones, the frequency should be as fast as the client can tolerate, with no ‘pauses’ between the felt/heard stimulus (Paulsen & Serin, 2018). Regardless, it’s ideal to pay attention to your client’s feedback, and find a speed that can be effective and comfortable.

What If Strong Emotion Surfaces--Should I Stop?

It depends. Ideally the client can keep "one foot in the here-and-now, and one foot in the memory" (Knipe, 2015, p.28) --maintaining the 'dual attention' needed for reprocessing (Shapiro, 2018, p. 357). If you ask the client how alert and present they are, and they appear present enough to acknowledge your question and indicate that they're 'still here'—without any signs that dissociation is at play--then it's best to continue, assuming the client says that's ok. This is what it looked like with example client Pablo:

T - "OK...And what are you noticing now?"
C - (fearful, eyes wide)"I want to escape! I can feel my knee being compressed!"

T - "You still with me? Does it feel like it's ok to keep going?"
C - "Yeah - I just feel like I want to get out of the car!"
T - "Just noticing that."

As long as the client can remain within their Window of Tolerance and maintain dual awareness, processing can proceed until the emotional charge reduces, just as it did in Pablo's reprocessing session after a number of additional sets of DAS. Sometimes, though, the client may need a bit of help.

Keeping Your Client in Their Window of Tolerance during Processing

If the client says they'd like to continue reprocessing, but they are 'skating' at the top edge of their Window of Tolerance, there are a number of ways you can help keep things moving along safely. Here are four strategies (in no particular order) that can be particularly helpful:

Option 1: Modify or change the form of DAS

- If you're using eye movements and the client is bothered by intrusive images, try shorter, faster passes in order to increase the client's level of distraction from them.

- If you're using taps or tones and the client experiences intrusive or overly-vivid imagery, trying transitioning to eye movements or else ask the client to keep their eyes open during the taps or tones.

- If you're using eye movements and the client begins crying heavily, but they are still consciously present with you, you can shift from eye movements to taps. (Ideally, you agreed upon this when you decided together, during Phase II: Preparation, which forms of DAS to use.)

For example, when Pablo became tearful a bit later on in the reprocessing the car accident, he struggled to keep his eyes open owing to a stronger flow of tears. The therapist might have offered the option of changing the form of DAS:

T - "OK...And what are you getting now?"
C - (crying heavily) "It's just--everything me and my family have been through the past two years."

T - "Pablo, it seems like it's hard for you to keep your eyes open right now. Does it feel like it's ok to continue? We can switch to taps instead of eye movements, if you like."

C - (still crying, but clearly present) “Yeah. Yeah, sure.”

T - “Where do you feel these feelings in your body?”
C - “In my chest and throat.”
T - “Just go with that.” (tapping on the backs of Pablo’s hands, palms facing down)

Elise went way outside her Window of Tolerance. This is an example of inadequate screening. When asked about what happened with the boyfriend, Elise tearfully admits that about 20% of the time she has amnesia for what she does when she is very angry. “I black out.”

The therapist went back and administered the MID and is shocked to discover a lot of amnesia, trance states, angry voices, dangerously toxic PTSD symptoms, abandonment and rejection issues and a diagnostic impression of “Dissociative Diagnosis Deferred.”

When asked about the angry voices, Elise admits that she hears them saying derogatory things about her, and at times hears arguing in her head. When asked about the trance symptoms, she says she feels zoned out a lot during the day and only remembers about half of what happens in her day-to-day life. When asked about amnesia for her childhood experience, she says her sister talks about good times at the grandparents’ house, but she doesn’t remember any of that and she has a gap of about 12 hours in the date rape memory. Also, sometimes she gets a feeling that something bad happened before she was adopted but she can’t put her finger on what it might be.

Option 2: Change the image/scene from color to black-and-white

By changing the image or scene to ‘black-and-white,’ it can seem (and feel) less immediate and real, and more tolerable to move through.

Option 3: Create distance between the client and the image/scene

If the client becomes overwhelmed because it’s as if they’re ‘in the room’ with the image or scene, suggest distance--you can say something like, “Imagine that you’re viewing the scene from a distance--as far back as you need to be for it to feel tolerable.”

Option 4: Shift attention from one channel of information (e.g., sight/images) to another (e.g., sensation)

This strategy is a bit of a ‘reroute’ from one track to another--the client is still ‘watching the movie,’ but maybe instead of watching the scariness of things, you invite the client to switch to notice only the sensation (or even just the muscle tension) that goes along with the scariness.

What if the Client Goes—and Stays—Outside Their Window of Tolerance?

If, when you ask the client whether they’re still ‘with’ you, they do not respond--or if you notice, in the course of a set of DAS, that the client seems to be frozen in terror, ‘zoned out,’ distant, or keeps going into a pronounced defensive response (suggesting they are re-experiencing the trauma), then pause reprocessing immediately. There are any number of reasons a client may cease to respond to you, and, in any such instance, it will be your responsibility to re-orient the

client to the 'here and now' and determine what needs to happen next. There are questions, though, that you can ask yourself in deciding how to move forward:

1. Is the client's 'outside the Window' response a one-time instance, or is it chronic?

   If it's very isolated, or it seems like a one-time only phenomenon, then it may be that the distancing maneuvers mentioned above could be enough to keep things moving. If it is chronic, then you must ask yourself the next question.

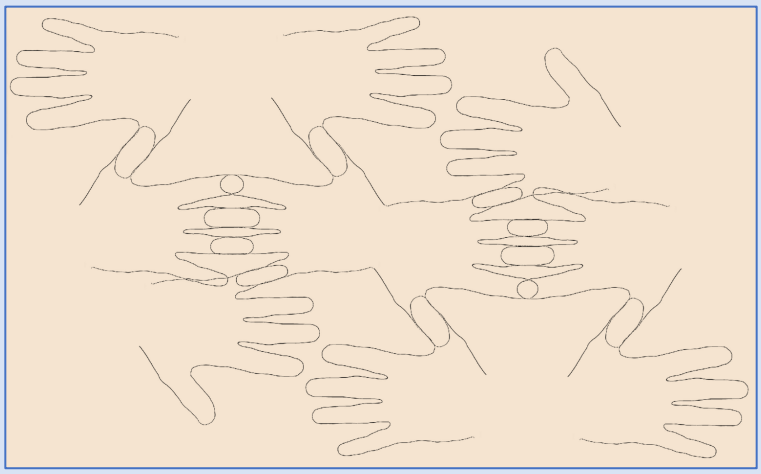
2. Did I (adequately) assess this person for dissociative features before proceeding to trauma accessing?

   Sometimes, we overlook something that's right under our nose, owing to our enthusiasm to help relieve a client's obvious pain. Sometimes, though, despite our best efforts to screen and assess, we see nothing--or not enough of something to raise a red flag upfront.

   Regardless, if the client demonstrates chronic difficulties with remaining within their Window of Tolerance, either during reprocessing or *after the session*, then you should most certainly take a step back from further reprocessing and work to understand with your client whether what you're seeing is simply the result of inadequate preparation, or else the result of previously undiagnosed dissociative symptoms.

One Hand? A Few Hands? Multiple Hands? It Matters.

In contrast to the single hand metaphor described above in reference to the channels of a target memory, the memory networks of clients presenting with complex trauma and dissociative features seem at times to lack linearity. Instead, the networks may be intricately interconnected and/or disconnected, overlapping, and sometimes involve layers or connections which are not apparent at first, almost like a house with many rooms, many floors, and even a number of sub-basements. This visual depicts what we imagine that might look like using the hand metaphor…



Because of this possibility, it is both very important to fully evaluate for pathological dissociation, in particular looking for the presence of protective self-states and amnesia, and ensure adequate Stabilization and Preparation prior to trauma accessing. The former prevents spontaneous accessing of an otherwise unknown or unappreciated labyrinth of "hands" which neither you nor your client may be prepared to handle. The latter increases the likelihood that you and your client will be able to limit spontaneous accessing, and handle any obstacles or surprises that do occur later in therapy.

When to Stay Out of the Way, and When to Intervene

As a general rule, it's best to 'stay out of the way' of the client's processing (Shapiro, 2018, p.122). The more you intervene in processing with talking between sets of DAS—a common inclination for those of us originally trained as talk-based therapists, to be sure!—the more likely the train will go off its natural course, or move in a direction that precludes adaptive resolution of the target memory. It can be so very tempting to shift into insight-oriented therapy between sets of DAS, but DON'T! It's a habit many therapists learning the basics of EMDR therapy have to work hard to break. Why are we stressing this? Because we've been there.

If the client's associations keep changing between sets, generally this is a sign that you can just let the train continue to move down the track until you reach a natural point of pause. The types of shifts and changes you might observe during reprocessing include:

- Body sensations – quality, location, and intensity
- Emotion - form and intensity (e.g., fear heightens, shifts to anger and then to calm)
- Picture/Image - form (i.e., a different image), size (e.g., bigger to smaller), vividness, disappears (i.e., the client can no longer bring it to mind)
- Sounds
- The memory unfolds sequentially, shifting/jumping from 'scene to scene,' etc.
- New memories surface
- Shifts in cognition, thoughts, and perception

Cognition, thought, and the quality of the client's perception often serve as indicators that emotional distress is subsiding and insight is deepening. In standard reprocessing, it is rather common to observe a shift, over the course of several sets of saccades, from predominantly negative associations to neutral/positive associations in relation to the target memory. For many clients, there's a point at which reprocessing seems to 'turn the corner,' when you can begin to sense the train moving more directly toward its final destination.

Intervening in Reprocessing

Although it is ideal when the train keeps moving along the track without the therapist jumping in during Phase IV: Desensitization, there are times when it is useful or necessary to intervene more directly. These instances can be categorized as follows:

Processing has naturally reached the end of a channel

Although in many instances during reprocessing the train just keeps moving down the track, shifting and changing from associative channel to associative channel—and even back to the target memory--without the therapist's prompting, in other instances the reprocessing simply reaches the end of a channel. You'll know processing has reached the end of a channel in an organic way when the client offers up *the same positive (or neutral) association after two successive sets of DAS*. When this happens, you'll return to the target memory. When this occurred in Pablo's reprocessing of the car accident, this is how it looked:

T - "OK...And what are you getting now?"
C – "Not much – things just seem kind of calm."
T - "Just notice that."

T - "OK...And what are you picking up on now?"

C - “Really, nothing. It’s the same.”

[RETURN TO TARGET]

When you return to target, one of two things most commonly happen. The client will check in with the memory and come up with more (disturbing) material, or they’ll register a SUD of 0 or 1. In the case of a SUD=1, there may still be a further channel that needs clearing out.

1) With additional disturbance surfacing:

T - “All right. So, if we return to the original memory—not just the worst part, but the whole memory in general—how disturbing does it feel in your body on a zero to ten scale now, where zero means it’s nothing or neutral, and ten feels like the most intense disturbance you can imagine?”
C - “Ah, it’s like a two now.”
T - “And where are you feeling that ‘two’ in your body?”
C - “My chest.”
T - “Just notice that.”

In this case, you’ll proceed with further sets of DAS until there is no more disturbance (SUD=0).

2) With no additional disturbance surfacing:

T - *“All right. So, if we return to the original memory—not just the worst part, but the whole memory in general—how disturbing does it feel in your body on a zero to ten scale, where zero means it’s nothing or neutral, and ten feels like the most intense disturbance you can imagine?*
C - “I’m not getting anything. That’s crazy.”
T - “Different, huh?”
C - “Yeah. Really different.”

At this point, it *appears* that Phase IV: Desensitization is complete, and reprocessing can proceed to Phase V: Installation.

‘Ecological’ Validity

Ecological validity is essentially the idea that the client’s experience of something seems appropriate given the current set of circumstances. The experience of grief is a good example.

One could think of ‘ecologically valid’ versus ‘excessive’ grief. In some situations with a grieving client, we may not see full adaptive resolution of a loss memory, where full resolution means SUD=0, VoC=7, and a clear body scan. Instead, we may see a significant ‘softening’ of the grief, which will continue to digest, on its own, in due time. Yes, there may be more work to do on a memory, but, in general, it’s wise to follow the client’s lead on whether they’ve gotten enough of what they needed from the reprocessing work.

The Therapist Says or Does Something to Impact Normal Processing

The therapist-client working relationship is a critical factor in successful reprocessing. Attunement counts for a lot, but it is of course challenging to be fully attuned to your client when

you've got your nose in a manual or worksheet, trying to make sure you remember all of this stuff in the midst of reprocessing a memory with a client!

Sometimes, we do or say things that do not mean to the client what they mean to us. It would be understandable, for example, for the therapist to want to reassure their client, or perhaps even show empathy with what their client is saying between sets of DAS.

However, the relationship between a client and their therapist remains a critical aspect of an *unfolding story*, even during trauma reprocessing. There may be aspects of the client's relational history that emerge unexpectedly in the course of reprocessing, such as:

- The client fears judgment if they express certain thoughts or feelings
- The client experiences expressions of care from others as wounding or insulting
- The client is highly attuned to facial expressions and gestures from others that suggest judgment or a need to be taken care of/protected
- An emergent fear of you, despite the client repeatedly insisting that they trust you

It may be that some of these sorts of 'tangles' will need to become reprocessing targets of their own, before it will be possible to reprocess other disturbing memories. Some of what arises may even be due to deeply embedded ego states that you've unknowingly 'woken up.' It might even be, if the client has an undiagnosed dissociative disorder, that you will encounter a dissociative 'switch' in the midst of trauma clearing. (The latter two possibilities, of course, invite you to pause trauma accessing, at least temporarily, to make certain you've truly got informed consent to continue reprocessing.)

And, as we noted earlier, it's best to *stay out of the way* of the natural course of reprocessing--the more the therapist contributes during or between sets of DAS, the less organic processing becomes. Sometimes, our commentary or 'additions' to reprocessing are more about our need than our client's need. At other times, though, we have no choice but to intervene in a more significant way.

Processing is Stalled or Blocked

There may be instances when you need to 'jump start' stalled or blocked processing by re-accessing disturbing sensations, either by bringing felt sense to bear upon the last association that surfaced or by returning to the target memory. For example, if the client (or the therapist) ends up talking quite a bit between sets of DAS, or if an environmental distraction interrupts processing, momentum can be lost. In such an instance, you can either redirect the client to their felt sense by asking, "And when you think about that [thing you're talking about], where do you feel it in your body?" then resume DAS once they have identified disturbance, or else return to the target memory and get things moving along again by asking about disturbance that surfaces when the client thinks about the memory, without assessing the SUD, then resume DAS.

There are a number of circumstances in which reprocessing may seem to become blocked:

SUD Does Not Change/Drop

The SUD is not changing, or it even increases from where you began and does not move naturally toward SUD=0.

A Thought, Sensation, etc., Does Not Move/Shift

Also known as 'looping,' this occurs when the client reports that same thought, sensation, or other piece of information stuck with them in two successive sets of DAS.

In either of these instances, you can first employ the following strategies:

Option 1: Modify or change the direction, speed, or type of DAS

- Change from lateral (side-to-side) to diagonal eye movements
- Change from faster to slower, or slower to faster, eye movements
- Widen or narrow the span of your hand movement during passes
- Shift from taps to eye movements, etc.

Sometimes, particularly with eye movements, it's almost as if the orienting response can become 'stale' with a lot of repetition. Changing the direction of the eye movements to a diagonal can have the effect of 'dislodging' stalled processing to get the train moving down the track again.

For clients who are apt to ruminate, using significantly faster eye movements can reduce the likelihood that they will get 'stuck' in their thoughts.

Option 2: Shift attention from one channel of information to another (e.g., image to sensation)

We can think of this intervention as a re-route to another sensory 'track' when something seems to be blocking the one we're currently on:

C - "I keep thinking about the look on the other driver's face."
T - "Where do you feel that in your body?"
C - "My stomach."
T - "Just notice that."

If the client is looping on a felt experience, it's best to re-route to a non-feeling channel of information. If the client is looping on a thought, then shift to a channel that has a sensory component.

Option 3: Return to the original target for new associations, SUD level, body sensations, etc.

Pablo was still stuck, even after making modifications to the eye movements and shifting attention to the body. Next, the therapist returns to target:

C - "I keep thinking about the look on the other driver's face."
T - "Where do you feel that in your body?"
C - "My stomach."
T - "Just notice that."

[BL-DAS] .....[then PAUSE]

T - "When we check back in with the original memory, how disturbing does it feel now on the 0 to 10 scale?"
C - "Hm, like a three."
T - "Where do you feel that in your body?"
C - "My stomach **and my hands**."
T - "Just notice that."

Only return to the target memory if there is enough time in session to continue to reprocess further material; otherwise, move toward Phase VII: Closure.

Option 4: Make a brief inquiry into the nature of the 'stuckness'
Here, you want to avoid getting into a long, drawn-out discussion, so check in *briefly* to see what's sitting out there on the track, keeping the train from moving along.

With Pablo, the therapist has already modified the eye movements, shifted channels from visual to somatic, and gone back to the target memory. No change. We'll pick up with Pablo's 'stuckness' following the previous set of DAS:

T - "OK...And how strong is that disturbance now?"
C - "Still a three."

Still not moving. Now, here is that brief inquiry:

T - "What keeps it from being a zero?"
C - "Guilt."
T - "Notice that."

If the SUD still doesn't move, even after a brief inquiry, you will need to determine whether there are **blocking beliefs** and/or **feeder memories** preventing movement.

Blocking Beliefs Are Present

This often occurs in the context of a SUD not resolving to '0' in Phase IV or the VOC not reaching '7' in Phase V. Shapiro (2018, p. 183) described this phenomenon, which one could think of as a more deeply embedded trauma memory preventing the resolution of the memory you're targeting. Picking up with Pablo from the last set of DAS, it might have looked like this:

T - "And what are you getting now?"
C - "Guilt. Like, serious guilt."

Here's another brief inquiry, but a little bit different this time:

> *T - "Are there words that go along with that guilt?"*
> C - **"It makes me feel like I somehow deserve this."**

This is a blocking belief, though perhaps it's worth tunneling down a bit more. ***Why*** does Pablo feel that way--what is the NC? The therapist then might ask:

> *T - Is there something about you that tells you that?*
> C - "It's all my fault."

Sometimes, just naming it may be enough to kick-start further processing. If you proceed and processing continues to 'loop,' then you can first attempt the strategies mentioned above for other kinds of stalled processing. If those interventions don't have an effect, and the SUD remains stuck, then you'll need to find out whether there is a ***feeder memory*** or a specific part of self that is associated with this blocking belief.

One hint that you *may* need to investigate the client's self-system for the source of the stuckness is a blocking belief that starts with *"I'm not allowed to…"* -- or something that implies this.

A Feeder Memory is Present

A feeder memory is essentially another, earlier disturbing memory that blocks processing of a disturbing memory of an experience from later in time. The feeder memory *may or may not be obviously connected* to the content of the memory you're in the midst of reprocessing, and it may not surface spontaneously in the natural course of reprocessing. A feeder memory may surface related to any of the elements of assessment: NC, picture, emotion and/or sensation. We just saw Pablo and his therapist stumble upon one:

> *T - "Are there words that go along with that guilt?"*
> C - **"It makes me feel like I somehow deserve this."**

The therapist then looked for a 'core' NC associated with that belief:

> *T - Is there something about you that tells you that?*
> C - "**It's all my fault.**"

The therapist then proceeded with standard interventions, but without any effect. That "It's all my fault" and those sensations in the stomach and hands persisted.

Now, using the NC, the therapist looks for a feeder memory via a form of **Floatback** (using a combination of emotion, body sensation, and cognition, but without an image):

> *T - "Can you notice that sensation in your stomach and hands, along with that sense of guilt, and let your awareness to take you back to the earliest time when you felt that it was all your fault?"*

[PAUSE FOR CLIENT TO BECOME AWARE]

C - (Looking a little distant) “Six years old. My grandmother’s house. I broke a dish. She was so angry with me.”

At this point, you can tap into this channel, from what appears to be an emotionally charged memory not directly related to the current target memory, to see if you can continue to reprocess the current memory, as Pablo’s therapist did:

T - “Where you do feel that in your body?”
C - “Just like earlier: My stomach and my hands.”
T - “Go with that.”

Sometimes, this small linkage to a previously dissociated channel of information will allow reprocessing to continue on the current memory. However, in other instances, you may continue to encounter blocking, which may lead to setting up a separate target for the feeder memory or NC and reprocessing that (along with any other memories that reinforce the NC) before returning to complete reprocessing of the original target memories. At other times, the feeder memory may not be readily apparent or available to the client--particularly if they have experienced complex relational wounding and have a more highly defended self-system.

Advanced Considerations

The Three Domains of Experience Always Matter

It’s important to remember that the flow of reprocessing generally moves in a particular order, from one domain of experience to the next:

Responsibility → Safety → Control/Choices

This order is pretty predictable. So, if we think back to Pablo’s original NC, it was “I’m not safe.” That’s in the realm of *Safety*. The blocking belief that surfaced was ‘It’s all my fault.’ That belief suggests a distorted sense of *Responsibility*. The idea of having choices or control is moot if one does not feel safe, and it’s really tough to feel a sense of safety if you’re vulnerable and all of the responsibility is on you--or worse, if one feels as though they are basically bad or defective and not deserving. Somehow, it seems as though a section of track from the car accident memory connected up with a section of track from the memory (or cluster of memories) that relates to the NC “It’s all my fault.” If those two pieces of track had not been connected up by the brain, then our processing on the car accident memory might just have continued moving on down the track, free of feeder memories.

Beyond EMDR Therapy: Intentionally Bridging to Implicit Memory to Aid Reprocessing

We’ve already described the Floatback technique and Affect Scan (Shapiro, 2018, p. 445) as means for identifying earlier memories, including the Touchstone Event. There are additional methods for connecting one section of track to another when you are working with fewer linkages.

Affect Bridge

Originally developed by John G. Watkins (1971) in the context of clinical hypnosis, it is essentially the same technique later described by Shapiro (1995) as the 'affect scan,' though it is unclear whether Shapiro 'borrowed' from Watkins or whether she 're-invented' it. However, the affect bridge differs from affect scan in two ways:

1) The intentional use of hypnotically-informed suggestion to heighten the targeted emotional state and separating it from all other aspects of memory prior to bridging back to another, earlier state when that same emotion was dysfunctionally-stored—with affect scan, the therapist is simply using whatever affect is presently available, without heightening it, and directing the client to "let" their mind to "scan back to an earlier time" (Shapiro, 2018, pp. 110-111), with the purpose of identifying memories to add to a targeting sequence.
2) The reduced involvement of the intellect when a person is in a heightened emotional state allows the client's mind to effortlessly lead them back to an earlier (or the earliest) time when they felt that emotion—with affect scan, there is no explicit discernment between the intellect taking an active or passive role in the process.

Somatic Bridge

The somatic bridge was developed by Helen H. Watkins (1992, p. 62) as a modification to the affect bridge, and focuses on a body sensation (e.g., an upset stomach, arm pain, etc.). The purpose of both the affect bridge and somatic bridge is to find a specific, earlier memory that, in terms of EMDR and AIP theory, might be blocking continued reprocessing and full, adaptive resolution of an old, painful memory.

Remember, though, that we are discussing advanced considerations here, which means we are also discussing advanced practice that is often more applicable to clients with much more complexity than a 'typical' client that you might be able to treat with what you're learning right now. However, where there is trauma, there is often trance. The more complex a client's trauma history, the more likely their treatment will benefit from understanding trance phenomena. And, the presence of trance, or trance-like perception—whether you or your client is aware that it's an active factor—brings us back to an important point: *Language, frame, and intention always matter, particularly when working with traumatized individuals.*

Interweaves: When the Train Has Ground to a Halt

Interweaves in EMDR therapy are brief statements or questions offered by you, the clinician, when the processing of a memory is blocked or stalled. The purpose of an interweave is to proactively provide a link to adaptive material, based on the block/stuck point in processing. It is a possible bridge to adaptive resolution of that channel or memory network. This is in contrast to most other times in EMDR therapy when the clinician is to stay "out of the way" and allow the Adaptive Information Processing system to work (See Shapiro, 2018, pp 256-282).

When to Interweave

Clients may need your intervention in the form of an interweave in the following situations:

1. To resolve 'looping' or kick-start blocked processing - when the client reports that the same thought, sensation, or other piece of information has stuck with them for at least two successive sets of DAS, or even after returning to Target.
2. Insufficient adaptive information is available - the stuck point reflects a gap in understanding or information needed to adaptively resolve the memory.

3. Lack of generalization of treatment effects - the specific target seems to be processing, but adaptive resolution does not generalize to related targets. *Example: "Well, I guess I know I'm safe now when I drive by that intersection, but…"*
4. Time pressures in the presence of an abreaction (for example, after having tapped into a major associative channel full of disturbance) or a complex target – during the last third of a one-hour session, interweaves may be offered to facilitate the closing of a channel or abreaction within the time available.

Types of Interweaves

Regardless of the type you use, a good interweave is:

- Brief – a question or statement, sometimes a brief client response, then "notice that."
- Fits, elicits, or is congruent with the client's known adaptive material and thinking style.
- Infrequent – clinicians new to EMDR are encouraged to use other methods first and to complete a few sessions and/or targets without offering an interweave in order to learn how that client processes naturally.
- Well-timed.

It takes time and practice to cultivate the skill of introducing interweaves in a way that propels, rather than intrudes upon, the organic flow of processing. The **cognitive interweave** is the most immediate, logic-based way of connecting the emotional right brain with adaptive information in the left brain.

Cognitive Interweave

The timing and sequencing of cognitive interweaves can be guided by keeping in mind the domains of Responsibility, Safety, and Choices. As described above, processing tends to flow in this order, and likewise interweaves in this order are often most effective.

Responsibility → Safety → Control/Choices

Examples:

1. Responsibility – *T: Whose responsibility was it, exactly?* C: Well, I guess they're the one who ran the stop-sign. *T: Notice that*...

2. Safety – T: *Remind me, how many times did you drive through that intersection – and how many times was there a collision?* C: Well, lots… and once… T: *Notice that…*

3. Choices – *T: What options did you have at the point you saw the oncoming vehicle?* C: Well, I could have turned to avoid them, but then the impact probably would have been on the passenger side where my daughter was… *T: Notice that…*

When connecting to adaptive information is not that simple, or perhaps adaptive material is lacking, the following interweave choices may be considered:

- New Information – brief psychoeducation related to the stuck point, for example if your client believes they should have been able to fight back when clearly their body was already in freeze/collapse.

- "I'm Confused" – bringing attention to an error in logic apparent in the stuck point, for example, your client seems to believe they caused a perpetrator to act, a drunk driver to drive, etc.

- Eliciting an adult/parent perspective – if your client has children, or knows children of the age that they were when the incident happened, offering a question such as "Would you blame your 6 year-old daughter if that happened to her?"

- Metaphor/Analogy – if your client has been generally observed to respond to the use of metaphor or analogy, offering a brief story or metaphor as an intervention can elicit an adaptive perspective and jump-start processing again.

- "Let's Pretend" – especially when a client is looping on something unsaid or undone in the incident, suggesting "Does it feel right to allow yourself to imagine saying those words?" or "What would you tell the perpetrator now if you had the chance?" If the client responds in agreement, then say "imagine that…"

- Socratic Method – this method offers questions to lead the client to a different or more adaptive conclusion based on information already known to you about the history of their family, the incident, etc. For example:

  C: I should have known better. It happened every time…
  T: You're saying you should have known to do something different?
  C: Yeah, clearly I knew that every time I talked back, what followed.
  T: What other options did you have?
  C: Well, none, because if I didn't, my younger sibling would get it worse…
  T: Notice that…

- Assimilation – When processing seems to have progressed well through the domain of responsibility, but seems to reach a plateau or become stuck on issues of Safety or Choice, a question to prompt orientation and assimilation may be helpful, such as "Are you safe now?" or more gently, "Are they hurting you in this present moment?"

Resource Interweaves

When additional resources have been identified and/or enhanced or installed in Preparation and Stabilization, these can be offered as potential adaptive links amid stuck or stalled processing. For example:

C: I was just so alone, I needed someone to be there to comfort me…
T: *Hmm, I wonder if one of your resource figures could fit... who could offer that comfort?*
C: Yeah, I can think of the dog I had in college, he always knew what I needed…
T: *Imagine that...*

Somatic Interweaves

When the looping or blocked processing is somatic in nature, interweaves focused on that aspect of experience may be effective. For example:

- Tension in legs: *T: What does it feel like the legs want to do?* C: They want to kick, run, get away! *T: Imagine that, whatever feels right…*

- Persistent sensation in throat: *T: If the sensation could speak, what would it say?* C: I'm not sure, but they would be angry words. *T: Notice that...*

Imaginal Interweaves

Similar to *Let's Pretend*, sometimes completion of an incomplete action, repair of a regret, or other imagined resolution is needed. An imaginal interweave can be suggested to allow a bridge to adaptive resolution, such as:

- C: I just wish I would have taken that conversation more seriously, knowing it might be our last… *T: Would it be okay to imagine doing what you wish could have happened?* C: Yeah, it's worth a shot… *T: Just imagine that...*

Ego State Interweaves

When you know the EMDR therapy process and your client well, any stuck point can be addressed with the offering of an interweave crafted to fit the gap you observe in processing. Ego State Therapy-informed applications of interweaves include:

- Orienting - aimed to orient the client to present time, and adaptive material in the present, such as "Does your whole person know that this incident is over, you're an adult now, and those words they told you did not come true?"

- Addressing internal conflict - when your client appears to be stuck due to conflicting beliefs or conflict between parts of self, such as: C: I know it's crazy and I didn't deserve it, but I just can't get over how everyone else thought she was such a model citizen. T: *Just let both of those be there, on one hand I know… on the other hand I can't…. (Shapiro, R., 2001/ 2005)*

"Hallmark" Red Flags in Phase IV: Desensitization

- Processing that looks very linear, like a movie of the event, with very little activation (despite perhaps a high initial SUD) and very little adaptive connection or generalization.

- The client abreacts in a way that they "go back there,"—they are re-experiencing the trauma as if it were happening in the present: They've lost their capacity for dual attention awareness and may be unable to 'hop back on the train' to notice from a distance.

- The client is on the train watching the scenery pass by, but they also seem kind of distant or 'gauzy,' suggesting that they've actually drifted into a trance and are no longer processing information.

- After reporting initial activation, your client then goes numb or blank, reporting little awareness of present activation or content related to the memory.

- The client stops and stares at you with confusion, anger, or fear.

Relationship Still Matters!

Clinicians new to EMDR often feel much like a robot that is reading a script and awkwardly waving their fingers. Believe it or not, establishment of a good therapeutic relationship still matters, and is a *necessary* support to the process of EMDR therapy (Shapiro, 2018, p. 72). As

you gain practice in the procedural steps of reprocessing a memory, you will find that less attention is required to follow the script/worksheet, and more attention will be available to attune to your client and offer a supportive (mostly) nonverbal presence during and between sets of DAS.

Remember the Phases and Prongs

While desensitization and reprocessing of past memories is a significant portion of the scope of EMDR therapy, completion of all 8 phases, and all 3 prongs (past, present and future) related to each target or issue is essential. Once the level of disturbance related to an incident drops, it is tempting for clients and clinicians to turn attention to other issues or incidents. However, completion of all 8 Phases in relation to a target memory is essential, similarly to how after initial cleaning of a wound, checking and changing the bandage until the wound is fully healed and no longer tender to the touch and redness has abated greatly increases the rate and stability of healing. *Don't worry, we'll be spending time learning about Future Prong soon!*

Phase V: Installation (of the Positive Cognition)

Overview

After the SUD=0 twice consecutively, the initial Positive Cognition (PC) is re-evaluated to see if it still fits for your client. Note that within the understanding of the AIP Model, the increased subjective Validity of the Positive Cognition (VoC) is not the result of correcting cognitive errors, but rather the organic, adaptive result of clearing/processing the previously maladaptively stored memory material. Sets of DAS are again administered while the client holds the Target/Incident in mind with the PC until the client reports the VoC=7 (completely true). With Pablo, Phase V started off like this:

T - "So, Pablo, let's go back to the original memory of the car accident. Just hold that in mind, along with those words, 'I'm safe now.' Do those words still feel like they fit, or is there another statement that feels like it fits better?"

The PC Still Fits

If the client's perception of themselves in relation to the memory still aligns with the original Positive Cognition, then proceed with re-evaluating the Validity of the Cognition (VoC):

T - 'So, holding in mind the memory of the car accident, how true does that belief, 'I'm safe now,' ***feel*** to you now, on a 1 to 7 scale, where 1 feels like it's not at all true, and 7 feels like it's totally true?'

Once the client reports a VoC, you can resume sets of DAS until the VoC=7 for two successive sets.

The PC No Longer Fits

Sometimes, with the reduction in disturbance that occurs during Phase IV: Desensitization, the client's perception shifts, and the original PC no longer fits--so a new PC is identified.
When the therapist asked Pablo to re-evaluate the Positive Cognition in terms of the target memory, Pablo could have said that it didn't feel that it quite fit anymore. Then, it would be a matter of helping Pablo find one that did fit. The client can review the list of Negative and Positive Cognitions (See Appendix D) for a PC that fits better.

Multiple PCs for the Same Target Memory

There are instances when the client may tell you that more than one PC fits. Pablo's situation is a good example, particularly when we take into account that feeder memory that came up relating to his grandmother and the broken dish. So, it could be that *both* 'I'm safe now' and 'I'm a good person' fit, in which case you can install each of them, in turn.

"Hallmark" Red Flags in Phase V: Installation

- All of the Red Flags from Phase IV, plus…
- Your client abreacts or offers overt resistance to the PC feeling true.
- Having the experience that internal (parts) or external (attachment figures and/or perpetrators) influences show up in your office to oppose the PC.
- After a session in which Installation was completed, your client reports significant emotional dysregulation, flashbacks, self-harm, substance use, etc.

Advanced Considerations

When targeting and reprocessing the earliest/first or worst memory in a lineage of related experiences, it is common for those related experiences to present or be presented by the client during Installation. In these cases, readjusting the scope of processing to the memory currently being targeted, and rechecking the VOC with the emphasis on certain words can clarify things:

> *"When you think of this incident we've been working on, how true do the words (PC) feel to you now...?"*

While completion of a standard 3-prong treatment plan does include generalization of the PC to all related past, present, and future experiences, many times multiple incidents must be targeted and reprocessed before generalization occurs.

Phase VI: Body Scan (to Identify/Process Latent Disturbance)

Overview

As a third and final 'quality control' step in reprocessing (after achieving SUD=0 and VOC=7), the client is asked to hold the Target/Incident and the PC together, mentally scan their body, and report where in their body they feel anything disturbing. If the client detects additional disturbance, further sets of DAS are employed until the disturbance has fully cleared and/or any positive associations stop changing.

The body is an often untapped/underutilized source of information in trauma therapy. Somatic information is just as valuable as emotional or cognitive information. The body often "holds" implicit memory. Also, attachment and preverbal trauma can show up as somatic symptoms.

Body Scan

The script for standard implementation of Body Scan is as follows:

> *"Now, hold in mind that memory of the car accident, along with those words, 'I'm safe now,' and scan your body, starting with the top of your head and scanning all the way down to the bottoms of your feet, and let me know where you feel anything."*

Body Scan serves as a final quality-control step of reprocessing, offering the client's brain and body an opportunity to present any latent disturbance or objection to letting go of the traumatic material. When in doubt as to whether a reported sensation is disturbing or not (e.g., tiredness), administer another set of DAS until the sensation dissipates, or is determined to be neutral or positive and stops changing.

Discussion of Example Client

Pablo still feels a little anxiety in his chest when he looks at the car accident scene. After a few more sets, the SUD is down to 1 on the 0 to 10 SUD scale. He says he is still thinking about the next time he drives past the accident site and has a tiny flutter in his stomach.

"Hallmark" Red Flags in Phase VI: Body Scan

- A surprisingly strong body sensation emerges.
- A new memory emerges when you administer another set of DAS to try to dissipate the sensation.
- A feeling of impending doom: Either that the memory will come back, or a sense that 'this is too good to be true.'
- A fear that, if the memory completely resolves, they'll 'forget' what happened and the same thing could happen in the future.
- A persisting disturbance (such as a headache) is not actually from the memory, but is instead a dissociated part of self that is attempting to communicate a concern through the body.

Advanced Considerations

D. Michael Coy, one of the developers of this training, uses specifically ego state-influenced language when working with his clients to complete the Body Scan. He describes it as looking for the "Three D's: Disturbances, Disagreements, and Deficits." In a manner of speaking, this way of thinking about Body Scan places it into a 'three-dimensional' context. So, an advanced application of Body Scan, employed when internal conflict and other signs of ego states/dissociation have been present, might look like this:

> *"Now, hold in mind that memory... along with those words [PC], and scan your body, starting with the top of your head and scanning all the way down to the bottoms of your feet, noticing <u>any signs of disturbance, disagreement, or anything that just feels 'missing.'</u>"*

This very much seems to open up the possibilities for what 'disturbance' could look like. Sometimes, the disturbance isn't explicitly felt in a bodily way, particularly if the felt sense of disturbance is held by another part of self not immediately connected to the body, or if processing is blocked by a conflict between two parts of self. If a conflict is present, then addressing it will much more likely allow any additional, as-yet-unprocessed, material to flow through. If that is the case, follow the procedures already described above until all disturbances have cleared.

Shapiro included sensory and somatic information as valuable aspects of the AIP. Imagery and sensations are frequently discussed in the eight phases as not only sources of distress but also

indicators of shifts occurring as memory reconsolidation takes effect. Using Floatback, clinicians are instructed to guide clients back using body sensation as the link between current and past experience for target selection. In this phase, Shapiro used the body to discover any remaining fragments of disturbance or associations, such as grief or anger, following the installation of the positive cognition. In a sense, this Phase seeks to align the mind and body so that the client can recall the target event and hold a positive belief and a clear (neutral or positive) body scan in the present moment.

Often, a more complex client has a conflicted or even non-existent relationship with the body. For these clients the body was the location of traumatic experience, where conflicting and confusing feelings occurred at the time(s) of harm, and the body remains a source of recurrent reminders of the events of the past. The possible presentations here are various and diverse – at times body parts may even house different parts of self. Somatization, derealization, and dysphoria can all be conceptualized as body-based experiences. For these clients, the body scan represents a challenge to find reliable information when the inner landscape can be feeling “fine” or “much better” in one area and at the same time hold vastly different pains and tensions that lead the clinician down several seemingly unending and multi-forked paths.

The body can provide 3 types of information: inner body sensation, movement impulses (tension is often a precursor to movement) and 5 sense perception. When using EMDR therapy with clients who have a conflicted relationship with their body, it can be helpful to check each of these aspects of bodily experience as it relates to the target event, especially when the client is triggered or averse to talking about the body or felt experience. If discussing the body is triggering, you might try referring to a specific region or part of the body, such as the shoulder or a leg, to determine if there is less disturbance. Or, invite the client to focus on the breath rather than an image while employing a few sets of DAS.

Phase VII: Closure (of a Session)

Overview

Closure processes are to be applied at the end of every session in which any Phase of EMDR therapy is applied, especially when traumatic and/or maladaptive material has been accessed. Containment and shifting to a positive or neutral affect state is facilitated, safety is assessed, and the client is instructed how to log and otherwise respond to any related material that comes up between sessions. Some debriefing of the session may occur, so long as traumatic material is not rehashed or re-accessed.

Steps to consider at the end of each session:

1. Give notice that session will end soon, at about 10 minutes prior to end of a one-hour session. Slow or stop access of or focus on traumatic or disturbing material.
2. Contain any traumatic or disturbing material the client wishes to set aside (example to follow).
3. Remind your client that the processing may continue after the session. Memory reprocessing is like a log jam. When EMDR removes the key log in the jam, the rest of the logs start to flow down the river. If other thoughts, memories, insights, or dreams come up, they may notice what’s happening, and keep a log (TICES below).
4. Offer options for relaxation, guided imagery, or accessing previously-enhanced resources (Calm/Safe Place, Lightstream, Emotional Shower).
5. Assess safety and orientation to present time/self before your client leaves session.

Closure

Implementation of Closure or Phase VII procedures starting in the initial session, and continuing through History Taking and Preparation, helps to set the precedent for a predictable pattern of accessing (traumatic, disturbing and/or maladaptive material) and re-regulating long before Desensitization / Phase IV is reached. EMDR therapy can be intense, and clients are often tired after session. However, in contrast to some models of trauma resolution, homework involving focus on traumatic material is not part of an EMDR treatment plan. Most clients who meet readiness criteria for standard EMDR therapy protocols and procedures find that any tiredness or roughness after session subsides after a nap or a good night's sleep, so long as Closure is practiced and implemented well.

Containerization

Containerization, or containment, is practiced in many models of therapy, and thus not scripted as such within EMDR procedures. The steps described here are comprehensively reviewed in an article by Katy Murray (2011) in the *Journal of EMDR Practice and Research*.

1) Describe to the client the reasons for using and functions of a container using language and metaphors that are helpful to the client and relate it to specific instances when it might be a useful resource. A couple of examples:

   "Sometimes therapy is like a home-improvement project, where we need to take out supplies, make a mess, and pick up or clean up several times before the project is done to allow normal life to proceed in the meantime." or…

   "Sometimes, therapy is rather like cooking or baking. We take out all of our supplies, use them to create something new, and set them back aside when we're finished. Everything goes back where we found it, until we need them again."

2) Create the container through language (eyes open or closed):

   "Imagine a container that would be strong, secure, and leak-proof. Although it may look small on the outside, it can be infinitely large on the inside, so that it can hold all of what you need to set aside into it. It may have a lid, and it may lock, to hold everything securely inside between sessions. It may be that a container has already come to mind. If not, just take a few moments to imagine one . . . What comes to mind?"

3) Enhance the experience of the container:

   "Just hold in mind the image of your container. If it feels comfortable, you might close your eyes to allow your container to feel more solid . . . You might notice its details coming into greater focus, and perhaps you're beginning to anticipate setting things aside into the container. Got it?"

4) Invite the client to set aside distressing material into the container using imagery.

   "Now, I'd like to invite you to set aside any disturbing thoughts, memories, body sensations, or pictures, easily and effortlessly, into your container."

5) Debrief and plan for use of the container in daily life for triggering situations, nightmares etc.

Some clients and clinicians prefer to add deliberate breathing to the containment exercise in a sequence such as this:

1. Inhale, notice whatever troubling material remains…
2. Exhale, allow that material to go into the container...

Be sure to honor the container. If you utilize containment at the end of session, prompt the client to remove material from the container as necessary for the focus of the next session. Containment is also viewed as a Phase II / Preparation strategy because it facilitates a helpful state change when utilized successfully.

Closure of an Incomplete Session

At about 15 minutes prior to the end of a session (amid Desensitization), look for signals that your client is at the end of a channel - for example, a lessening in disturbance, no change, and/or adaptive or generalizing associations. When these signs are present, or about 10 minutes prior to the end of session, you might say:

T - We will do one more set before we close for today, just notice that…
C - Okay.

T - What do you notice?
C - Not much, I'm just feeling tired.

T - That was some good work today! So, remember, you only need to take with you what you want to take with you from our work today. Everything that is unresolved or that you want to set aside can stay in your container until we choose to return to anything that is still important. Do you recall your container?
C - Yeah, the trunk, on the continental shelf. The divers are ready to take stuff down there.

T - Great! So just notice any bits from today or related memories that you want to set aside… breathing in and noticing, exhale and let them make their way into the trunk… inhale notice any pictures, thoughts, emotions, body sensations that are left… exhale let them go into the trunk… Keep doing that until everything you want to leave is in there.
C - Okay, I think it's all in there.

T - Good. And the trunk is where you want it to stay until we return to process anything that is still important?
C - (nods)

T - Okay, so would you like to visit your "Breeze" resource (Calm/Safe Place) or the light shower before you go today?
C - I think I'll visit the "Breeze."

T - Sounds good. Take a moment, notice the place and everything that goes with "Breeze."
C - (visibly relaxes, then stretches)

T - You're able to get there?
C - Mm hmm. (smiles, opens eyes, stretches feet)

T - Good. So, if anything comes up related to this memory or any other potential EMDR targets, dreams, insights, etc, note them as we discussed, and use your container and resources if you need them.
C - Okay. I think I'll be good.

T - (smiles) So, our next session is ___. What do you have planned for this evening?
(orienting client to present, monitoring to make sure they appear alert, oriented, and aware of themselves and their environment, as well as stable when standing/walking).

Closure still applies for sessions in which a target has been completed through Phase VI: Body Scan. While your client may appear and feel much more regulated compared to other times, containment of any related material and shifting attention to Calm/Safe Place or another resource is still recommended.

Safety Assessment

After containment and shifting state and attention, it is important to assess whether your client is oriented to present time/self, feels a sense of adult-ness, and able to drive or otherwise go about their day. If they show any signs of confusion, are wobbly upon standing, or spontaneously abreact, take steps to establish safety. These can include offering a drink of water, guiding your client with orienting and grounding strategies such as pressing the balls of their feet into the floor, or suggesting they wait in the lobby until they feel safe to drive or call a ride. Also, remind your client of how to reach you between sessions. If indicated, consider scheduling a time to check in briefly via phone the next day, or an additional session. Your clinical judgment and knowledge of your client are key in discerning what is needed.

TICES Log

TICES stands for **T**rigger - **I**mage - **C**ognition - **E**motion - **S**ensation/SUD. A worksheet version of this log is available in Appendix C (Adapted from Shapiro, 2018, p 441-442). Standard use of this tool includes sharing a paper copy of the log with clients who have begun EMDR therapy, and instructing them to log anything disturbing that arises by completing as many categories as possible on the log. Most clients do not complete all fields for each experience - that is okay. After noting the experience, clients are encouraged to use their container, Calm/Safe Place, and other self-regulating strategies.

Why use the TICES Log? Often, this tool gives clients a way to notice and respond to disturbances in session, and a strategy to contain and re-regulate afterward. TICES Log notations can be used as early as Phase I / History Taking to guide the client to note and report information that could aid in treatment planning based on present symptoms. It can also capture information reflecting related events or changes in content and quality of classic PTSD symptoms such as flashbacks and nightmares.

Vertical Eye Movements

Shapiro (2018) included vertical eye movements (VEMs) as an option to assist closure of an incomplete session, and purports that they seem to have a calming effect. She suggests pairing VEMs with prompts to use a container, and "put it away for now" (p 253).

As noted above, some researchers have observed that VEMs reduce the vividness of memories, although presumably without promoting activation of inter-hemispheric communication (Hornsveld et al., 2011; Menon & Jayan, 2010). Others observe that VEMs may

tax working memory and reduce the emotionality of memories as effectively as horizontal eye movements (Gunter & Bodner, 2008; Hornsveld et al., 2011; Landin-Romero, Moreno-Alcazar, Pagani, & Amann, 2018).

For these reasons, we suggest that VEMs may be used as a transitional "downshift" from horizontal eye movements at the end of an incomplete reprocessing session, followed by other closure strategies.

"Hallmark" Red Flags in Phase VII: Closure

- The client doesn't know if they will be able to cope with the new information that came to light in the session.
- The client can't get grounded in the present – they feel childlike or stuck in the trauma.
- The client experiences a spontaneous abreaction at the end of session –*might there be attachment dynamics, such as separation anxiety, that got activated?*
- Containment didn't work, either because the client imagined placing a part or an emotion—*rather than material that makes emotions happen*—in their container.
- The client has trouble setting aside material in the container, saying "it won't go." Or, the client reports that they need to keep the memory close to them, or that they are 'not allowed to' or 'not supposed to' set something aside.

Advanced Considerations

Safety First, Safety Last

Reliable, predictable, and adequate Closure is essential to safe and effective EMDR therapy. To support ego-strengthening, a rule of thumb is that the client should do as much as they are able to at a given time. For example, if you have practiced Containment with them multiple times with success, and they appear to be in their Window at the end of session, a simple prompt such as *"Let's take a moment for you to set aside anything you would like to leave behind in your container... let me know when you're done, or if you need help...."* may be sufficient. At other times, and when the client is less practiced at Containment and/or less regulated, more intervention may be necessary.

As you learn the process of EMDR therapy, and learn the patterns of your clients, you will come to recognize more immediately when they are hyper- or hypo-aroused, what methods are most effective for them, and how much involvement is required by you to support the Closure process. Many clients benefit from multiple steps of closure at the end of session, for example:

1) Container
2) Brief attention to Calm/Safe Place or another resource-oriented memory
3) Orienting to present and safety assessment
4) Closing the Meeting Place and ensuring all parts are where they need to be prior to the end of the session

Orienting to the present moment in this context could look like, 1) asking a question about their plans for the day/week, 2) confirming the date/time of the next session, 3) reminding of the TICES log, or 4) having them check to make sure they have all belongings before leaving your office. If your client appears to struggle with directing their focus and attention to any of these items, further safety assessment and Closure strategies may be needed before they can safely travel/drive to their next destination.

Here, There, or Everywhere: Is Your Client Truly Present at Closure?

It is very easy for a client to 'seem' present—you've likely seen it at the end of sessions already: 'Yeah, I'll be fine'—but are they, really? Although considerations relevant to a client being not-fully-present at the close of a session are highlighted above and by Shapiro (2018, p. 318), when there is a concern about a client's ability to achieve and maintain closure, additional measures may be taken to ensure real safety post-session. As we noted above, some form of trance tends to manifest during heightened emotional experience. Since we are working with clients to resolve traumatic memories, it makes sense that we might want to have a way of checking our client's level of alertness against some kind of objective measure.

The Howard Alertness Scale

Hedy Howard (2008) developed this scale to ensure that clients were fully alert, aware, and present in their self and in the room following a session in which the client experienced trance. The scripted procedure below is adapted from Howard (2017):

Howard Alertness Scale

Pre-Intervention
Let's check in with how alert, aware, and present you are now. We'll be measuring your alertness on a 1 to 10 scale: 1 represents a very low level of alertness, and 10 represents a very high level of alertness. I'd like to ask you to pay attention to your five senses and how you're thinking.

Take a moment now to notice how awake and alert you feel at this time. Gather information from all your senses:

- *Look around you and notice the various things that you see, including their clarity and colors*
- *Notice the sounds around you and the quality of whatever you hear*
- *Notice the feelings in your body, including the feeling of the chair against your body and the feeling of your feet against the floor*
- *Notice how connected you feel to your body and how aware you are of your surroundings. Notice how present you feel in this time and place*
- *Notice how clearly and logically you are thinking, and how your mind moves from thought to thought as you focus on different things around you*

  On a scale from 1 to 10, where 1 is very low, 5–6 is medium, and 10 is very high, what number best describes how alert you feel right now?

Post-Intervention
Checking back in with your five senses and the quality of your thinking (be explicit about each dimension of experience, as above, if needed), how alert, aware, and present are you feeling now on a 1 to 10 scale, where 1 means a very low level of alertness, and 10 means a very high level of alertness?

If your client is not at least as alert as they were at the start of the session, then it's extremely important to spend more time working with your client to assist them in re-alerting to their 'baseline' level before they leave your office.

Phase VIII: Reevaluation and the Three Temporal Prongs

Overview

Reevaluation applies to the beginning of every session subsequent to the initial intake session in order to assess the effect of the prior session, whether that be history taking in Phase I (e.g., Did the client become destabilized after the session by talking about their trauma history?), or preparation exercises in Phase II (e.g., Did the client have any trouble implementing installed resources? Why so?). Based upon reevaluation of the previous session, there could be a need to change the treatment plan.

Reevaluation also applies when the prior session involved application of Desensitization, Installation, and/or Body Scan. In addition to reevaluating the target memory (steps to follow), this phase includes inquiring and tending to any new insights, memories, dreams, or other apparent results of the processing that occurred in the previous session. This attunement is necessary to identify needs, and to identify signs of adaptive resolution and/or remaining maladaptive or unprocessed material.

If the TICES log has been completed by the client, you may review that together to identify any changes, any related events or issues that have been identified, or other information that may inform the current three-prong treatment plan.

Questions to ask or consider with your client in Reevaluation after a session in which a Past target was incomplete may include:

- Was the Closure of the previous session effective?
- How long did it take for any fatigue or continued processing to resolve/settle after the last session?
- What was their experience after the last session?
    - Are there any signs of reduction in symptoms or related material?
    - Are there any signs of decreased functioning or increased symptoms? If so, does this reflect need for a change in focus or pace of therapy?

If the previous session involved completion of a Past target through Phase VI/Body Scan, questions to ask or consider include:

- Has the individual target been resolved?
- Have any associated events or associated material been activated? How does this need to be addressed?
- Have symptoms and issues directly related to the incident resolved?

If the previous session involved completion of Present or Future prong, questions to ask or consider include:

- Have symptoms and issues related to the incidents/treatment plan resolved?
- Has the client encountered previously disturbing/triggering stimuli without activation?
- Have all the necessary targets been reprocessed?
- Does the client feel empowered and able to employ all known skills, knowledge, and abilities in the present?

- Does the client have an optimistic (within what is realistic) view of their future as it relates to the just-completed treatment plan?
- Are changes evident in the client's social and relational functioning?

Reevaluation (of the previous session's Target)

Procedurally, Reevaluation involves checking the work of the previous session, and hopping back on the train to complete the journey.

Reevaluation Following an Incomplete Target

Steps to Reevaluate (and resume processing) after the previous session ended with an incomplete target:

The next EMDR therapy session begins with reevaluation of the Target that had been worked on in the previous session.

1. **Check the Target:** *"When you turn your attention back to the incident/experience we worked on last session, what do you notice now?"*

2. **Check the SUD:** *"On a scale of 0-10, where 0 is no disturbance or neutral and 10 is the highest or most intense you can imagine, how disturbing does it feel to you now?"*

   → If they report '0,' return to Desensitization with the direction: *"Notice the original incident/experience, and notice feeling neutral"* and begin sets of BL/DAS. A few more sets will likely bring forward additional channels of unprocessed material if they remain.

   → If they report disturbance return to Desensitization by then asking: *"Where do you notice that disturbance in your body?"* With that information direct them with, *"Turn your attention back to the incident/experience, notice feeling* (repeat sensation and location(s) they identified in their body), *and follow my fingers."* Begin sets of BL/DAS.

Reevaluation Following a Completed Target

Steps to Reevaluate after the previous session ended with a completed target (0 SUD, VOC of 7 and clear Body Scan):

1. **Check the Target:** *"When you turn your attention back to the incident/experience we worked on last session, what do you notice now?"*

2. **Check the SUD:** *"On a scale of 0-10, where 0 is no disturbance or neutral and 10 is the highest or most intense you can imagine, how disturbing does it feel to you now?"*

   → If the SUD is greater than 0 return to Desensitization.

   → If the SUD is 0, check the VOC. "*When you think of the incident, how do the words "I'm safe now" feel to you now, on a scale from 1 to 7, where 1 feels completely false and 7 feels completely true?"*

   → If the VOC is less than 7, return to Phase VI: Installation.

→ If the VOC is 7, check Body Scan: "*Hold in mind that incident, along with those words, (state PC), and scan your body, starting with the top of your head and scanning all the way down to the bottoms of your feet… what do you notice?*"

→ If any possible disturbance arises, introduce sets of DAS, returning to Phase IV: Desensitization and/or Phase V: Installation, as needed.
→ If only positive or neutral sensations are present, and no other signs of unprocessed material related to this target are evident, proceed to the next incident or prong identified on the client's treatment plan.

In summary, Reevaluation involves checking the SUD, VOC (if SUD=0), and Body Scan (if SUD=0 and VOC=7) at least one session after processing of the selected Target was originally completed ensures that the work has remained stable and no occluded information has presented itself.

Discussion of Example Client

Pablo's last session was complete through the body scan. His week was not bad but he did have some anxiety driving past the accident scene and loud noises continue to startle him. When asked to look at the target again, his SUD is 4/10 and he feels the anxiety in his chest.

"Hallmark" Red Flags in EMDR therapy: Phase VIII: Reevaluation

- If the SUD repeatedly rebounds upon Reevaluation - for example, last SUD of previous session was a 1, the client reports a SUD of 7 upon Reevaluation with no clear explanation as to why the SUD has (re)elevated to that degree.
    - This may be evidence of feeder memories, secondary gain, and/or ego states blocking access/resolution.
- If the client presents resistance to returning to reprocessing after seeming to progress normally through the processing of the previous session, without clear explanation. This may indicate there is more going on beneath the surface than you (or the client) are aware.
- If the client reports difficulty staying in their WoT after session due to fatigue, depression, derealization, etc., attributed to the past session. This may indicate the need for a slower pace, more resourcing, more attention to Closure, possible feeder memories, among other considerations.

Advanced Considerations

As you learn the process of EMDR therapy in general, you will discern more quickly with each client when it is working, when to adjust course, when to slow down, etc.

- Intrusions come up (flashbacks, images, thoughts) of a different memory between sessions - consider whether the client can contain the new memory and resume processing of the current target. If the intrusions point to an earlier memory, they may indicate a feeder memory which needs to be targeted and reprocessed before returning to the current target.
- Significant reactivity, emotionality, or "discombobulation" after a reprocessing session, especially if it persists into the next day: consider slowing down. Possible adjustments could include restricted processing (EMD or EMDr), reducing the amount of time focused

on Desensitization in session while increasing the time allowed for Closure, and increasing the time between reprocessing sessions.

- Post-reprocessing symptoms (headaches, nightmares, body memories): consider reevaluation of dissociative features and symptoms, and inquiring into your client's subjective experience of these symptoms. Do they, for example, feel as though one element in a mobile has been pulled, which set off a sequence of unanticipated and intolerable motion? Headaches and nightmares in this context can indicate internal conflict or backlash – for instance, an internalized likeness of the perpetrator punishing the part of self that held the trauma for seeking help or standing up for themselves. This 'backlash from within' may indicate that additional focus on dissociative processes and relationship among parts of self may be needed to support reprocessing of the current target memory.
- Possible looping (revisiting the same material repeatedly): consider whether reprocessing is re-addressing the same material at different levels (e.g., responsibility/worth, safety, control/choices), and/or whether the client seems to be gaining perspective (increasingly adult or objective perspective on a childhood memory). In this case, the 'Lighthouse metaphor' (Danylchuk & Connors, 2016) may be helpful – as the light (attention during processing) rotates, different aspects of the scenery may be noticed in different ways at each rotation. This is distinct from looping, which would imply that no change in perspective was occurring.

3 Temporal Prongs

Conceptualizing Points of Entry for Treatment

Just as human experience spans the past, present and future (at minimum, depending on your beliefs in metaphysical and spiritual realities), so also the EMDR therapy process involves attention to past, present, and future. Encoding of memory - recording of our experience - relies on processes of association, assimilation, and accommodation. Referring to the AIP Model, early/past experience that is unprocessed, or processed in a way that is not adaptive beyond the time and place of that experience, is seen as the foundation from which present symptoms and patterns emerge. Many clients and clinicians find that therapies which focus on only the present symptoms, behaviors, or cognitions fail to provide lasting results; conversely, some find that therapies which focus predominantly on the past may not necessarily equip clients to move forward into the future. So, too, with EMDR therapy, attention to past, present, and future is considered essential to a complete course of treatment.

Past (employs Standard 8-Phase Protocol)

EMDR therapy in its standard form can be used to desensitize and reprocess any experience for which the client has an ability to access - the image or picture can be real or imagined. Past memories to target and reprocess are identified according to client history and symptoms. Selection and sequencing of Past memories for reprocessing will be discussed in detail later on in the training.

Present (employs Standard 8-Phase Protocol)

After all Past related events have been targeted and reprocessed - or deemed no longer disturbing - related present experiences are evaluated and targeted if any disturbance remains. By the time reprocessing of the Past prong has been completed, these experiences may be deemed "recent." Examples of Present/recent related events include: previous nightmares related to the past experience, previously identified situations or triggers which elicited hyperarousal, startle response, or other presentations maladaptive in the present environment.

Future (employs 'Future Template' unless Standard 8-Phase Protocol is needed)

After all Past and Present/recent events have been targeted and reprocessed, or deemed no longer relevant or disturbing, attention is turned to the future. Here, anticipated or imagined future experiences which may have previously been disturbing or activating to the client are identified. Any that remain disturbing are targeted and reprocessed using the standard method.

Sometimes clinicians and clients wonder, “How can you target something that hasn't happened yet?” The thing is, if you have imagined or worried about something, your brain has a memory network for that imagined experience; thus, targeting that imagined future experience allows any maladaptive forecasting to be resolved in the same way foundational memories were resolved, and allows adaptive information from reprocessing and Installation within Past and Present prongs to be woven into the framework for future experience.

Once all identified future experiences related to the current treatment plan have been targeted and reprocessed (or deemed no longer disturbing), a ‘Future Template’ is employed. Future Template involves identifying how the client wants to see themselves, act, respond, feel, and think in the imagined future scenario.

Scripts for this procedure will be provided in practicum, and additional options can be found in Marilyn Luber’s *Scripted Protocols* (2009).

State Change vs. Trait Change

Many types of change can and do occur within therapy. All 3 prongs are primarily geared toward facilitation of ‘State Change,’ that is, changing the client’s emotional, physical, and cognitive state around an incident, issue, or pattern. This change in state *allows* for the client to more easily access their full array of adaptive memory networks to apply and build upon what they already know. For example, a client who already knows how to drive, has knowledge of the information covered in an exam, or understands how to set healthy boundaries in their relationship will likely, after reprocessing of related memories, be able to function in those areas with much greater ease than before. Similarly, a client who has completed years of psychotherapy focused on practicing coping skills may find that they automatically implement these skills without the deliberate effort that was required prior to EMDR therapy.

When dysfunctional traits (also behavior patterns, beliefs) are manifestations of unprocessed or maladaptively stored memories, ‘Trait Change’ may also occur. This realization coupled with the tenets of the AIP Model has led to the application of the EMDR therapy to a variety of mental health pathology (addiction, anxiety, and schizophrenia, to name a few). However, if a client lacks the skills necessary to drive well, the academic knowledge and skills covered in the exam, or how to set boundaries, they will still need to gain those skills and knowledge. Nevertheless, resolving the related disturbance may allow them to learn and implement learning much more quickly than they could before. Similarly, a client who has a strong personality trait of introversion may find relief from symptoms of social anxiety as a result of reprocessing the underlying/contributing experiences, and may still prefer solitude or socialization in small groups.

3 Domains/Dimensions of Experience

As you may have noticed, the Negative and Positive Cognitions (See Appendix D or Shapiro, 2018, p 443) are organized into three categories:

1. Responsibility: to include themes of defectiveness, worth, shame, and action/guilt.
2. Safety: to include themes of vulnerability and trust.
3. Control/Choices: to include themes of power, choice, and trusting oneself.

Francine Shapiro and others have found that often, “processing these three concerns, generally in this order, is an integral part of successful treatment” (Shapiro, 2018, p 259). These dimensions of cognitive and emotional experience can be helpful to keep in mind during multiple Phases of EMDR therapy:

Phase I: History Taking

Presenting issues may lean toward one or more dimensions, which can be helpful in organizing traumatic experiences, mining for potential adaptive information, and choosing a treatment plan.

Phase II: Preparation

Guiding selection of additional resources to install (i.e. where to build and strengthen adaptive information to support current functioning and trauma resolution).

Phase III: Assessment

Selection of target, and selection NC/PC based on information from prior phases. When it fits with the client’s experience, and they are wavering between a NC related to responsibility and another NC, selection of a NC within the domain of Responsibility is likely to support most effective and efficient reprocessing.

Phases IV-VI: Desensitization, Installation, and Body Scan

Identifying shifts from maladaptive to adaptive, when a new channel has opened in processing, and appropriate cognitive interweaves. Utilizing cognitive interweaves in this order (responsibility, safety, control/choices) can accelerate resolution of target memories, particularly early trauma which tends to produce cognitive and emotional maladaptations related to appropriate responsibility and self-blame (Shapiro, 2018, p. 260).

Phase VIII: Re-evaluation

Evaluating shifts in previous cognitive and emotional patterns in Present and Future prongs.

An EMDR Therapy 'First Aid' Kit: What to Do When Things Go Too Deeply Too Quickly

EMDR therapy is a powerful clinical modality (or tool, depending on how you are using it). If you discover that using this "power tool" has led to processing going too deeply too quickly, bringing up more than the client can handle, and catapulting them outside their WoT, here are a few concepts that may serve as coordinates to guide you in helping your client back to a present, oriented, grounded state.

First, a few quotes from giants in the field of treating complex trauma and dissociative disorders:

> *"The slower you go, the faster you get there"* (Kluft, 1993).
>
> *"Don't just do anything, stay/be there"* (Steele, Boon, & Van der Hart, 2017).

These words speak to the paradox reflected in how processing small bits of trauma slowly can be more stabilizing overall than taking on a seemingly larger piece of therapeutic work, and how our most accessible and reliable tool in the therapy room is ourselves –assuming our capacity to self-regulate and be there with the client in the midst of whatever happens. Further and more advanced training is highly recommended if you find the need for these approaches is a common occurrence among your clientele.

Stabilizing (Orienting, Containment, Grounding)

As outlined above, standard grounding methods may need to be adjusted to support the client if they have already exceeded their Window of Tolerance. Familiarizing yourself (and your client) with several strategies early in therapy is recommended so that effective orienting and containment tools are readily accessible.

Due to the phenomenological nature of many symptoms experienced by clients presenting with complex trauma and dissociative disorders, it is essential to attend to both general/external and internal activation and stabilization – and sometimes necessary to distinguish between them. For example, if your client is experiencing intense internal conflict between parts of self, naming 5 blue things they can see will at best provide a brief distraction.

Step one, when at all possible, is to ask your client if they know about what is happening, and what they need in this moment. Step back from the trauma by making it clear that you will not be doing another set of DAS right now and tune in to your client.

To slow down or distance from continued processing or visual activation:

- Use vertical EMs, slowly, perhaps synced with inhale/exhale of breath (Shapiro, 2018, p 253)
- Invite the client to make the image black and white
- Pull the shade on the window of the train down until activation decreases
- Project the scene on a screen, and 'zoom out' or adjust the volume, etc., as needed.

Notably, the latter three of the above interventions were borrowed from the hypnosis tradition.

When the "too much" is predominantly physiological hyper- or hypo-arousal, these strategies may be helpful:

- Cycle through the Four Elements stages until the client can access a positive visualization or resource
- Offer a mint/hard candy and/or drink of water (unless these are known to be aversive or triggering)
- Invite the client to notice their breathing, and or a less-activated area of their body (earlobe, or pinky-toe for example)
- Offer an orienting smell or sensation (cold, mint, etc.—but make certain to pre-arrange with your client the scent you plan to use!)

To decrease internal conflict, these phrases may be helpful:

- "Is it okay to allow both of those thoughts/parts/feelings/sensations to be there right now?"
- "Hmm, I could imagine there is a good reason this is happening...I wonder what, if anything, you pick up on from inside?"
- For more complicated conflict resolution techniques, refer to approaches used in earlier sessions, such as Fraser's Dissociative Table technique.

If the client does not appear to be oriented to present/adult self, these phrases may be helpful:

- "I'm just wondering, does all of you know that it's the year 2020, your name is ___, you are ___ years old? What's my name? and we're in my office in _____ (city, state, country)? Does all of you know that ____ isn't here right now? (or is dead, in prison, etc)"
    - Having a current, common magazine or other publication with the month/year in larger type can be very helpful with this
    - Asking a more oriented part of self to project adaptive information onto a screen in the 'meeting place' for disoriented/confused parts to see inside can be effective. *An example of 'adaptive information' here could be images/scenes from an alleged perpetrator's funeral/burial to show that they have died and are no longer a threat.*
- "For a moment, just look out through your eyes at your hands/hair/wrist (bangles, etc.) /backpack/watch (or other identifying and potentially orienting item). Whose is that? How do you know?"
    - EMDR therapist Deborah Wesselmann came up with the idea of using a pair of baby shoes to help orient younger parts of self to the present, adult body by comparing the baby shoes to the size of the adult feet.
    - Although asking a part of self to look at themselves in a mirror can be helpful, it's best to ask first whether they feel comfortable doing that. Reasons for asking that have come up for therapists in the past include an instance when a client was abused while looking in a mirror at themselves (resulting in a phobia of mirrors) and another in which the client learned, growing up, that looking in mirrors was vain, and thus sinful, and so avoided mirrors to avoid 'punishment from God.'
    - Asking a part of self to notice the length of their hair, particularly if that part perceives itself to have shorter or longer hair than the current, adult body has.
    - Orienting parts of self using present-day technology can be helpful, but may also not provide a concrete enough frame of reference for that part of self to have the desired effect.
    - Parts that are patterned after perpetrators (variously known as 'introjects,' 'protector parts,' 'exiles,' etc.) often have a particularly strong reaction to being oriented; thus, the therapist should be prepared for strong emotions and utter disbelief/denial—the more dissociative the client, the stronger the disbelief may be.

Professional, Legal, and Ethical Issues

Consent as a Moving Target in EMDR Therapy

As you are orienting yourself and your clients to EMDR therapy, it may be helpful to educate and inform your clients about the process of EMDR, meaning that it involves 8 Phases and 3 Prongs. When clients understand that Desensitization (what people commonly think of when they have heard about EMDR therapy) is only Phase IV of the process, this can help them to make informed decisions if other needs or issues arise during the course of reprocessing a target memory. Similarly, when clients have been oriented to the Past, Present, and Future prongs and the AIP Model, they will more easily be willing to set aside happenings between sessions to allow the memory network to be completely reprocessed through the Future Template. This ideal trajectory is not always possible; however, allowing your client to make an informed decision between continuing the EMDR treatment plan and addressing a recent experience with talk therapy or other methods is essential.

Keep in mind the omnipresent need to check in with your client, every session within Reevaluation, and more often if WoT concerns arise, feeder memories emerge, and any issues come forward which may impact the established treatment plan. If working with a dissociative system, listen for feedback from all parts of the self. If there's a holdout, address it before proceeding.

Integrating EMDR Therapy into Your Practice

Integration of a new model of psychotherapy into your place of practice can help your clients in a new way. This process can be amazing, but you may need to adjust your practice in multiple ways. While each setting is unique, common questions and areas of adjustment are listed here:

- ☑ **Intake forms and procedures** - How do the current documents and procedures support History Taking, diagnostic evaluation, and general screening for readiness for EMDR? If you have the option to change them, what could be improved to support this integration?
- ☑ **DES or other method to detect dissociation** - What will be your standard practice for administering the DES? Is it more appropriate for your clientele to administer the MID instead? When and how will you administer this screening or assessment?
- ☑ **Setting and insurance items** - Does your workplace, supervisor, or third-party payor have any say or stake in your practice of EMDR?
- ☑ **Notes/documentation** - What will be your standard method of documenting sessions in which EMDR therapy is utilized?
- ☑ **Session length** - Do you have the option to offer extended sessions for reprocessing? How will you pace EMDR sessions, within whatever session length you have?
- ☑ **Scope of treatment** - Does your workplace or clientele influence the length or depth of treatment? If so, how can you best implement EMDR within those parameters?
- ☑ **Established clients** - How will you introduce EMDR therapy to clients with whom you already have an established relationship? What needs to be done to adequately complete Phases I and II with these clients?

The Value of Continued Training & Consultation

Once you have completed EMDR Therapy Training (including consultation hours following Module IV), you will be fully *trained* to implement the basic EMDR protocol and procedures as appropriate within your area of clinical specialization and may refer to yourself as 'EMDR Trained.' Many adapted protocols have been published and some have begun to be researched for their effectiveness. If you wish to apply those adapted for your area of clinical expertise (e.g.,

addiction, children, dissociative disorders), we recommend you seek literature, advanced training, and specialized consultation in these areas and adapted protocols.

> ***Competency & Scope of Practice***
>
> Training in the standard EMDR therapy protocol *does not alone* make a clinician competent to apply EMDR to any clinical presentation - only within the scope of the clinician's established education, training and expertise.
>
> Consult the standards of practice for your clinical discipline or licensure, and any contracts with third-party payers such as insurance companies, for any limitations to the application of EMDR within domains specific to your practice. While EMDR therapy is recognized as a valid and robust treatment model by many organizations, some entities may still limit its use.

As with any practice of psychotherapy, continuing education is essential to maintain your basic skills, develop those skills into artful practice, and remain up-to-date regarding changes and developments in the field. So also, with EMDR therapy, continued training and consultation is recommended. Options available include:

- Journal of EMDR Practice and Research – A quarterly, peer-reviewed publication dedicated to leading-edge literature related to EMDR therapy. Some articles are open access, and the entire publication is available to current members of EMDRIA.
- EMDRIA On Demand - Many advanced trainings are available via remote learning or webinar. 'EMDRIA On Demand' offers many inexpensive webinars for CE credit, available on the EMDRIA website.
- EMDRIA Annual Conferences - Much of the cutting-edge EMDR developments and research are presented first at the annual conferences prior to publication. These conferences also provide valuable networking opportunities with your favorite EMDR authors, teachers, and peers via Special Interest Groups (SIGs).
- EMDRIA Special Interest Groups (SIGs) - Discussion groups online between conferences focused on areas of clinical expertise or research.
- Pursuing EMDRIA Certification - As described in the introduction, after completion of this training (and related consultation) you may choose to continue your formal development as an EMDR clinician by pursuing EMDRIA Certification. Requirements can be found at www.emdria.org

For clinicians interested in training and support related to working with dissociative disorders, ISSTD offers the following resources:

- ISSTDWorld Online Community – A forum for members worldwide to connect, share information, learn about treatment resources, and much more.
- Annual and Regional Conferences - Many clinical practice, theory, and research workshops are offered, in addition to plenary presentations from experts in trauma and related fields.
- Professional Training Program - Offers three levels of training in understanding and treating dissociation. Distance learning and in-person options are available worldwide.
- Webinars, ISSTD News, and the Book Club - Enhance learning alongside other professionals or read and learn from the authors of recent books and peer-reviewed articles addressing dissociation.

- Adult and Child/Adolescent Treatment guidelines for dissociative disorders
- Special Interest Groups (SIGs) - Meet at conferences and communicate online via member forums.
- Regional Communities (RCs) and Regional Online Communities (ROCs) – Connect, learn, and share resources both in-person and virtually with other ISSTD members in your city, state, or other locality to develop a solid support system of dissociation-informed clinicians and researchers.
- The ISSTD journals are rich sources of leading-edge information: *The Journal of Trauma & Dissociation* and *Frontiers in the Psychotherapy of Trauma and Dissociation* (ceased publication in 2020).

Applications of EMDR Therapy Beyond PTSD

A wide range of presenting issues and situations can be addressed using the AIP Model and EMDR therapy. Current and emerging adapted applications of EMDR therapy can be found in the *Journal of EMDR Practice and Research*, the EMDR International Association Conference, other regional EMDR professional associations (such as EMDR Canada) and many advanced EMDR therapy trainings. Many applications of EMDR therapy are in the process of becoming scientifically validated; some have been shown effective at the level of case studies and clinical examples.

Protocols and Procedures for Special Situations

Several minor and more long-standing adaptations of the basic EMDR protocol are listed and described here. In all cases, sufficient completion of Phases I and II are still necessary - to include screening/assessment for pathological dissociation, and completion of Calm/Safe Place - prior to application of any of the following procedures within this section. The focus of these adaptations is primarily symptom reduction, rather than comprehensive treatment of an issue, pattern, or disorder/diagnosis.

EMD

An application of the most original form of EMDR therapy, EMD is used to restrict or contain processing in circumstances where associations and generalization of processing may be detrimental to the client. Clients with more complex presentations, whose readiness (primarily affect tolerance) is mildly questioned, or whose presentations have indicated that they need an extended preparation or a more slowly paced treatment plan may benefit from EMD as an initial application. EMD may continue to be used with such clients until tolerance for accessing traumatic material and the desensitization process has been established.

Francine Shapiro outlined the original (1989) EMD procedures in pages 220-222 of her 2018 text; the specific procedures outlined here reflect application of EMD for purposes of containing processing, which were not specific considerations when EMD was first developed. The key difference in this protocol is that the target material is continually referred back to rather than pursuing channels/associations that stem from the target.

Steps to apply EMD (restricted processing):

1. Agree upon single incident or fragment to be targeted. Contain other memories or pieces of the memory as needed. Instruct the client to use the Stop signal if material external to the agreed upon incident or fragment comes up in processing.
2. Target setup: select agreed-upon target (single incident, or a fragment of a more complex incident) and set up in standard fashion.
3. Proceed to Desensitization using shorter sets of DAS (5-10 passes at first, increasing to 12-20 passes if processing stays contained and the client can tolerate it).
4. After every set, return to target and check the SUD: "When you think of the incident, how disturbing does it feel to you now?"

a. Occasionally, to measure processing of channels, also check the target by asking "When you think of the incident, what do you notice now?"
b. Continue until SUD = 0, or until the client is able to tolerate EMDr (see below) or EMDR (standard processing).
c. If you choose to continue until SUD = 0, proceed to Installation, and apply shorter sets (~5 passes) during Installation until the VOC stops increasing. Skip Body Scan.

Pros of EMD:

- Can be used to target an isolated sensory experience, intrusive sound, smell, or image, etc.
- Allows processing and decreasing of disturbance around a single incident or piece of an incident when a client's WOT may not tolerate standard reprocessing.
- Prevents activation of related memories (prior to or after the incident targeted).
- Can be helpful in working in a more contained way with specific parts of self.

Cons of EMD:

- By design, processing (and relief of symptoms) is much less likely to generalize beyond the fragment or incident targeted.
- May need to re-target when client's affect tolerance allows in order to fully reprocess all related channels and sustain relief of symptoms, or to fully complete 3-prong treatment plan.

Example - Employing EMD with Elise

Setting up: Elise and her therapist have set up positioning for EMs and have already used tapping in the original Calm/Safe Place exercise. After stumbling into more than they bargained for a few sessions prior when attempting to work on a recent breakup, Elise feels like even more of a loser. The therapist asks her if there ever was a time where she got angry, she didn't have amnesia (meaning she is sure that she can recall the event in its entirety), and she felt she kept it under control and wasn't ashamed of herself.

Step 1 – Setup & Container

She remembers an incident from age 13 when her 7-year-old sister stole $20 from mother's purse. Elise was trying to get her to put it back, but Jessica ran off with it. When their mother realized that the money was missing, she automatically blamed Elise. Elise got angry and defended herself without blaming her sister. She was grounded in her room. Elise rebelled and escaped through the window and stayed at a friend's overnight. She is still angry at 5/10 that her mother didn't believe her.

Since this incident doesn't involve dissociated anger, is not related to any of her areas of amnesia, is not related to her experience of date rape and is not directly related to her issue of

abandonment which could be behind the rage, the therapist decides it could be a target for EMD. Elise agrees that she would like to feel differently about this incident and would like to have a second chance at reprocessing. (T = Therapist, C = Client/Elise)

Containerization
T – *"Now, before we begin, I'd like to invite you to set aside anything that may be on your mind about the present or past… allowing it all to go into your container… leaving out only this incident from when you were 13 years old and Jessica stole the $20… let me know when everything else is in the container, and it is closed and locked…"*
C – "Got it. My dog is guarding it and will let me know if anything tries to get out."
T – *"Good, and you're back here in my office?"*
C – "Yes. And it's Tuesday." (with a sassy smile)

Step 2 – Target Setup/Assessment
Picture
T – *"Indeed. So, now what picture best represents the worst part of this incident when you were 13 years old?"*
C – "There was a moment when I was sitting in my room, mad at my mom and mad at myself for not standing up for myself, and mad at Jessica for existing. My mom blamed everything on me, I knew she wouldn't believe me if I told her Jessica did it."

Negative Cognition
T – "*What words go best with that picture that express your negative belief about yourself now?*"
C – "I'm a total loser. I'm not even worth standing up for."
T – *"Hmm, those are two very big thoughts. Which one fits better?"*
C – I'm not worth standing up for.

Positive Cognition
T – *"When you bring up that picture, what would you prefer to believe about yourself now?"*
C – Ugh. Well, I want to believe that I'm worth it, but that sounds bogus.
T – *"That's okay if it sounds bogus. What would 'I'm worth it' mean about you exactly?"*
C – "That I'm allowed to have a voice."

Validity of Cognition (VoC)
T – "*Right! So, when you think of this incident, how true do the words "I'm worth having a voice" feel to you now, on a scale from 1 to 7, where 1 feels completely false and 7 feels completely true?"*
C – About a 2. Mostly bogus.

Emotion(s)
T – "*Okay. When you think of the incident, and the words "I'm not worth standing up for," what emotions do you feel now?"*
C – (More quietly). I guess it is shame.

SUD
T – *"Mm-hmm. On a scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the highest or most intense disturbance you can imagine, how disturbing does it feel to you right now?"*
C – About a 6.
Location of Body Sensation
T – "*Where do you feel the disturbance in your body?"*
C – In the pit of my stomach.

Step 3 – Proceed to Desensitization using shorter sets of DAS
T – *"Okay, we're almost ready to go. Remember that you're in my office, it's Tuesday, and you're watching this memory as though it's scenery that you can see from the train. Your job is to notice it, and whatever you're feeling and thinking now as you look at the memory of when you were 13 years old. Any questions?"*
C – Nope. Let's do this.
T – *"You're ready! (smiling) As we start, notice that picture of that moment sitting in your room, the words 'I'm not worth standing up for' and the pit of your stomach, while you follow my fingers with your eyes…"*

(set of 5 passes)

T – "Take a breath, let it go… was that speed okay?
C – Yeah, it was okay.

Step 4 - After every set, return to target and check the SUD
T –"Good. When you think of the incident, how disturbing does it feel to you now, 0-10?"
C – Still a 6. Just noticing how I hated everything about that bedroom.
T - "Yeah. Just notice that."

(set of 7 passes)

T – "Take a breath, let it go…how disturbing does it feel to you now?"
C - "I'm remembering hearing Jessica's voice, being all cute to get mom's attention. I feel angry. Maybe a 7."
T - "Just notice that."

(set of 8 passes)

T – "Breath… how disturbing does it feel to you now?"
C - "Down a little, maybe a 6.5."
T - "Just notice that."

(set of 9 passes)

T – "Take a breath… how disturbing does it feel to you now, 0-10?"
C - "I feel defeated. About a 5."
T - "Just notice that."

(set of 10 passes)

T – "Take a breath… how disturbing does it feel to you now?"
C - "About the same."

4a - Check the Target to measure the processing of channels
T - "Okay. "When you think of the incident, what do you notice now?"
C – "I notice what an impossible battle it was. I couldn't win. So, I left."
T – *"Mmhmm… and how disturbing does it feel to you now, 0 = neutral and 10 = the highest?"*
C – Eh. A heavy 4.
T – *"Just notice that – you're doing great."*

(set of 10 passes)

T – "Take a breath… how disturbing does it feel to you now, 0-10?"
C - "A little lighter, but still a 4.
T - "Just notice that."

(set of 10 passes)

T – "Breath… how disturbing does it feel to you now?"
C - "I think it can be a 3."
T - "Just notice that."

(set of 10 passes)

T – "Take a breath… how disturbing does it feel to you now, 0-10?"
C – "About the same."
T - "Okay. "When you think of the incident, what do you notice now?"
C – I feel sad. Lonely… (eyes moistening)
T – *"That makes sense… and how disturbing does it feel to you now, 0 = neutral and 10 = the highest?"*
C – 4.
T – "And where do you feel that in your body?"
C – My eyes.
T – "Just notice that."

(set of 10 passes)

T – "Take a breath… how disturbing does it feel to you now?"
C – "(tearful) it just really sucked living in that house and being 13… about a 4."
T – "Just notice that…"

(set of 12 passes)

T – "Take a breath… how disturbing does it feel to you now, 0-10?"
C – "3."
T – "Just notice that."

(set of 12 passes)

T – "Take a breath… how disturbing does it feel to you now?"
C – "About the same."
T – "Okay, so when you think of the incident, what do you notice now?"
C – "Well, I'm thinking about how jealous I was of Jessica. How I always feared that my parents would send me away. She was such a brat, but I couldn't blame her for stealing the $20 because I couldn't bear to risk being sent away."

T - "Does your 13 year-old self know that never happened, that they never sent you away?" (Cognitive interweave to bridge to adaptive material, and keep processing in EMD frame)
C - "Huh. I hadn't thought of that, I guess not."
T - "Just notice that."

(set of 12 passes)

T – "Take a breath… how disturbing does it feel to you now?"
C – "Still a 2 or so."

T - "Just notice that."

(set of 12 passes)

T – "Take a breath… how disturbing does it feel to you now, 0-10?"
C – The same.
T – "Okay, so when you think of the incident, what do you notice now?"
C – How there were at least 2 brats living in that house. Me and Jessica."
T – "How is the disturbance now thinking about that?"
C – "Still a 2."
T – "Just notice that."

(set of 12 passes)

T – "Take a breath… how disturbing does it feel to you now?"
C – "About the same."
T – "Okay, we'll do one more set before we close for today. Just notice that."

(set of 10 passes)

T – "Take a breath… how disturbing does it feel to you now?"
C – "About the same, but I think it went better this time!"
T – "Exciting, huh!? So, would you like to leave whatever is left in your usual container, or create a new container just for this experience?"
C – I think I can use a siphon to put the remnants of this in the container.

T – "Okay, take a few breaths, and let me know when it's all in the container or if you need help."
C – It's there.
T – "Good. Would you like to check in with the 4 Elements or your Calm Place before we close today?"

……

They continue with closing the session, and the therapist ensures that she is grounded and oriented before she leaves. The next session Elise reports being proud of herself that she "did EMDR" and agrees to check to see what is left to process related to the 13-year-old incident.

T – "Alright. Let's check in with that incident we started processing last time. Can you manage to take out just what is left related to the 13-year-old incident, leaving everything else in the container?"
C – Yes… I think so. Got it.

T – "Good, so when you think of that incident, what do you notice now?"
C – It's just like an old photograph of myself that I don't like very much. I don't know anybody who likes being 13 years old with a cute younger sister.

T – (noting perspective, empathy for self) "Mmhmm… So how disturbing does it feel to you now, 0 = neutral, 10 = the highest you can imagine?"
C – It's weird. I don't feel much now. I think it's neutral.
T – Just notice that while we do a short set.

(set of 8 passes)

T – "Take a breath, let it go…how disturbing does it feel to you now?"
C - "About the same."
T - "Just notice that."

(set of 8 passes)

T – "Take a breath, let it go…how disturbing does it feel to you now?"
C - "Same."

They then proceed to Installation, checking the PC, and doing short sets (3-5 passes) until the VOC stays at a 5.5 for several sets. They determine to stop there rather than risking activation of associated material. Elise gets to celebrate an EMD success!

EMDr

Contained, but less restricted, processing of a single incident can be managed through what is referred to as EMDr ('EMD little r'). This method is helpful when the client can manage affect associated with a single specific incident but need to prevent accessing of related incidents. For example, if your client wishes to target a loss that occurred 5 years ago, while containing other losses or related experiences that are known and activating to the client.

Steps to apply EMDr:

1. Agree upon the single incident to be targeted. Containerize related memories if needed. Instruct the client to use the Stop signal if material external to the incident comes up in processing.
2. Target setup: Select agreed target (single incident) and setup in standard fashion
3. Proceed to Desensitization using standard sets (24 passes) of DAS
4. After every set, check the target by asking "When you think of the incident, what do you notice now? *Repeat until no change is reported*
5. When no change is reported, check the SUD. If SUD is greater than '0,' repeat steps 3 through 5.
6. When SUD = 0 twice consecutively, proceed to Installation and Body Scan as in standard protocol, unless related/external incidents if necessary.

Pros of EMDr

- Allows for clients with good readiness and affect tolerance to target a single incident with much less likelihood of activating feeder memories or related incidents.
- Some association and generalization of processing is allowed.
- As with EMD, can be helpful in working in a more contained way with specific parts of self.

Cons of EMDr

- Full processing (EMDR) of the incident, targeting related incidents, and especially targeting and reprocessing earlier/touchstone incidents is still necessary to complete a full 3-prong treatment plan, and may be necessary to resolve present symptoms and maladaptive patterns.

Protocols for Recent Traumatic Events & Disaster Response Settings

Based on clinical observation, it takes at least 2 months before a memory is stored in a manner which is referred to as consolidated. This period can be longer (6 months - years) if the experience is ongoing, or some time passes before the individual feels that the event is 'over' - some refer to this time in which consolidation happens as the *post-trauma safety period*. Practically speaking, this means that after 2 months, the experience is more likely to be held in long-term memory, in a form which can be targeted and reprocessed as a single target. Prior to consolidation, the experience may be stored in fragments, which require a modified approach to target and reprocess effectively. Three approaches for targeting recent (or unconsolidated) experiences are outlined in Shapiro's 2018 text:

- **Recent Event Protocol** - originally published by Shapiro in 1995. A scripted protocol is available in Luber's book (2009, pp. 143-154) and recommended for trainees to accompany this manual.
- **EMDR Protocol for Recent Critical Incidents (PRECI)** - can also be used in a group format (Jarero, Artigas, Uribe, & Garcia, 2016).
- **Recent Traumatic Episode Protocol (R-TEP)** - outlines strategic use of EMD and EMDr to restrict processing to the recent/current event (Shapiro, E. & Laub 2008).

Self-use

Many an EMDR clinician and client have wondered about the efficacy of self-administered EMDR therapy. A few bits, especially resourcing elements from Phase II / Preparation, have been applied to some success, as noted here:

- *Getting Past Your Past* (Shapiro, 2012) – Francine Shapiro wrote this text for the general public to be able to understand and apply pieces of the AIP Model and EMDR therapy. Precautions and directions are given regarding when the included practices may or may not be safe to self-administer.

- *Self-Care for EMDR Practitioners* (Daniels, 2009, pp. 615-616) – Found toward the end of several *Scripted Protocols* volumes edited by Marilyn Luber, this script is intended for use after a session or at the end of a clinical workday. A positive belief and a few short sets of self-administered DAS are applied to a presently-held experience.

- Other forms of self-use: After successful completion of Calm/Safe Place, you may encourage your clients to use their cue word/phrase to practice accessing that resource state. Some clinicians extend or revisit Preparation and resourcing applications of EMDR to "tap in" recent or presently held positive and adaptive experiences. For example, passing a test, meeting a goal, crossing a relational hurdle.

> ***A Note on Adapted Protocols***
>
> Protocols have been adapted to address diagnoses other than PTSD, special situations or special populations all closely relate to the standard protocols and procedures you are learning in this training. Learning these adapted protocols may help you apply EMDR therapy more broadly in your practice, while maintaining fidelity to established EMDR therapy concepts.

While the AIP Model and EMDR therapy can be effectively applied to many presenting issues, it bears reiterating that you, the clinician, must have training and experience in treating couples

and families, for example, prior to applying EMDR therapy to address a dynamic within the couple or family system. This training and experience, aided by reading literature or attending workshops on applying standard or modified EMDR therapy protocols and procedures with couples and families, will equip a clinician trained in systemically-oriented therapy to use EMDR therapy to address couple and family issues.

Protocols for Diagnoses other than PTSD

Protocols for issues and disorders other than PTSD are often referred to as 'adapted protocols.' These adaptations have been made and documented by experts in treating those specific disorders or populations, and when some reason has been found to modify the procedure and/or protocols within the standard 8 Phases of EMDR therapy. None of these are entirely different from the standard protocols and procedures; most include the standard protocols and procedures, adding, subtracting, or re-ordering an element or two.
Adapted protocols have been developed and published for applying EMDR therapy to many issues and diagnoses that may co-occur with trauma-related symptoms, or present or be addressed separately. See Shapiro (2018, p. 402-415), the Francine Shapiro Library, and the *Journal of EMDR Therapy Practice and Research* for a review of literature on many diverse applications. These include the following:

- Addictions (behavioral, process, and substance)
- Treatment of sex offenders and other perpetrating groups
- Anxiety Disorders (phobias, panic disorder)
- Obsessive-Compulsive Disorders
- Physical Illness and somatic disorders (cancer, chronic pain, phantom limb pain)
- Eating Disorders
- Mood Disorders (Bipolar Disorder, Depression)
- Schizophrenia and psychotic disorders
- Performance Anxiety / Enhancement (athletic, professional, academic)

Many established adapted protocols can be found in the aforementioned, edited volumes by Marilyn Luber (*Scripted Protocols* series, via Springer Publishing Company) as well as in those edited by Robin Shapiro (*EMDR Solutions*, and *EMDR Solutions II*).

Working with Specific Populations

Different populations may benefit from slight modifications to the standard protocols and procedures to adjust to the common needs of that specific population when they present with trauma-related symptoms. See Shapiro (2018) pages 380-400, other pages identified below, and review the literature for valuable insights and modifications in serving these populations within the frame of the AIP Model and EMDR therapy, that include:

- Children
- Military Personnel
- Complex PTSD
- Dissociative Disorders (Shapiro, 2018, p 96-97, 342-345, 498-503)
- Older Adults
- Experiencers of Recent Incidents / Disasters
- Group treatment of trauma-related symptoms

EMDR Therapy with Children & Adolescents

Despite studies that examine the usefulness and efficacy of EMDR therapy in the treatment of PTSD and trauma in children, there remains a dearth of randomized control trials. Shapiro's 2018 revised text highlighted eight published RCT's that demonstrated the efficacy of EMDR therapy with children (Shapiro, 2018, p. 323). Since then, the following related studies have been published:

- A systematic review of available RCT's has been published (Manzoni et al. 2021);
- A qualitative evaluation of EMDR G-TEP as an integrated group parenting intervention (Kaptan et al., 2022);
- Two individual case studies (Gokcen, Yilmaz, & Kardag, 2022);
- Studies that assess the efficacy of EMDR group therapy with refugee children (Lempertz et al., 2020; Karadağ & Karadeniz, 2021), brief therapy with children (Olivier, de Roos, & Bexkens, A., 2021), and intensive EMDR combined with prolonged exposure and activity (van Pelt et al., 2021);
- An RCT examining the efficacy of EMDR therapy for children aged 4-15 that met subthreshold criteria for PTSD after medical trauma involving hospitalization Meentken et al. (2020); and
- An RCT measuring the effectiveness of EMDR therapy and KIDNET (child version of Narrative Exposure Therapy) with children who are refugees and displaying symptoms of PTSD (Velu et al. (2022).

A need for additional research has been identified to analyze the efficacy of EMDR therapy with children and youth in individual treatment, group treatment, and across different symptom clusters and functional issues aside from PTSD.

Additional reading is available through a variety of published texts to support child and adolescent therapists to adapt and modify EMDR therapy to make it developmentally appropriate. It is recommended that only therapists trained and experienced in working with children and youth should be utilizing EMDR therapy with this population.

Books

Adler-Tapia, R., & Settle, C. (2008). *EMDR and the art of psychotherapy with children: treatment manual*. Springer Publishing Company.

Adler-Tapia, R. (2012). *Child psychotherapy: Integrating developmental theory into clinical practice*. Springer Publishing Company.

Beckley-Forest, A., & Monaco, A. (Eds.). (2020). *EMDR with children in the play therapy room: an integrated approach*. Springer Publishing Company.

Gomez, A. M. (2012). *EMDR therapy and adjunct approaches with children: Complex trauma, attachment, and dissociation*. Springer Publishing Company.

Greenwald, R. (1999). *Eye movement desensitization reprocessing (EMDR) in child and adolescent psychotherapy*. Jason Aronson.

Lovett, J. (1999). *Small wonders: Healing childhood trauma with EMDR*. Simon and Schuster.

Lovett, J. (2014). *Trauma-attachment tangle: Modifying EMDR to help children resolve trauma and develop loving relationships*. Routledge.

Settle, C., & Adler-Tapia, R. (2008). *EMDR and The Art of Psychotherapy With Children*. Springer Publishing Company.

Tinker, R. H., & Wilson, S. A. (1999). *Through the eyes of a child: EMDR with children*. WW Norton & Co.

Wesselmann, D., Schweitzer, C., & Armstrong, S. (2014). *Integrative team treatment for attachment trauma in children: Family therapy and EMDR*. WW Norton & Company.

Additional Training and Resources

- EMDRIA Children & Adolescent Special Interest Group (for members only): https://www.emdria.org/group/emdr-with-children-adolescents/
- ISSTD Children & Adolescent Special Interest Group (for members only): https://www.isst-d.org
- EMDR UK - EMDR with Children and Adolescents: https://emdrassociation.org.uk/a-unique-and-powerful-therapy/children-adolescents/

Additional specialized training is offered through different EMDRIA Approved treatment providers and organizations.

Procedural Adaptations

Adaptations are often needed to ensure EMDR therapy is applied in ways that maintain fidelity to the standard protocols and procedures while developmentally appropriate for the child/youth. Consideration of differences in brain development and incorporation of important relational and attachment-based elements are most essential. Shapiro (2018) identified the creation of a safe psychological environment is of the utmost importance when applying EMDR therapy with children to ensure its effective and successful use. Modifications recommended in the literature include changes in language to align with a child's developmental age, and the creative inclusion of play, movement, the imagination, expressive arts, stories, metaphors, and analogies to make EMDR therapy responsive to the needs of younger clients.

The following sections offer a summary of established considerations for adapting each phase of EMDR therapy for children and adolescents.

Phase I

When working with children, simultaneous collaboration with the caregiving or support system of the child is essential. History taking is best done in a three-step process:

1. with the caregiver(s) alone,
2. with the child and caregiver(s) together, and
3. independently with the child.

This structure allows EMDR therapists to gather information from all perspectives, mitigates further exposure to potentially distressing information for the child, and assesses the attachment relationship and the degree of caregiver involvement across the phases of EMDR. Areas of inquiry include:

- critical adverse events in parent-child relationships;
- traumatic events experienced by the child or family;
- ongoing exposure to trauma within the home, community, or systems involved with the child;
- the degree to which the caregiving system has the capacity to provide emotional attunement and appropriate support, and how it may be built and enhanced in (in Phase II) to provide supportive presence;
- past and present child attachment experiences, interactions, and dynamics; and,
- activation/triggering of a caregiver's trauma history within the parent-child relationship.

Gentle recommendations may be made to caregivers to engage in EMDR therapy directly to address their own experiences, when relevant and/or appropriate, to enhance their ability to support their child and relate to them in different, non-wounding ways (Shapiro, 2018, p. 330). When assessed to be appropriate, caregivers are ideally integrated into therapeutic work, with the therapist attuning to areas in the relationship where repair may be beneficial.

EMDR therapists are encouraged to observe the language of the child and how they use both verbal and non-verbal language to communicate and express themselves. Maps, timelines, and storybooks may be used to explore and detail their life experiences, allowing clinicians to determine potential targets for reprocessing and potential resources, skills, and capacities that may be built and/or enhanced within Phase II / Preparation.

Careful screening and assessment of dissociation in children is essential. The information obtained in Phase I informs the direction and pace of Phase II work and whether extended preparation is needed to reduce dissociative symptoms and build affect tolerance. This additional preparatory work supports building readiness for work in the later phases of EMDR therapy.

Tools to screen for dissociative symptoms in child and adolescent populations are described in pages 83-84 of this manual.

Diagnostic Instruments

Though not normed specifically for adolescent populations, there is an adolescent version of the Multidimensional Inventory of Dissociation (A-MID). The A-MID is similar to the adult version with only slight modifications to the format and phrasing of a small number of items.

The SCID-D-R (Structured Clinical Interview for DSM-IV Dissociative Disorders-Revised, Steinberg,1994) can also be utilized as a formal assessment of dissociation with adolescents as young as 11 years old. As a semi-structured clinical interview, younger clients would need to remain engaged with the therapist for the duration of the assessment, which often takes 3-4 hours and is broken down into five sections that span the five core dissociative symptoms (amnesia, derealization, depersonalization, identity confusion, and identity alteration). The SCID-D has been used in multiple publications as the assessment measure of dissociative symptoms and disorders in adolescents (Bozkurt et al. 2015; Diseth & Christine, 2005; Plattner et al., 2003).

Phase II / Preparation

Using developmentally appropriate language, the clinician will provide explanations about EMDR therapy to the child through the use of psychoeducation, age-appropriate references, descriptions, stories, and metaphors (Adler-Tapia & Settle, 2008; Gomez, 2013; Greenwald, 1999). It's also important to ensure that EMDR is not described as a "magical cure." Instead, clinicians are encouraged to offer descriptions and explanations that focus on the building of a child's self-healing and self-efficacy to support growth, development, and interdependence as a means of counteracting experiences of powerlessness and dependency. As age-appropriate psychoeducation is provided, EMDR therapists work alongside children and their caregiving systems to build needed resources, capacities, skills and enhance mastery experiences based on the information gathered in Phase I.

Depending on the child's developmental age and stage, Phase II work may also focus on building cognitive, emotional, and somatic literacy skills, and the ability to scale and measure the magnitude of them, which supports and builds the foundation for later phases. Similarly to working with older populations, Phase II work with children builds state change capacities, building the ability to flexibly shift from an unpleasant emotional state to a more pleasant one through the use of a Calm/Safe Place. Both physical and imaginal containers may be built - using boxes, bags, and more (Shapiro, 2018; Gomez, 2013).

Engaging through the language of play to build affect tolerance improves a child's ability to maintain focus and connection to the process. Modifications may also include the use and

intentional inclusion of drawing, building, expressive arts, imagination, stories, collaging, and sand tray, according to the child's interests. When there is a history of complex trauma and/or dissociative symptoms are assessed, extended Preparation will be needed as informed by the information gathered in Phase I, the clinician's observations, and child and caregiver's reports. Factors to determining readiness to proceed into the reprocessing phases of EMDR therapy include considerations around present day safety and re-traumatization, biological and basic needs being met, good enough state change, affect tolerance and co-regulation capacities, support from a good enough attachment system, and presence of comorbid physical or developmental conditions.

Phase III / Assessment

Developmentally appropriate and attuned language is likewise encouraged in Phase III when selecting the target memory, for example from a box of hurts (Shapiro, 2018; Gomez, 2013; Greenwald, 1999). Adapted phrasing such as the "yuckiest" part or picture of the event, the mixed-up thought, and the uncomfortable feelings and sensations is helpful when engaged in the procedural steps of this phase (Shapiro, 2018; Gomez, 2013). Use of movement and play-based methods may be incorporated in this phase (e.g. setting up the target memory in a sand tray, dollhouse or drawing it) and allowing children with different levels of verbal communication to share the details in distanced, titrated, and developmentally appropriate ways.

With very young children, negative and positive cognitions may be optional, or they may be suggested to them, depending upon their cognitive structure and development. For school-aged children, clinicians may support children to elicit the "mixed up" or "bad thought" through the use of negative/positive cognition cards, or other play or art-based mediums. Scaling with the VOC and SUD may be physicalized through the use of various tools (pictures of thermometers, faces, measuring cups, color gradations, floor mats) or with the hands to indicate the size of how upsetting or yucky the hurt feels to them now. Modifications will continue to be based on what is developmentally appropriate for the child to concretize scaling the core organizers of experience. The 2018 Shapiro text (Appendix F) offers aids to assist EMDR therapists who work with children and adolescents.

Phases IV-VI

Considerations in the beginning of the reprocessing phases are based on the therapist's clinical judgment, and includes previously agreed upon decisions around whether to have caregivers present, whether attachment repairs may be needed as interweaves, and a safe physical environment to support reprocessing. Similarly to working with older populations, children and adolescents are asked to focus on the upsetting image, mixed up thought, and where the distress lives in the body, while BL-DAS is introduced. The continuum of processing (EMD, EMDr, EMDR) is utilized similarly to with older populations, allowing therapists to contain the content as needed. With younger children, the storytelling method (Lovett, 1999) may be used to facilitate reprocessing of target memories.

Clinicians may offer greater support and engagement in Phase IV to help the child maintain focus by engaging the child's imagination, integrating movement, and offering corrective experiences without pressing the child for details (see Shapiro, 2018, p. 328). Watching for shifts in affect and behavior in the child and reporting in between sets may require a creative approach by having children draw the situation or experience as it changes, providing additional support when there are challenges with verbalizing (Adler & Tapia, 2016; Kiessling, 2018).

When introducing EMDR therapy into work with children, it is additionally important to recognize that because younger children experience difficulty tracking across the midline of the brain, modifications in the typical use of eye movements may be necessary to accommodate this limitation, such as variations on the two-handed method (Shapiro, 2018, p. 64), where the right

and left index fingers are alternated in the ‘up’ position, so that the client’s focus alternates back-and-forth without having to continuously track the finger across the midline. To hold a child’s attention, clinicians are also encouraged to do so with finger puppets or toys (Shapiro, 2018, p. 325) to support a full range of eye movement, and when there are concerns around close contact with the clinician, spots can be placed on the wall with colored circles, pictures, or comic book heroes to support the child in moving their eyes from side to side and also maintaining a more comfortable distance from the clinician (Shapiro, 2018, p. 326). Many children, however, prefer tactile stimulation and taps can be incorporated through the use of “buzzies,” a game of pattycake (Shapiro, 2018; Tinker & Wilson, 1999), use of brushes (Gomez, 2013), drumming, and with the butterfly hug (Shapiro, 2018; Jarero, Artigas & Montero, 2008).

Although memory reprocessing often moves quickly with children, cognitive interweaves may still be needed if reprocessing is deemed to be blocked, stuck, or looping or if the child’s tolerance for remaining with the unpleasant affect is low. While children generally have less access to adaptive information due to their age and lack of life experience, pace and length of treatment still varies from one child to another. Some children will have fewer associations to work through, while others may have a more complex history of symptoms and experiences. Interweaves can be play based, and may incorporate drawing, movement, tools, the imagination, the child’s interests, or toys and puppets (see Shapiro, 2018, p. 329), and often offer appropriate, missing information and psychoeducation. When the treatment plan involves caregiver participation in session, clinicians may support caregivers to offer their child reparative statements in between sets of BL-DAS. For example, after adequate planning preparation, caregivers may be invited to provide interweaves that alleviate the child from inappropriate responsibility for shared traumatic experience (preparation for such an intervention may include the caregiver reprocessing the experience in their own EMDR therapy).

Phases VII-VIII

Closure with children is based on the unique needs of the child, while attending to all of the standard considerations for this phase. For example, the state change strategies practiced in Phase II may be re-introduced in a sequence of using their container, their calm/safe place, and then allowing for free play at the end of session. Free play includes activities and play that include laughter and fun to encourage co-regulation, and may also include caregivers. Caregivers and children may be given scales and logs to keep track of changes and symptoms in between sessions (e.g. TICES log), which can either be shared together during re-evaluation, or alternatively, shared separately by the caregiving system (Shapiro, 2018, p. 330).

In Reevaluation with children and adolescents, the scales and logs used to track information, challenges, and changes in symptoms and behavior is explored. Sharing the logs may be done dyadically with the caregivers and child, or alone with the caregiving system, depending on the child’s needs, symptoms, and level of affect tolerance.

When stabilization is a continued focus in the treatment plan, EMDR therapists may deepen positive shifts and mastery experiences with slow, short sets of BL-DAS, anchoring them as adaptive information and inner resources for the child. This may include rehearsal of a positive future template – with developmentally appropriate adaptations as discussed throughout this section.

Additional Considerations

Shapiro (2018) detailed a need for additional considerations and tailored modifications when working with children and adolescents with intellectual disabilities, autism spectrum disorders, comorbid conditions, and histories of complex trauma. Modifications are based on both the child’s developmental level and are aligned with child specific EMDR adaptations. Clinicians may determine the approach that is most attuned to the child, their needs, and their developmental level such as being more directive, titrating and distancing strategies, simplifying

or repeating instructions, including visual cues and/or support persons for reassurance, selection of BL-DAS based on considerations related to sensory hyper or hypoactivity, and mindful planning around how to break down session time (Shapiro, 2018, p. 333).

Careful consideration and assessment for complex trauma and dissociation is crucial when working with children and adolescents, similarly to work with older populations. Clinicians can find further information on the treatment of dissociation in children and adolescents in *Guidelines for the Evaluation and Treatment of Dissociative Symptoms in Children and Adolescents: ISSD Task Force on Children and Adolescents, July 2000*.

Part III - Overview of Established Modifications of EMDR Therapy for Complex Trauma and the Dissociative Disorders

The following are established (presented, published, and widely accepted) modifications of EMDR therapy or models of EMDR therapy treatment planning for complex trauma and dissociative disorders. This is not an exhaustive list; we highly recommend referencing EMDR Scripted Protocols: Special Populations, edited by Marilyn Luber (2010), for a handy go-to source for a number of the protocols described below, as well as others. Procedures described here are either described in detail in book chapters or peer-reviewed articles, or else taught as advanced trainings you will be qualified to once you have completed this EMDR therapy training. Each procedure is marked as Beginner, Intermediate, or Advanced.

Stage 1 – Stabilization/Containment

Resource Development and Installation (RDI)

In 1995, Leeds introduced the terminology resource installation to describe a general strategy of combining positive imagery with short sets of DAS (Leeds, 1995). He then renamed it “resource development and installation” (RDI) to encompass a wide range of resource development interventions, such as skills building, use of metaphors, art therapy, imagery, and hypnosis for developing resources used before applying BL-DAS as well as the application of brief sets of BL-DAS for the installation or strengthening of these resources (Leeds, 1996). Leeds published case reports describing this procedure (Leeds, 1998; Leeds & Shapiro, 2000) and in 2001 provided a summary of the RDI procedure that was included in the appendix of the second edition of the standard reference text on EMDR (Leeds, 2001). In 2002, Korn and Leeds published a case series with the first and, to date, only published treatment outcome data on the use of RDI in the stabilization phase of treatment of Complex PTSD. Their data, while uncontrolled, were positive, showing clinically significant changes on several standard and behavioral measures (Korn & Leeds, 2002). Two expanded modifications of the RDI protocol have been developed: One, by Janina Fisher (2001), is “intended to facilitate the development of internal resources and increased affect tolerance in clients with more severe symptomatology and/or a paucity of positive experiences” (p. 1). The other, by Don Beere (2010), is specifically intended for use with clients with dissociative disorders.

EMDR Therapy Techniques to Enhance Orientation

Twombly (2000) describes three EMDR stabilization technique: 1) Current Time and Life Orientation is designed to help ego states with time distortions; 2) Height Orientation helps child ego states realize that the body is adult; and, 3) Installation of the Therapist and the Therapist’s Office help lay the groundwork for dual attention (Twombly, 2000, 2005).

Stage 2 – Memory Processing Techniques to Reduce Dissociation

Flash Technique

This EMDR therapy technique is used during Phase II: Preparation. Anchoring in and starting from a resourced state, a brief glimpse of the painful trauma picture allows clients to reduce the disturbance without actually feeling the pain. Defenses are not activated and there is less need to 'dissociate' (Manfield, Lovett, Engel, & Manfield, 2017).

Titration of the Memory

Kluft (1988) developed the "*fractionated abreaction*" technique in order to make the processing of traumatic memories more tolerable. In fact, working with the client to select a portion of the memory and then following the agreed-upon work through to completion helps the client feel in control of the memory and the abreactive process. Kluft recommends starting with a very small piece (what he calls "dosage control") to ensure the processing is a positive experience, then picking up the pace of processing as confidence grows (Kluft, 2013). Memories can be fractionated by the following dimensions: a) by time (select a small segment of time); b) by percentage (of distress); c) by BASK (behavior, affect, sensation, knowledge) dimensions; and/or, d) by carefully selecting the ego states(s) or alternate identities that will be involved in looking at the memory (Kluft, 1997).

With EMDR therapy, specifically, Paulsen (2009) recommends fractionating by the Phase III components: image, emotion, negative cognition, and body sensation, or by reprocessing with only one alter at a time to avoid flooding. She also recommends using all of the elements of her ARCHITECTS approach (see also Paulsen, 2009, below).

Wreathing Protocol

The wreathing protocol (Fine & Berkowitz, 2001) is an organizing scheme for planned fractionated abreactive (traumatic energy release) work with clients diagnosed with DID and OSDD, which integrates clinical hypnosis with EMDR therapy. This approach helps ensure 1) a secure 'holding environment,' reinforced by the use of hypnotic techniques; 2) a more rapid processing of selected fragments of traumatic experience; and 3) a planful, consistent, and predictable structure from which the patient can effect abreactions (Fine & Berkowitz, 2001).

Since clients with DID are highly hypnotizable and naturally use hypnotic phenomena to manage distress, the intentional use of heterohypnosis (hypnotic induction by a second person) can help them gain mastery over their dysfunctional auto-hypnotic states and dissociated material (Kluft, 1992). EMDR is a powerful methodology, but premature abreactive work can promote regression, decompensation, and uncontrolled affect bridging (Fine, 1991). EMDR therapy methods can resolve traumatic memories more rapidly and effectively than hypnosis. Thus, this wreathing technique uses hypnosis for stabilization, affect management, containment, and grounding, and employs EMDR therapy to process traumatic memory material.

Level of Urge to Avoid (LoUA): Targeting Avoidance Defenses

For clients who want to process a traumatic memory but find that unconscious defenses are a frustrating barrier, the client's avoidance defense may be the best point of access. Based on A.J. Popky's 'Level of Urge' scale (or LoU, part of his DeTUR addictions protocol), Knipe (2008) targets the positive affect (typically relief or containment) associated with the avoidance: "What is good about not thinking of that memory?" or "How much would you rather think about something else on a 0 to 10 scale?" The SUD rating on the urge to avoid is the LoUA. Sets of DAS (typical length) are then employed until the LoUA reaches 0 or leads into the previously avoided traumatic material. Knipe cautions that the client must be sufficiently resourced prior to

processing the avoidance defense (owing to the probability that a significantly lowered LoUA will lead directly into trauma processing) and there must be enough time remaining in the session to work through the intense trauma-related affect that may emerge.

Constant Installation of Present Orientation and Safety (CIPOS) and the Back of the Head Scale (BTH)

CIPOS (Knipe, 2008) is a protocol that reinforces, with short sets of BL-DAS, the client's awareness of being present in the therapist's office, and alternates it with quick (2-to-10 second) imaginal glimpses of the traumatic material. The client develops a greater sense of control over the dissociation, the memory, and their ability to stay present. Knipe combines CIPOS with the Back-of-the-Head (BTH) scale. The client imagines a line that begins at the back of their head through to a point roughly 15 inches in front of their face. They rate their current level of dissociation by pointing to where along that line they feel they are at the present moment.

Modified EMDR Therapy Interventions Spanning All 3 Stages of Trauma Treatment

ACT-AS-IF Model

Sandra Paulsen's (2009) illustrated book, entitled, *Looking Through the Eyes of Trauma and Dissociation,* describes her ACT-AS-IF model, which is an integration of EMDR therapy and (primarily) Ego State therapy, with other theoretical approaches, in a stage-oriented approach. There is a heavy emphasis on safety, assessment for dissociation, explanation of how dissociation and dissociative self-systems work, and detailed guidelines for ego state work and addressing dissociative symptoms. The acronym spells out:

Assessment,
Containment and stabilization,
Trauma accessing,
Abreactive synthesis,
Skills strengthening,
Integration, and
Follow-up.

Additionally, Paulsen situates the EMDR therapy standard protocol in a larger, dissociation-focused treatment frame with the acronym ARCHITECTS:

Access system,
Refine target,
Consent reaffirmed,
Hypnosis or
Imagery,
Titration tools,
EMDR/BL-DAS,
Closure,
Tranquility tools, and
Stabilize, synthesize and soothe.

Paulsen's model was recently expanded to include neuroaffective and somatic elements as the NEST approach to EMDR Treatment Planning:

Neuroaffective,
Embodied,
Self-system, and
Therapy (Paulsen, 2018).

This expanded model is based on extensive neurobiology and somatic interventions detailed in a 2014 book she co-edited (Lanius, Paulsen, & Corrigan, 2014).

Dissociation of the Personality in Complex Trauma Related Disorders and EMDR

A series of three articles were published by Van der Hart, et al. that outline the therapeutic tasks in treating structural dissociation of the personality and how to incorporate EMDR as an intervention in all 3 stages of trauma treatment. In the first stage, this includes resourcing, overcoming the phobias of attachment, trauma, trauma-related mental actions, dissociative parts, perpetrator-imitating parts and young weak parts. In the treatment of traumatic memory stage, this includes preparation, exploration, fractionating, structuring processing, determining the respective roles of parts, keeping the client within the window of tolerance, resolving attachment to the perpetrator, containment and guided realization. In the 3rd stage, grief work, and overcoming the phobias of fusion, normal life, and intimacy are the focus (Van der Hart, Groenendijk, Gonzalez, Mosquera, & Solomon, 2013 & 2014; Van der hart, Nijenhuis, & Solomon, 2010; see also Steele, Van der Hart & Nijenhuis, 2008).

EMDR and Dissociation: The Progressive Approach

The Progressive Approach is a comprehensive EMDR treatment of dissociation that is based on Structural Dissociation theory (Gonzalez and Mosquera, 2012). The EMDR-AIP model is expanded by redefining “dysfunctionally stored memories” as “dysfunctionally stored information” (DSI). DSI includes trauma memories as well as related dysfunctional elements generated in the client’s intrapsychic experience such as defenses, affect intolerance, dissociative phobias, dysfunctional positive affect, and the interaction among the different parts. The progressive approach involves the gradual and dynamic application of DAS-BL to the processing of DSI from the very early stages of therapy. Therapists work through the adult part to develop communication, empathy, and collaboration with the parts, as well as metacognitive processes, integrative capacities, and self-care.

The careful targeting of dissociative phobias with EMDR is a key process in the therapy. For example, in processing the phobia of dissociative parts, the therapist focuses on the emotion and somatic sensation that one part feels towards another with very short sets of bilateral stimulation and psychoeducation.

The Tip of the Finger Strategy (TFS) targets a small fragment of a sensation, emotion or irrational belief that is peripheral to the traumatic memory. In other words, the target is just the tip of the finger in the EMDR hand metaphor. The goal of TFS is to decrease disturbances that are blocking an Emotional parts of Personality (EP’s) capacity for orientation to the present and collaboration with other parts. Only a few short sets are used. For example, rage in a self-harming EP.

Phase III: Assessment elements of the EMDR therapy protocol can be fractionated, as an early introduction to EMDR processing. A specific, circumscribed element of the traumatic memory is selected (e.g., a smell). This is especially useful when traumatic material comes up that is intrusive and may pose a risk, and the client has ability to maintain dual attention and cooperation within the system (Gonzalez & Mosquera, 2012).

EMDR Introject Decathexis (Id) Protocol

This protocol (Coy, 2020) is very advanced, and requires practical knowledge of EMDR therapy, clinical hypnosis, and Ego State Therapy, as it integrates all three approaches seamlessly. For many clients with complex trauma histories, some ego states may actually be patterned after an external perpetrator (an ‘introject,’ in psychodynamic terminology). These parts of self can be so highly charged with energy that they believe they are the outside perpetrator, and often behave as its original model did. This can translate into verbal and emotional abuse, as well as re-

enacting physical and sexual harm toward other parts of self and the body, as if the traumatic event itself was 'trapped' in an endless loop. The Id Protocol was developed to aid in the challenging tasks of directly engaging and diffusing this 'trapped' energy, thus safely facilitating permanent transformation of often harmful internalized--and externalized--dynamics.

Strategic Developmental Model (SDM) for EMDR

Maureen Kitchur (2005) designed SDM to be an efficient and comprehensive method for delivering EMDR to complex trauma clients. SDM interweaves strategic structure, techniques and language with a developmental orientation. Clinicians first identify (using a genogram) and then chronologically treat with EMDR all the nodal events in an individual's life that are likely to have impeded developmental progress. Clearing the developmental path by clearing out foundational memories and working with younger ego states first, results in faster and more comprehensive resolution of all other targets and presenting problems and less dissociation.

Targets are selected in the following age group order: middle childhood (4-11), early childhood (0-3), adolescent, and adult. Within each age group (except for early childhood), the memories are targeted as follows: most disturbing memory of parent's relationship, most disturbing memory of one parent then the other, and then known traumas in chronological order (Kitchur, 2005).

Inverted EMDR Standard Protocol for Complex PTSD

Developed by German psychiatrist and EMDR innovator Arne Hofmann (2010), the inverted protocol addresses the three prongs of experience in reverse order--Future, Present, then Past—to aid in gradually increasing the client's affect tolerance and sense of mastery over their ability to self-regulate as they move backward toward reprocessing touchstone events in their trauma history. The protocol, in print form, offers specifics on how to structure treatment and benchmarks to help determine when it is safe to move to the next prong of treatment.

Ego State Interventions

The Cross-training Model

Forgash and Knipe (2008) developed a model that brings together EMDR Therapy, Ego State Therapy, and dissociative disorders treatment methods. The goal is to "meet the adaptational needs of the present and undo the dissociative quagmires." This practical model is mainly focused on Stage 1 stabilization, although they do outline strategies for Stages 2 and 3 trauma treatment. Specifically, in Stage 1, they discuss psychoeducation, history taking, use of BL-DAS, initial ego state work (in detail), creating a 'home base' and 'workplace,' an 'orientation to present reality' exercise, the 'constructive avoidance' technique, ego-strengthening activities, containment, affect regulation, self-soothing, relaxation, the 'affect dial' (borrowed from the hypnosis tradition), and somatic work.

The 'Loving Eyes' Procedure

Reasoning that the "loving eyes of an adult are often an essential element in the process of healing from childhood trauma," Knipe (2008) developed the 'loving eyes' procedure to help the client with the phobia of their emotional parts (EPs). Employing conversation and "compassionate validation" (Knipe, 2015) (i.e., ventral vagal engagement methods), reduces dissociation (Knipe, 2008), and this paves the way to reprocessing the EP's trauma memory using EMDR therapy methods. When the Phase III: Assessment questions are too overwhelming and dual attention is not possible, this technique offers an entry to the memory (Knipe, 2015).

Dissociative Table

This is a powerful imagery technique that offers "access to the inner ego system of those suffering from disorders of dissociation" (Fraser, 1991). The technique creates an opportunity for the client to become familiar with their "internal cast" (i.e., dissociative identities or ego states), it opens up inner dialogue, and it is useful throughout treatment (Fraser, 2003). In its original incarnation, the client is asked to imagine a boardroom with a table and the ego states are all invited to take a chair. Fraser, in his original (1991) and "revisited & revised" (2003) papers, outlined cautions on the use of the technique, as well as additional techniques such as the 'spotlight,' the 'screen,' the 'middleman,' and the 'change room.' Kathleen Martin (2012) builds on Fraser's original instructions with eight clearly defined steps, and adds several innovations for use by EMDR therapists. Martin suggests that the dissociative table first be used in Phase II: Preparation, and then throughout treatment.

Attachment-Focused Interventions

Attachment-Focused EMDR

The attachment-focused (AF) approach to EMDR was developed to treat clients with relational traumas and attachment deficits (Parnell, 2013). Clients who have experienced childhood traumas that have impacted their sense of safety and capacity to form close emotional relationships require adjustments to the EMDR procedures. The five principles of AF-EMDR are: 1) foster client safety; 2) develop and nurture the therapeutic relationship to facilitate healing; 3) use a client-centered approach; 4) create reparative neuro-networks through the use of Resource Tapping (Parnell, 2008); and, 5) use modifications of the EMDR therapy standard protocol whenever client needs indicate. Parnell provides many clinical examples of inner and imagined attachment resources (including nurturing and protector figures, the inner advisor, inner helpers, the ideal mother, the essential spiritual self, the heart refuge, and the circle of love), how to weave these resources into EMDR work, and how to modify and structure EMDR in patients with attachment trauma (Parnell, 2013).

Integrative Team Treatment for Attachment Trauma in Children

Wesselman, Schweitzer & Armstrong. (2014) offer EMDR-integrated information non treatment planning, preparation, and cognitions according to attachment styles of the child client and their parents/caregivers. Attachment resource development exercises include the following: Messages of love, playing baby, circle of love and safe place for the little one. Self-regulation development and installation activities include: Mindfulness, talking to the brain, talking to the body, belly breath and speaking to the inner child (Wesselman et al., 2014).

Potter & Wesselman (2016) have also discussed how to prepare adults with attachment trauma for EMDR therapy.

Accessing Early Trauma

EMDR Early Trauma (ET-EMDR) Protocol/Early Trauma Approach

Paulsen (2017) & O'Shea have developed an EMDR therapy protocol for repairing very early trauma and neglect from the attachment period. Early trauma and neglect are implicit memories (right hemisphere, unconscious, and non-verbal) that are associated with somatic syndromes and require modifications to EMDR therapy standard protocol. The steps are as follows: 1) All later, consciously-registered traumatic material is set aside in a container; 2) the client's ventral vagal nervous system is accessed by establishing a Safe State (as opposed to a 'safe *place*') using tactile BL-DAS; 3) the hard-wired affective circuits (see Panksepp, 1998) are reset using tactile BL-DAS; 4) Baby's story is reprocessed temporally, again using tactile BL-DAS, beginning in a time before conception, and continuing through the time of conception, the

stages of gestation, the time of birth, the first week of life, and then incrementally through the first, second, and third years of life (age 0 to 3). Each targeted time period moves through three phases: REVIEW, RELEASE, and imaginal REPAIR. Time periods may be fractionated into smaller segments (e.g., gestation month-by-month) to ensure that the client can tolerate the reprocessing, particularly in instances where a significant amount of sensory material is surfacing. PauOne or more developmentally-appropriate Positive Cognitions are installed in Phase V, and Phase VI: Body Scan is completed. 5) Closure and containment of incompletely processed material is the final step in a session, which may occur in the span of a typical therapy session, or else as an extended session taking place over one or multiple days (Panksepp, 1998).

Strategic Developmental Model

SDM provides guidelines for when to target early childhood memories (if there is a memory, corroborated event, or attachment wound) and techniques to work with early memories (Kitchur, 2005).

Other Relevant Protocols

Many of the protocols mentioned above are found in *EMDR: Scripted Protocols: Special Populations* (Luber, 2010). Other relevant recommended protocols include:

- Modified Resource Development and Installation (RDI) Procedures with Dissociative clients (Beere, 2010a)
- An EMDR protocol for Dissociative Identity Disorder (DID) (Beere, 2010b)
- The Inverted EMDR standard protocol for unstable Complex Post-Traumatic Stress Disorder (Hoffmann, 2010)
- The bottom-up processing protocol (Lanius, U., 2010)
- Protocol for releasing stuck negative cognitions in childhood-onset Complex Post-Traumatic Stress Disorder (C-PTSD) (Gelinas, 2010)

Recommended Reading (in addition to above)

- Shapiro (2018) textbook
    - Dissociative Disorders section. pp. 342-345
    - EMDR Dissociative Disorders Task Force Position Paper. pp. 499-503.
- Gelinas (2003) review of integrating EMDR into phase-oriented treatment of trauma.

Other Psychotherapies that have been combined with EMDR to manage dissociation

- Internal Family Systems (Schwartz,1995; Twombly & Schwartz, 2008)
- Sensorimotor Psychotherapy (Ogden & Fisher, 2015; Fisher, 2000; Ogden & Gomez, 2013)

Example Clients Elise & Carol – Treatment Stages 1 and 2

Now that we have reviewed several modifications of EMDR therapy procedures for application with clients who present with complex trauma and dissociation, let's revisit the example clients, Elise and Carol.

Elise

MID Results (see handouts)

MID includes a lot of amnesia, trance states, angry voices, dangerously toxic PTSD symptoms, abandonment and rejection issues and a diagnosis of "Dissociative Diagnosis Deferred."

Extended Stabilization

Elise will need an extended stabilization phase because of her amnesia, abandonment issues, history of suicide attempt, and OSDD diagnosis. The amnesia is not only for her childhood but during 20% of her rage attacks.

Her big traumas include early (less than age 3) memories of Mom's abuse/neglect; an incident at age 9 where her adopted paternal grandparents treated her really unfairly compared to their real granddaughter; the date rape (which will turn out to be a gang rape) at age 15 that really destroyed her life; and her adult abusive relationships. We can postulate that she has an angry ego state that is partially dissociated from the adult self, a very young abandoned ego state, an age 9 rejected state, and a traumatized dissociated teen ego state from the date rape.

Her strengths include the fact that she has been working really hard to turn her life around, seems to be functioning well, and is insightful. She is really eager to work hard in therapy, she is likeable with a good sense of humor, and her physical health is good.

Extended Preparation

She has been taught the calm/safe place, light stream, the container and the four elements skills. She is good at imagery and has successfully used the skills on everyday events. It would help to do more guided practice with the therapist using these skills on more difficult problems such as her anger or when Picture, NC, Affect, and Sensation are called up for a traumatic memory, to learn to shut it down. Practice with the Back of the Head scale and grounding techniques is also important.

Possible options within EMDR therapy:

The first task is to carefully help her gain control of her anger, which precipitates the suicidal urges. Options include the dissociative table technique, ego state therapy, the loving eyes technique, the progressive approach to phobia of voices and inner parts, the Flash technique, CIPOS and Installation of the Therapist and the Therapist's Office.

The date rape memory will need to be fractionated and processed over several sessions with careful attention to Window of Tolerance and Dual Attention. After the angry ego state is able to cooperate, EMD, CIPOS and Flash are options to start with. For the experiences prior to age three, ET-EMDR is a logical protocol to use. Attachment-focused EMDR with the installation of nurturing figures may also be helpful.

Carol

DES Results

Mean DES is 49.6 and probability of pathological taxon is 100%.

MID Results (see handouts)

Carol's Mean MID Score is 48.6 and the diagnoses are DID and PTSD. She endorses 5/6 General Dissociative Symptoms, 10/11 Partially Dissociated Intrusions symptoms and all 6 Fully Dissociated Actions (Amnesia) at a clinically significant level. She strongly endorses child, angry and persecutory self-states and endorses "I have DID." She also had dangerous persecutory voices, toxic PTSD and dissociated self-harm behavior.

Extended Stabilization

From the history, we can see that Carol has a number of severe red flags such as inability to control flashbacks, inability to function in everyday life, an unstable family situation, and a history of worsening in therapy. She has very few skills, has trouble with boundaries and is outside her WoT during history taking. Her MID clearly indicates DID with very significant amnesia and identity alteration experiences. She has highly endorsed a number of dangerous symptoms that will require extensive stabilization.

Extended Preparation

Carol will not be ready for memory processing with EMDR for a long time. After some ego state therapy, she might be able to engage in resource development and do some Progressive EMDR work on reducing phobias of inner parts and symptoms.

Trajectory Considerations

She is going to require a very lengthy Stage One Stabilization Phase focusing on DID treatment, probably years. The first tasks are reducing the pervasive day to day amnesia and helping her gain control over the toxic flashbacks that make her want to hurt herself.

Her Stage Two treatment will likely also be lengthy as her memories will need to be greatly fractionated. She may have layers of memories that are currently hidden by amnesia.
The slope of her trajectory is hard to estimate currently. The fact that she has little personality pathology and has a supportive husband are good signs. We don't yet know how fast she can learn skills and use them.

Treatment of Persons with a Dissociative Disorder (OSDD/DID)

Instruction in the treatment of persons who meet criteria for more complex forms of trauma that involve a number/variety of dissociative symptoms, up to and including OSDD and DID, is beyond the scope of this manual. We strongly recommend training and supervision if you are treating a client with OSDD or DID. For training, we recommend the Professional Training Program (PTP) of the International Society for the Study of Trauma and Dissociation (ISSTD). https://www.isst-d.org/training-and-conferences/professional-training-program/

We also recommend the following readings:

Treatment Guidelines

Adult Dissociative Identity Disorder Treatment Guidelines
https://www.isst-d.org/resources/adult-treatment-guidelines/

Child and Adolescent Dissociative Symptom Treatment Guidelines
https://www.isst-d.org/resources/child-adolescent-treatment-guidelines/

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Appendix A: EMDR Therapy Qualification Levels

Designation	Qualifications
E***MDR Trained***	Completion of an EMDRIA Approved EMDR 'Basic' Training of at least 50 hours total: • Minimum of 20 hours of in-person, didactic learning • Minimum of 20 hours of practicum • Minimum of 10 hours of consultation on implementing basic EMDR therapy protocols and procedures with clients

EMDRIA Certified	Following completion of an EMDRIA-Approved EMDR 'Basic' Training, the following minimum criteria must be met:
	• Hold an independent, professional license with at least 2 years' clinical experience
	• Conduct at least 50 EMDR therapy sessions with at least 25 clients
	• Complete a minimum of 20 hours of consultation with an EMDRIA Approved Consultant, and obtain a letter of recommendation from the Consultant regarding utilization of EMDR with clients
	  ○ 15 hours may be completed with a Consultant-in-Training (CIT)*
	  ○ 10 hours may be completed in a group consultation setting
	• Provide signed affidavit attesting to having met the above requirements
	• Obtain letters from each consultant verifying that consultation hour requirements have been met
	• Obtain two (2) letters of recommendation from colleagues
	• Complete 12 hours of EMDRIA Credit (EC) programming

EMDRIA Approved Consultant (AC)	After completion of all EMDRIA Certification requirements, the following minimum criteria must be met: • Three years' experience implementing EMDR therapy after receiving 'Basic' Training Certification of Completion • Conduct at least 300 sessions with at least 75 clients utilizing EMDR therapy • Complete at least 20 hours of consultation-of-consultation with an EMDRIA Approved Consultant • Provide signed affidavit attesting to having met the above requirements • Obtain letters from each Approved Consultant verifying that consultation-of-consultation hour requirements have been met • Obtain two (2) letters of recommendation from colleagues • Complete 12 hours of EMDRIA Credit (EC) programming (EC) every 2 years **(A clinician who is working toward AC has declared this with EMDRIA, and is working with a senior AC, and is referred to as a Consultant-in-Training)*

Refer to EMDRIA's website, at https://www.emdria.org/, for further details.

Appendix B: Dissociative Experiences Scale, 2nd Edition

Name _____ Age:_____ Date: _____

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

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

1.	Some people have the experience of driving a car and suddenly realizing that they don't remember what has happened during all or part of the trip. Choose a number to show what percentage of the time this happens to you.	
2.	Some people find that sometimes they are listening to someone talk and they suddenly realize that they did not hear all or part of what was said. Choose a number to show what percentage of the time this happens to you.	
3.	Some people have the experience of finding themselves in a place and having no idea how they got there. Choose a number to show what percentage of the time this happens to you.	
4.	Some people have the experience of finding themselves dressed in clothes that they don't remember putting on. Choose a number to show what percentage of the time this happens to you.	
5.	Some people have the experience of finding new things among their belongings that they do not remember buying. Choose a number to show what percentage of the time this happens to you.	
6.	Some people sometimes find that they are approached by people that they do not know who call them by another name or insist that they have met them before. Choose a number to show what percentage of the time this happens to you.	
7.	Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something as if they were looking at another person. Choose a number to show what percentage of the time this happens to you.	
8.	Some people are told that they sometimes do not recognize friends or family members. Choose a number to show what percentage of the time this happens to you.	
9.	Some people find that they have no memory for some important events in their lives (for example, a wedding or graduation). Choose a number to show what percentage of the time this happens to you.	
10.	Some people have the experience of being accused of lying when they do not think that they have lied. Choose a number to show what percentage of the time this happens to you.	
11.	Some people have the experience of looking in a mirror and not recognizing themselves. Choose a number to show what percentage of the time this happens to you.	
12.	Some people sometimes have the experience of feeling that other people, objects, and the world around them are not real. Choose a number to show what percentage of the time this happens to you.	
13.	Some people sometimes have the experience of feeling that their body does not belong to them. Choose a number to show what percentage of the time this happens to you.	

14.	Some people have the experience of sometimes remembering a past event so vividly that they feel as if they were reliving that event. Choose a number to show what percentage of the time this happens to you.	
15.	Some people have the experience of not being sure whether things that they remember happening really did happen or whether they just dreamed them. Choose a number to show what percentage of the time this happens to you.	
16.	Some people have the experience of being in a familiar place but finding it strange and unfamiliar. Choose a number to show what percentage of the time this happens to you.	
17.	Some people find that when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them. Choose a number to show what percentage of the time this happens to you.	
18.	Some people sometimes find that they become so involved in a fantasy or daydream that it feels as though it were really happening to them. Choose a number to show what percentage of the time this happens to you.	
19.	Some people find that they are sometimes able to ignore pain. Choose a number to show what percentage of the time this happens to you.	
20.	Some people find that they sometimes sit staring off into space, thinking of nothing, and are not aware of the passage of time. Choose a number to show what percentage of the time this happens to you.	
21.	Some people sometimes find that when they are alone they talk out loud to themselves. Choose a number to show what percentage of the time this happens to you.	
22.	Some people find that in one situation they may act so differently compared with another situation that they feel almost as if they were different people. Choose a number to show what percentage of the time this happens to you.	
23.	Some people sometimes find that in certain situations they are able to do things with amazing ease and spontaneity that would usually be difficult for them (for example, sports, work, social situations, etc.). Choose a number to show what percentage of the time this happens to you.	
24.	Some people sometimes find that they cannot remember whether they have done something or have just thought about doing that thing (for example, not knowing whether they have just mailed a letter or have just thought about mailing it). Choose a number to show what percentage of the time this happens to you.	
25.	Some people find evidence that they have done things that they do not remember doing. Choose a number to show what percentage of the time this happens to you.	
26.	Some people sometimes find writings, drawings, or notes among their belongings that they must have done but cannot remember doing. Choose a number to show what percentage of the time this happens to you.	
27.	Some people find that they sometimes hear voices inside their head that tell them to do things or comment on things that they are doing. Choose a number to show what percentage of the time this happens to you.	
28.	Some people sometimes feels as if they are looking at the world through a fog so that people or objects appear far away or unclear. Choose a number to show what percentage of the time this happens to you.	

DES Factor Analysis

Manual for Dissociative Experience Scale, Carlson and Putnam, 1992
Factor analysis derived from a wide range of psychiatric and non-clinical subjects (N=1574)

"Using a Cutoff of 30 for the Average Score to identify those who may be severely dissociative will result in the correct identification of 74% of those who are [highly dissociative] and correct identification of 80% of those who are not [highly dissociative]. Studies have shown that 61% of those who scored 30 or above who were not [highly dissociative] had posttraumatic stress disorder or a dissociative disorder other than [DID]." (Carlson & Putnam, 1992)

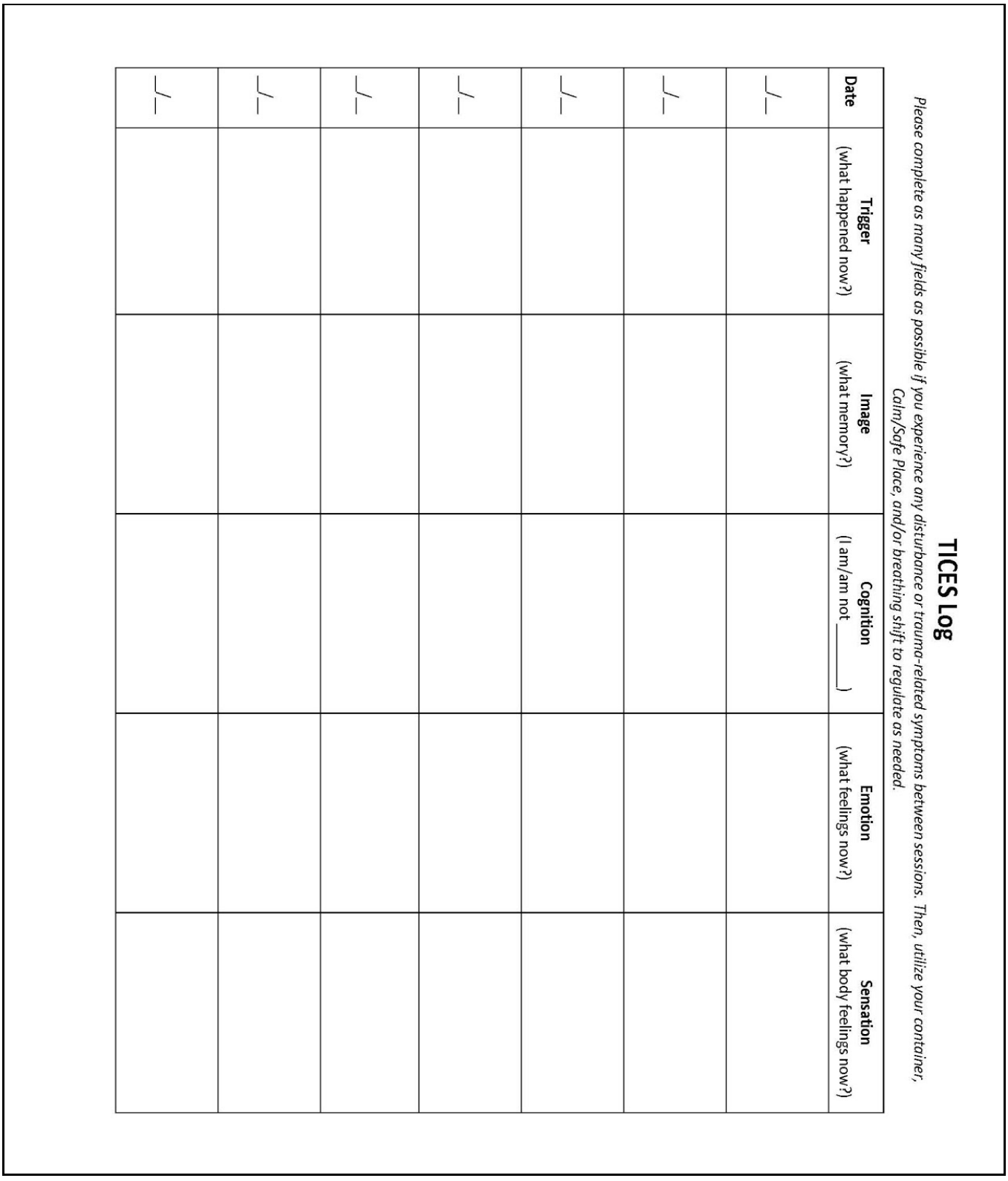
Overall DES Score: _____

DES Mean Score: **/28 = _____**

Taxon-Clinically Significant		Depersonalization/ Derealization		Amnestic Dissociation (Amnesia)		Absorption & Imaginative Involvement	
Item #	Score	Item #	Score	Item #	Score	Item #	Score
3.	_____	7.	_____	3.	_____	2.	_____
5.	_____	11.	_____	4.	_____	14.	_____
7.	_____	12.	_____	5.	_____	15.	_____
8.	_____	13.	_____	6.	_____	16.	_____
12.	_____	27.	_____	8.	_____	17.	_____
13.	_____	28.	_____	10.	_____	18.	_____
22.	_____	TOTAL =	_____	25.	_____	20.	_____
27.	_____	**/6 = Mean:**	**_____**	26.	_____	22.	_____
TOTAL =	_____			TOTAL =	_____	23.	_____
/8 = Mean:	**_____**			**/8 = Mean:**	**_____**	TOTAL =	_____
						/9 = Mean:	**_____**

Appendix C: Worksheets and In-Session Tools

TICES Log (Adapted from Shapiro, 2018, p 441-442)



TICES Log

Please complete as many fields as possible if you experience any disturbance or trauma-related symptoms between sessions. Then, utilize your container, Calm/Safe Place, and/or breathing shift to regulate as needed.

Date	Trigger (what happened now?)	Image (what memory?)	Cognition (I am/am not _____)	Emotion (what feelings now?)	Sensation (what body feelings now?)
__/__					
__/__					
__/__					
__/__					
__/__					
__/__					
__/__					

Emotional Shower* – Closure & Containment Strategy

Modified from Lightstream by Jennifer A. Madere, 2014

Toward the end of a session (any Phase), prompt the client to notice what they want to take with them from today, and what they want to leave behind in their container. Invite them to breathe in, noticing whatever images, thoughts, emotions or body sensations are currently in their awareness, and breathe out, allowing whatever they want to leave behind to go into their container. Secure the container.

After any disturbing material has been contained, invite them to notice any residue that may be left behind. Ask the client: *Where is that located in your body right now? If it had a shape, what would it be? How big is it? Or if it had a size, what would that be? If it had a color, what would that be? Are there any other words that come to mind to describe the feeling right now? For the rest of this exercise, you get to choose whether water or light fits better to carry away the emotional residue represented by this* _____ (e.g., red Velcro ball in your chest). *Does water or light sound better to you right now?*

- If the client needs guidance: *Some clients prefer water because it's like a shower that can be warm, or a cool waterfall. Some clients prefer light because it reminds them of the sun or other brightness. Which would you like to try?*

What do you need to feel more of (or instead) right now? (e.g., calm, clarity, energized) *What color represents that for you?*
Okay, now imagine that this colored light/water is shining/flowing down from a source above your head. The source can be the sun, a showerhead, or whatever you choose. Got it?

Now, allow the _____ (color) light/water to shine/flow down, around, over and through the residue we located, and any other residue that remains from our work today.

As you breathe in, notice whatever's there, as you breathe out, notice the light shining / water flowing down, carrying with it some of the residue each time... Take a few more breaths in, noticing anything that's still there, now out, noticing the light shining / water flowing down… How's that going? What are you noticing? If some change or positive response, continue.

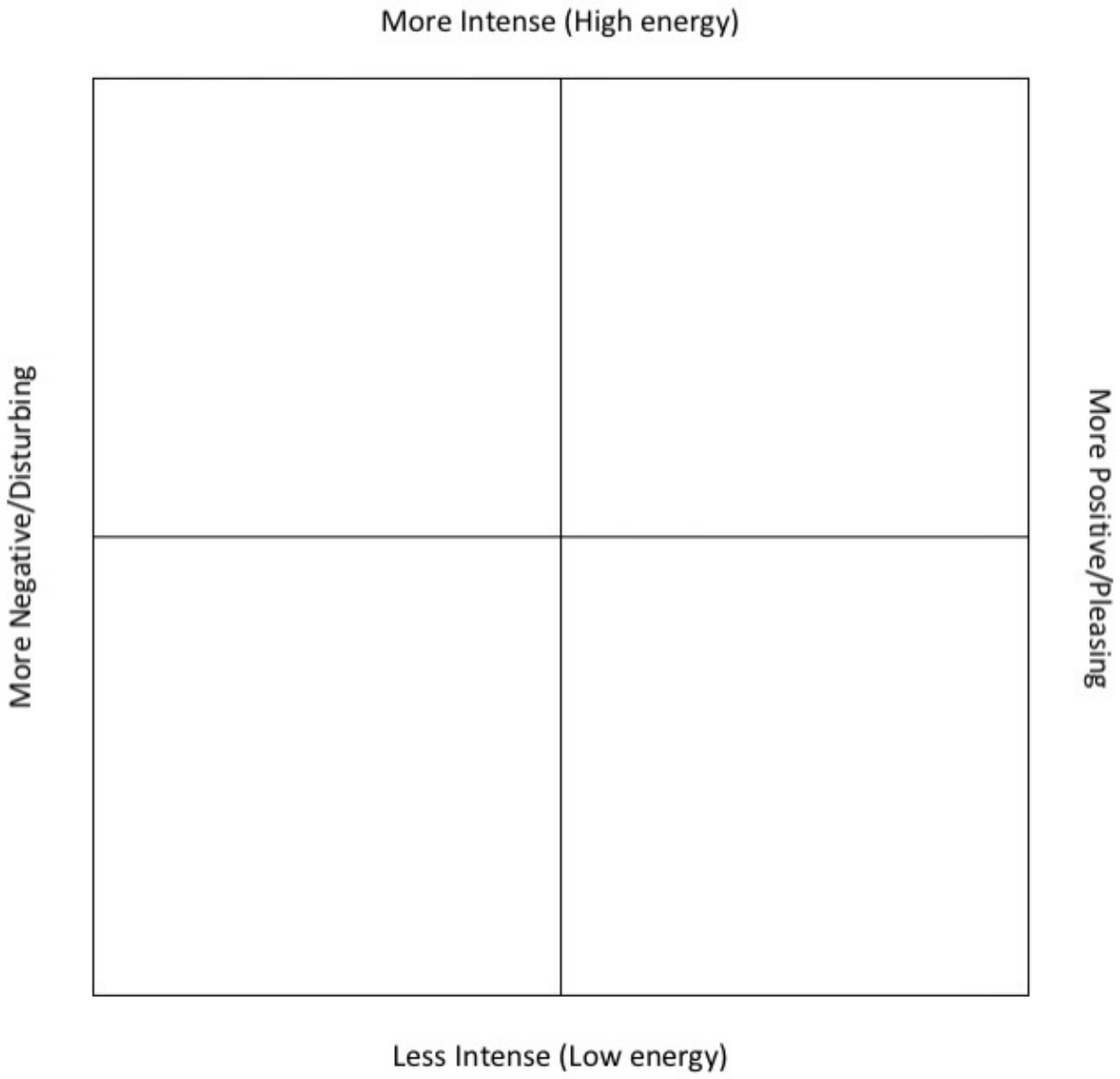
Keep noticing anything that's left, breathing, and allowing the light / water to continue to diffuse/erode it. Let me know when the light shines / water flows clear, or you feel it's time to stop.

- If the client typically experiences a slight down-regulating effect with DAS, slow taps may be added to enhance/install this experience as a resource. If VEMs have been experienced to have a regulating effect with this client, VEMs may be done with the client's in/out breaths.

To close: *Now open your eyes (if they're closed), wiggle your feet, stretch, or whatever your body needs to do... You may use this and/or your container anytime you need it. Let me know it goes for you when you try it on your own!*

**This exercise is not strictly scripted and may be modified to fit the imagery that feels most comfortable for your client.*

Plotting Emotion and Sensation by Quadrant (Madere, 2017)



Appendix D: Negative and Positive Cognitions

Examples of Negative / Positive Cognitions

(Adapted from Shapiro, 2018, pp 443-444)

Negative Cognitions	Positive Cognitions
Responsibility/Defectiveness	
I'm not good enough	I am good enough/fine as I am
I don't deserve love	I deserve love; I can have love
I am a bad person	I am a good (loving) person
I am incompetent	I am competent
I am worthless/inadequate	I am worthy; I am worthwhile
I am shameful	I am honorable
I am not lovable	I am lovable
I deserve only bad things	I deserve good things
I am permanently damaged	I am/can be healthy
I am ugly/my body is hateful	I am fine/attractive/lovable
I do not deserve . . .	I can have/deserve . . .
I am stupid/not smart enough	I am intelligent/able to learn
I am insignificant/unimportant	I am significant/important
I am a disappointment	I am okay just the way I am
I deserve to die	I deserve to live
I deserve to be miserable	I deserve to be happy
I am different/don't belong	I am okay as I am
I have to be perfect (out of inadequacy)	I am fine the way I am
Responsibility: Action	
I should have done something*	I did the best I could
I did something wrong*	I learned/can learn from it
I should have known better*	I do the best I can/I can learn
*What does this say about you?	
(e.g., I am shameful/I am stupid/I am a bad person)	I'm fine as I am
I am inadequate/weak	I am adequate/strong
Safety/Vulnerability	
I cannot trust anyone	I can choose whom to trust
I cannot protect myself	I can learn to protect myself
I am in danger	It's over; I am safe now
I am not safe	I am safe now
I am going to die	I am safe now
It's not okay (safe) to feel/show my emotions	I can safely feel/show my emotions
Power/Control/Choice	
I am not in control	I am now in control
I am powerless/helpless	I now have choices
I cannot get what I want	I can get what I want
I cannot stand up for myself	I can make my needs known
I cannot let it out	I can choose to let it out
I cannot be trusted	I can be trusted
I cannot trust myself	I can/learn to trust myself
I cannot trust my judgment	I can trust my judgment
I cannot succeed	I can succeed
I have to be perfect	I can be myself/make mistakes
I can't handle it	I can handle it

Appendix E: Annotated Bibliography & References for Special Populations

The following is a selection of research on specific topics. A comprehensive, constantly-updated trove of all EMDR therapy-related conference presentations, articles, books, and other publications may be accessed via the web-based Francine Shapiro Library, at https://emdria.omeka.net.

Effects of EMDR Therapy - EEG

Pagani, M., Högberg, G., Fernandez, I., & Siracusano, A. (2013). Correlates of EMDR therapy in functional and structural neuroimaging: A critical summary of recent findings. *Journal of EMDR Practice and Research, 7,* 29–38.

> "EMDR-related neurobiological changes were monitored by EEG during therapy itself and showed a shift of the maximal activation from emotional limbic to cortical cognitive brain regions. This was the first time in which neurobiological changes occurring during any psychotherapy session have been reported, making EMDR the first psychotherapy with a proven neurobiological effect" (p. 29).

Effects of EMDR Therapy - SPECT Scanning

Levin, P., Lazrove, S., & van der Kolk, B. A. (1999). What psychological testing and neuroimaging tell us about the treatment of posttraumatic stress disorder (PTSD) by eye movement desensitization and reprocessing (EMDR). *Journal of Anxiety Disorders, 13,* 159-172.

> "Following EMDR, the subject experienced improvement in his level of distress, which correlated with decrements in PTSD and depressive symptomatology on psychological testing" (p. 159).

Lansing, K., Amen, D. G., Hanks, C. & Rudy, L. (2005). High resolution brain SPECT imaging and EMDR in police officers with PTSD. *Journal of Neuropsychiatry and Clinical Neurosciences, 17,* 526-532.

> "All police officers showed clinical improvement and marked reductions in the PDS (mean reduction from scores of 43.2 to 5.2). In addition, there were decreases in the left and right occipital lobe, left parietal lobe and right precentral frontal lobe, as well as significant increased perfusion (>0.001) in the left inferior frontal gyrus. Conclusions: In our study EMDR was an effective treatment for PTSD in this police officer group, showing both clinical and brain imaging changes" (p. 526).

Oh, D. H., & Choi, J. (2004). Changes in the regional cerebral perfusion after Eye Movement Desensitization and Reprocessing: A SPECT study of two cases. *Journal of EMDR Practice and Research, 1,* 24-30.

> "After EMDR, cerebral perfusion increased in bilateral dorsolateral prefrontal cortex and decreased in the temporal association cortex. The differences between participants and normal controls also decreased. Changes appeared mainly in the limbic area and the prefrontal cortex. These results are in line with current understanding of neurobiology of PTSD. EMDR treatment appears to reverse the functional imbalance between the limbic area and the prefrontal cortex" (p. 24).

Effects of EMDR Therapy - fMRI

Richardson, R., Williams, S. R., Hepenstall, S., Gregory, L., McKie, S., & Corrigan, F. (2009). A single-case fMRI study EMDR treatment of a patient with posttraumatic stress disorder. *Journal of EMDR Practice and Research, 3,* 10-23.

"The initiation of the EMDR protocol with provision of ABS was associated with a marked change in brain activation within the prefrontal cortex demonstrating a ventromedial shift. The authors argue that the structure of the EMDR protocol encourages such a ventromedial activation, which is then intensified by ABS to overcome the block to information processing that has been preventing natural healing from occurring spontaneously" (p. 10).

Rousseau, P.-F., El Khoury-Malhame, M., Reynaud, E., Boukezzi, S., Cancel, A., Zendjidjian, X., . . . Khalfa, S. (2019). Fear extinction learning improvement in PTSD after EMDR therapy: an fMRI study. European Journal of Psychotraumatology, 10(1), 1568132. doi:10.1080/20008198.2019.1568132

Zantvoord, J., Zhutovsky, P., Ensink, J., Op den Kelder, R., van Wingen, G., Lindauer, R. (2021). Trauma-focused psychotherapy response in youth with posttraumatic stress disorder is associated with changes in insula volume. *Journal of Psychiatric Research,* 132, 207-214. https://doi.org/10.1016/j.jpsychires.2020.10.037.

Effects of EMDR Therapy – PET

Rousseau, P. F., Malbos, E., Verger, A., Nicolas, F., Lançon, C., Khalfa, S. et al. (2019). Increase of precuneus metabolism correlates with reduction of PTSD symptoms after EMDR therapy in military veterans: an 18F-FDG PET study during virtual reality exposure to war. *European Journal of Nuclear Medicine and Molecular Imaging,* 1-5.

Verger, A., Rousseau, P. F., Malbos, E., Chawki, M. B., Nicolas, F., Lançon, C., . . . Guedj, E. (2020). Involvement of the cerebellum in EMDR efficiency: a metabolic connectivity PET study in PTSD. *European Journal of Psychotraumatology*, 11(1), 1767986.

- This study investigated the precuneus metabolic PET connectivity changes in military participants suffering from PTSD – PET scans were administered before and after EMDR therapy. The precuneus is a key region in the "default mode network" in the resting-state brain, and has important functions for self-related mental representations and integration of past and present information. None of the participants had received formal exposure or cognitive-behavioral therapy before the EMDR procedure. All participants were symptom-free and no longer diagnosed with PTSD after standard protocol EMDR therapy. This study also supports the role of the cerebellum in PTSD and the bottom-up theory of how PTSD develops and resolves.

Mechanisms of EMDR Therapy

Baek, J., Lee, S., Cho, T., et al. (2019). Neural circuits underlying a psycho-therapeutic regimen for fear disorders. *Nature, 566,* 339-343.

Baek et al. successfully induced a lasting reduction of fear in mice by pairing visual alternating bilateral sensory (ABS) stimulation with a conditioned stimulus. They traced the neural pathways from the superior colliculus (SC; portion of midbrain involved in visual-attentional processing) to the basolateral complex of the amygdala (BLA; involved in encoding fear and fear extinction).

Jellestad, L., Zeffiro, T., Piccirelli, M., et al. (2021). Interfering with fear memories by eye movement desensitization and reprocessing. *International Journal of Psychophysiology, 166,* 9-18.

In a fear conditioning procedure using videos of spiders, pursuit eye movements were effective in reducing fear-conditioned skin conductance response. This result supports the proposition that EMDR can interfere with reactivated fear memory reconsolidation.

Landin-Romero, R., Moreno-Alcazar, A., Pagani, M., Amann, B. L. (2018). How Does Eye Movement Desensitization and Reprocessing Therapy Work? A Systematic Review on Suggested Mechanisms of Action. *Frontiers in Psychology, 9,* 1395, 1-23. Doi: 10.3389/fpsyg.2018.01395

"Seventy-five studies were selected for review and classified into three overarching models; (i) psychological models (ii) psychophysiological models and (iii) neurobiological models. The evidence available from each study was analyzed and discussed. Results demonstrated a reasonable empirical support for the working memory hypothesis and for the physiological changes associated with successful EMDR therapy. Recently, more sophisticated structural and functional neuroimaging studies using high resolution structural and temporal techniques are starting to provide preliminary evidence into the neuronal correlates before, during and after EMDR therapy" (p 1).

Phaf, R. H., Hermans, M. E., Krepel, A., et al. (2021). Horizontal eye movements foster approach to negative pictures but do not change emotional valence: A dopaminergic regulation hypothesis. *New Ideas in Psychology, 62,* 100872.

A new dopaminergic regulation hypothesis is proposed based on two experiments exploring eye-movement (EM) effects. Results indicate that EMs foster an approach reaction to negative pictures but do not change their valence. EMs raise a direct dopamine signal from Superior Colliculus to Substantia Nigra. Individuals with same sided eye, handedness, and dopamine dominance experience the largest effects of EMs.

de Voogd, L. D., Kanen, J. W., Neville, D. A., Roelofs, K., Fernández, G., & Hermans, E. J. (2018). Eye-movement intervention enhances extinction via amygdala deactivation. *The Journal of Neuroscience, 38*(40), 8694 – 8706.

Both working-memory tasks and goal-directed eye movements enhanced extinction-based psychotherapy. Both tasks also deactivated the amygdala and altered connectivity between the amygdala and the dorsal frontoparietal network and between the amygdala and the ventromedial prefrontal cortex.

Zegerius, L., & Treur, J. (2020). Modelling metaplasticity and memory reconsolidation during an eye-movement desensitization and reprocessing treatment. *11th Annual International Conference on Brain-Inspired Cognitive Architectures for Artificial Intelligence*, Brazil. Doi. 10.1007/978-3-030-65596-9_74

A computational adaptive network model was presented to simulate the effect of EMDR therapy on persons with PTSD. Psychological traumas impair (extinction) learning by so-called 'negative metaplasticity' whereas EMDR shifts this back to 'positive metaplasticity'. This revitalizes extinction learning and memory reconsolidation. The adaptive network model and its simulation confirmed the functionality of the neural processes and the effective treatment results of EMDR.

Are Eye Movements Necessary?

Lee, C. W., & Cuijpers, P. (2013). A meta-analysis of the contribution of eye movements in processing emotional memories. *Journal of Behavior Therapy & Experimental Psychiatry, 44,* 231-239.

"The aim of this meta-analysis was to examine current published studies to test whether eye movements significantly affect the processing of distressing memories… 15 clinical trials and compared the effects of EMDR therapy with eye movements to those of EMDR without the eye movements… and 11 laboratory trials that investigated the effects of eye movements while thinking of a distressing memory versus the same procedure without the eye movements in a non-therapy context… Data indicated that treatment fidelity acted as a moderator variable on the effect of eye movements in the therapy studies. Results … suggest the processes involved in EMDR are different from other exposure based therapies" (p. 231).

De Jongh, A., Ernst, R., Marques, L., & Hornsveld, H. (2013). The impact of eye movements and tones on disturbing memories of patients with PTSD and other mental disorders. *Journal of Behavior Therapy and Experimental Psychiatry, 44,* 447–483.

"Eye movements were found to be more effective in diminishing the emotionality of the memory than 'recall only.' There was a trend showing that tones were less effective than eye movements, but more effective than 'recall only.' The majority of patients (64%) preferred tones to continue with. The effects of taxing working memory on disturbing memories did not differ between PTSD patients and those diagnosed with other conditions. The findings provide further evidence for the value of employing eye movements in EMDR treatments. The results also support the notion that EMDR is a suitable option for resolving disturbing memories underlying a broader range of mental health problems than PTSD alone" (p. 447).

Houben, S. T. L., Otgaar, H., Roelofs, J., Merckelbach, H., & Muris, P. (2020). The effects of eye movements and alternative dual tasks on the vividness and emotionality of negative autobiographical memories: A meta-analysis of laboratory studies. *Journal of Experimental Psychopathology, 11*(1)*,* 1–14.

A meta-analysis of fifteen laboratory studies involving 942 participants compared the effects of eye movements (EMs) and/or alternative dual tasks (ADTs; e.g., counting) on the vividness and emotionality of negative autobiographical memories with recall only (control) conditions. EMs and ADTs produced similar vividness and emotionality decreases. However, EMs yielded a stronger overall vividness reduction than ADTs.

EMDR via Telehealth

Bursnall, M., Thomas, B. D., Berntsson, H., Strong, E., Brayne, M., & Hind, D. (2022). Clinician and patient experience of internet-mediated eye movement desensitization and reprocessing therapy. *Journal of Psychosoc Rehabil Ment Health*, 1-12. doi:10.1007/s40737-022-00260-0

McGowan, I.W., Fisher, N., Havens, J. et al (2021). An evaluation of eye movement desensitization and reprocessing therapy delivered remotely during the Covid–19 pandemic. *BMC Psychiatry, 21***,** 560. https://doi.org/10.1186/s12888-021-03571-x

Mischler, C., Hofmann, A., Behnke, A., Matits, L., Lehnung, M., Varadarajan, S., Rojas, R., Kolassa, I.-T., Tumani, V. (2021). Therapists' experiences with the effectiveness and

feasibility of videoconference-based eye movement desensitization and reprocessing. *Frontiers in Psychology, 12*:748712. doi: 10.3389/fpsyg.2021.748712
Papanikolopoulos, P., Prattos, T., & Foundoulakis, E. (2022). Pandemic Times and the Experience of Online EMDR Practice in Greece: A Qualitative Study on Obstacles and Perspectives. *Journal of EMDR Practice and Research*, EMDR-2021. doi:10.1891/emdr-2021-0033
Smyth-Dent, K., Becker, Y., Burns, E., Givaudan, M. (2021). The acute stress syndrome stabilization remote individual (ASSYST-RI) for telemental health counseling after adverse experiences. *Psychology & Behavioral Science International Journal,16*(2): 555932. DOI:10.19080/PBSIJ.2021.16.555932

EMDR Therapy - Group Treatment

These studies describe the most recent effects of the Integrative Group Treatment Protocol (IGTP). This adapted protocol is available in:

Artigas, L., Jarero, I., Alcala, N., & Cano, T. L. (2009). The EMDR integrative group treatment protocol (IGTP). In M. Luber (Ed.), *Eye movement desensitization and reprocessing (EMDR) scripted protocols: Basics and special situations* (pp. 279-288). New York, NY: Springer Publishing Co.
Jarero, I., Artigas, L., Uribe, S., & Garcia, L. E. (2016). The EMDR integrative group treatment protocol for patients with cancer. *Journal of EMDR Practice and Research, 10*(3), 199–207.
Jarero, I., Roque-López, S., Gómez, J., & Givaudan, M. (2014). Third research study on the provision of the EMDR integrative group treatment protocol with child victims of severe interpersonal violence. *Revista Iberoamericana de Psicotraumatología y Disociación, 6*(2), 1–22.

A recent review of 4 different EMDR Group Treatments showed significantly reduced PTSD, depression and anxiety symptoms at post-treatment compared with pre-treatment or controls:

Kaptan, S. K., Dursun, B. O., Knowles, M., Husain, N., & Varese, F. (2021). Group eye movement desensitization and reprocessing interventions in adults and children: A systematic review of randomized and nonrandomized trials. *Clinical Psychology and Psychotherapy, 28*(4), 1–23.

EMDR with Special Populations

EMDR with Couples

Doğan, C. K., Yaşar, A. B., Gündoğmuş, I, (2021). Effects of EMDR couple protocol on relationship satisfaction, depression, and anxiety symptoms. *Journal of EMDR Practice and Research, 15*(4), 219-230.
Linder, J. N, Niño, A., Negash, S., Espinoza, S. (2021) Integrating EMDR and EFT To Treat Trauma In Couple Therapy: A Literature Review. *International Journal of Systemic Therapy, 32*(4), 251-272. DOI: 10.1080/2692398X.2021.1954862
Negash, S., Carlson, S. H., Linder, J. N. (2018). Emotionally Focused Therapy and Eye Movement Desensitization and Reprocessing: An Integrated Treatment to Heal the Trauma of Infidelity. *Couple and Family Psychology: Research and Practice*. http://dx.doi.org/10.1037/cfp0000107

EMDR with Children & Adolescents

Adler-Tapia, R., Settle, C. (2009). Evidence of the efficacy of EMDR with children and adolescents in individual psychotherapy: A review of the research published in peer-reviewed journals. *Journal of EMDR Practice and Research*, *3*(4), 232-247.

Barron, I. G. (2018). EMDR therapy with children and adolescents. *Journal of EMDR Practice and Research, 12*(4), 174-176.

Gokcen, C., Yilmaz, G., & Karadag, M. (2022). ADHD symptoms persist even when PTSD symptoms progress: An EMDR case report.Dusunen Adam, Journal of Psychiatry and Neurological Sciences, 35(5), 64-68. doi:10.14744/DAJPNS.2022.00174

Hensel, T. (2009). EMDR With children and adolescents after single-incident trauma: An Intervention study. *Journal of EMDR Practice and Research*, *3*(1), 2-9.

Kaptan, S. K., Yilmaz, B., Varese, F., Andriopoulou, P., & Husain, N. (2022). What works? Lessons from a pretrial qualitative study to inform a multi-component intervention for refugees and asylum seekers: Learning Through Play and EMDR Group Traumatic Episode Protocol. *Journal of Community Psychology*.

Karadağ, M., & Karadeniz, P. G. (2021). Comparison of group eye movement desensitization and reprocessing with cognitive and behavioral therapy protocol after the 2020 earthquake in Turkey: a field study in children and adolescents. *European Journal of Therapeutics, 27*(1): 40-4.

Lempertz D, Wichmann M, Enderle E, Stellermann-Strehlow K, Pawils S, Metzner F (2020) Pre–post study to assess EMDR-based group therapy for traumatized refugee preschoolers. Journal of EMDR Practice and Research, 14(1), 31–45.

Manzoni, M., Fernandez, I., Bertella, S., Tizzoni, F., Gazzola, E., Molteni, M., & Nobile, M. (2021). Eye movement desensitization and reprocessing: The state of the art of efficacy in children and adolescents with post traumatic stress disorder. *Journal of Affective Disorders, 282,* 340-347.

Meentken, M. G., van der Mheen, M., van Beynum, I. M., Aendekerk, E. W., Legerstee, J. S., van der Ende, J., & Utens, E. M. (2020). EMDR for children with medically related subthreshold PTSD: short-term effects on PTSD, blood-injection-injury phobia, depression and sleep. *European Journal of Psychotraumatology*, *11*(1), 1705598.

Olivier, E., de Roos, C., & Bexkens, A. (2021). Eye movement desensitization and reprocessing in young children (Ages 4–8) with posttraumatic stress disorder: A multiple-baseline evaluation. Child Psychiatry & Human Development. doi:10.1007/s10578-021-01237-z

van Pelt, Y., Fokkema, P., de Roos, C., & de Jongh, A. (2021). Effectiveness of an intensive treatment programme combining prolonged exposure and EMDR therapy for adolescents suffering from severe post-traumatic stress disorder. European Journal of Psychotraumatology, 12(1), 1917876. doi:10.1080/20008198.2021.1917876

Velu, M. E., Martens, I., Shahab, M., de Roos, C., Jongedijk, R. A., Schok, M., & Morren, T. (2022). Trauma-focused treatments for refugee children: Study protocol for a randomized controlled trial of the effectiveness of KIDNET versus EMDR therapy versus a waitlist control group (KIEM). Trials, 23(347). doi:10.1186/s13063-022-06178-z

Bilingual Speakers and Non-Western Cultures

Ateş-Barlas, A. (2022). EMDR Therapy for Bilinguals. Journal of EMDR Practice and Research, 16(1), 39-46. DOI: 10.1891/EMDR-2021-0022

Mbazzi, F. B., Dewailly, A., Admasu, K., Duagni, Y., Wamala, K., Vera, A., Bwesigye, D., Roth, G., 2021). Cultural Adaptations of the Standard EMDR Protocol in Five African Countries. Journal of EMDR Practice and Research, 15(1), 29-43. DOI: 10.1891/EMDR-D-20-00028

Persons Marginalized/Oppressed due to Race, Ethnicity, Culture or Country of Origin

Lipscomb, A., & Ashley, W. (2021). A critical analysis of the utilization of eye movement desensitization and reprocessing (EMDR) psychotherapy with African American clients. *Journal of Human Services: Training, Research, and Practice,7*(1), article 3.

Nickerson, M. (2016). Cultural competence and healing culturally based trauma with EMDR therapy: Innovative strategies and protocols. New York, NY: Springer Publishing Co.

Persons with Specific Religious Beliefs/Practices

Khalid Abdul-Hamid, W., & Hacker Hughes, J. (2015). Integration of religion and spirituality into trauma psychotherapy: An example in Sufism? Journal of EMDR Practice and Research, 9(3), 150-156.

Heuertz, E. M., & Sperling, C. L. (2019, April 25-27). Integrating psychological healing with spiritual healing: Comparing and contrasting eye movement desensitization & reprocessing (EMDR) with inner healing prayer [Conference presentation]. Catholic Psychotherapy Association (CPA) Annual Conference, Atlanta, GA, United States.

EMDR with Military Veterans

Hurley, E. C. (2018). Effective Treatment of Veterans With PTSD: Comparison Between Intensive Daily and Weekly EMDR Approaches. *Frontiers in Psychology, 9,* 1458. doi: 10.3389/fpsyg.2018.01458

Hurley, E. C. (2021). *A clinician's guide for treating active military and veteran populations with EMDR therapy.* Springer Publishing Company.

Kitchiner, N. J., Lewis, C., Roberts, N. P., & Bisson, J. I. (2019). Active duty and ex-serving military personnel with post-traumatic stress disorder treated with psychological therapies: systematic review and meta-analysis. *European Journal of Psychotraumatology, 10*(1), 1684226. doi:10.1080/20008198.2019.1684226

Russell, M. (2006). Treating combat-related stress disorders: A multiple case study utilizing eye movement desensitization and reprocessing (EMDR) with battlefield casualties from th Iraqi war. *Military Psychology, 18*(1), 1-18.

Russell, M. (2008). Treating traumatic amputation-related phantom limb pain: A case study utilizing eye movement desensitization and reprocessing (EMDR) within the armed services. *Clinical Case Studies, 7*(2), 136-153.

Silver, S. M., Rogers, S., & Russell, M.C. (2008). Eye movement desensitization and reprocessing (EMDR) in the treatment of war veterans. *Journal of Clinical Psychology: In Session, 64*(8), 947—957.

EMDR is Effective in Conditions Other Than PTSD

Building on EMDR's success in treating PTSD, clinicians and researchers have expanded their investigation into the effectiveness of EMDR in treating other conditions. Much of what has been published are case reports or case series. However, a number of Randomized Controlled Trials (RCTs) have been published, especially in the last decade.

RCTs have shown effectiveness in the treatment of:

- Phobias, especially specific phobias
    - Dental (Doering, Ohlmeier, Jongh, Hofmann, & Bisping, 2013)
    - Flying (Triscari, Faraci, D'Angelo, Urso, & Catalisano, 2015)
    - Injections (Meentken, van der Mheen, van Beynum, et al., 2020)
    - Death anxiety (Fotovvat, Moradi-Baglouee, Soleimani, & Mafi, 2021).
- Social Anxiety Disorder (Lafmejani, Biniaz, & Rezaei, 2020).
- Panic disorder (Horst et al., 2017)
- Obsessive Compulsive Disorder (Talbot, 2021; Nazari, Momeni, Jariani, & Tarrahi, 2011)
- Bipolar Disorder (Novo et al., 2014)
- Depression (Gauhar, 2016; Jahanfar, Fereidouni, Behnammoghadam, Dehghan, & Bashti, 2020)
- Addictions (Hase, Schallmayer, & Sack, 2008)
- Schizophrenia and schizoaffective disorder (Van den Berg et al., 2015)

- Personality Disorders (Hafkemeijer, de Jongh, van der Palen, & Starrenburg, 2020).
- Pain (Gerhardt et al., 2016; Rostaminejad, Behnammoghadam, Rostaminejad, Behnammoghadam, & Bashti, 2017; Suarez et al., 2020)
- Post myocardial infarction anxiety (Moradi, Zeighami, Moghadam, Javadi, & Alipor, 2016) and depression (Behnam Moghadam, Alamdari, Behnam Moghadam, & Darban, 2015; Karimi, Behnammoghadam, Moazamfard, & Bashti, 2020); and post coronary artery bypass graft surgery depression and stress (Abdoli Bidhendi, Rafieinia, Pourhosein, Sabahi, & Shahmansouri, 2021).
- PTSD in Cancer patients (Capezzani et al., 2013)
- PTSD in Multiple Sclerosis (Carletto et al., 2016)

Case reports or case series show effectiveness in complicated grief, body dysmorphic disorder, fibromyalgia, migraine, musculoskeletal pain, trigeminal neuralgia, neuropathy, olfactory reference syndrome, and chronic fatigue. The subject of EMDR for conditions other than PTSD has been recently reviewed in Valiente-Gomez et al.(2017), Shapiro (2018), and Scelles & Bulnes (2021). Below is a selection of references, some annotated, that describe the use of EMDR therapy to treat commonly occurring treatment issues.

Addictions

Markus, W. & Hornsveld, H. K. (2017). EMDR Interventions in addiction. *Journal of EMDR Practice and Research, 11*(1), 3-29.

O'Brien, J. M. & Abel, N. J. (2011). EMDR, addictions, and the stages of change: A road map for intervention, *Journal of EMDR Practice and Research, 5*(3), 121-130.

Palumbo, R., Protokowicz, J., & Roberto, A. (2020). What You Need to Know: Eye Movement Desensitization and Reprocessing Therapy as a Path to Recovery for Patients with Substance Use Disorder. *J Addict Nurs, 31*(3), 225-226.

Alcohol Dependency

Perez-Dandieu, B., & Tapia, G. (2014). Treating trauma in addiction with EMDR: a pilot study. *Journal of Psychoactive Drugs*, *46,* 303–309.

Anti-Oppression & Discrimination Related Issues

Lipscomb, A., & Ashley, W. (2021). A critical analysis of the utilization of eye movement desensitization and reprocessing (EMDR) psychotherapy with African American clients. *Journal of Human Services: Training, Research, and Practice,7*(1), article 3.

There are minimal references to diversity, culture, or context in EMDR literature. The authors utilized an anti-oppressive, Critical Race theoretical perspective to examine four cases of African American clients who received EMDR intervention to gain insight on the unique treatment nuances, such as stigma, shame regarding help seeking and historical trauma. Emphasis is on critiquing the treatment protocol, the positionality of the clinician, and clinical implications for future anti-oppressive practice with African Americans.

Bipolar Disorder

Novo, P., Landin-Romero, R., Radua, J., Vicens, V., Fernandez, I., Garcia, F., et al. (2014). Eye movement desensitization and reprocessing therapy in subsyndromal bipolar patients with a history of traumatic events: a randomized, controlled pilot-study. *Psychiatry Research, 219*, 122–128.

Moreno-Alcázar, A., Radua, J., Landín-Romero, R., Blanco, L., Madre, M., Reinares, M., et al. (2015). The EMDR therapy protocol for bipolar disorder, in M. Luber (Ed.), *Eye movement desensitization and reprocessing (EMDR) therapy scripted protocols and summary sheets: treating anxiety, obsessive-compulsive, and mood-related conditions*. New York: Springer.

Valiente-Gomez, A., Moreno-Alcazar, A., Gardoki-Suoto, I., Masferrer, C., Porta, S., Royeula, O. & … Amman, B. L. (2019). The state of art of EMDR in bipolar disorder. *Journal of EMDR Practice and Research, 13*(4), 307-312.

COVID-19 Related Issues

Perri, R. L., Castelli, P., La Rosa, C., Zucchi, T., & Onofri, A. (2021). COVID-19, isolation, quarantine: on the efficacy of Internet-based eye movement desensitization and reprocessing (EMDR) and cognitive-behavioral therapy (CBT) for ongoing trauma. *Brain Sciences, 11,* 579.

Thirty-eight patients with acute stress disorder associated with COVID-19 quarantine or disease were randomly assigned to EMDR or CBT treatment administered online for 7 sessions. Results revealed that both treatments reduced anxiety by 30%, and traumatic and depressive symptoms by 55% post-treatment and at one month follow-up. They concluded that Internet-based EMDR and CBT are equally effective brief treatments.

El-Abbassy, A. A., El Berry, K. I., El Mageed, H. H. A., & Amer, H. M. (2021). The effect of eye movement desensitization and reprocessing technique on COVID-19 induced anxiety, depression, sleep quality among emergency nurses. *Annals of the Romanian Society for Cell Biology, 25*(5), 3185 – 3205.

100 Emergency Department nurses with COVID-19 induced anxiety, depression, and sleep pattern disturbance were studied in a pre-post treatment study design. There was a significant improvement in the mean total scores of anxiety, depression, and nurses' sleep quality from pre- to post-treatment.

Moench, J., & Billsten, O. (2021). Randomized controlled trial: self-care traumatic episode protocol, computerized EMDR treatment of COVID-19-related stress, *Journal of EMDR Practice and Research, 15*(2), 99-113.

A randomized controlled trial of mental health clinicians using the Self-Care Traumatic Episode Protocol (a computerized intervention adapted from the EMDR Group Traumatic Episode Protocol) indicated that STEP was more effective than waitlist in increasing general self-efficacy and reducing symptoms of depression, anxiety, and stress related to COVID-19.

Depression (unipolar)

Baptist, J., Thompson, D. E., Spencer, C., Mowla, M. R., Love, H. A., & Su, Y. (2021). Clinical efficacy of EMDR in unipolar depression: changes in theta cordance. *Psychiatry Research, 296,* 113696.

Hase, M., Balmaceda, U. M., Hase, A., Lehnung, M., Tumani, V., Huchzermeier, C., & Hofmann, A. (2015). Eye movement desensitization and reprocessing (EMDR) therapy in the treatment of depression: A matched pairs study in an inpatient setting. *Brain and Behavior, 5*: e00342. Doi: 10.1002/brb3.342.

Jahanfar, A., Fereidouni, Z, Behnammoghadam, M., Dehghan, A., & Bashti, S. (2020). Efficacy of eye movement desensitization and reprocessing on the quality of life in patients with major depressive disorder: a randomized clinical trial. *Psychology Research and Behavior Management, 13*, 11-17.

Review findings suggest that EMDR may be considered an effective treatment for improving symptoms of depression, with effects comparable to other active treatments:

Carletto, S., Malandrone, F., Berchialla, P., Oliva, F., Colombi, N., Hase, M., Hofmann, A., & Ostacoli, L. (2021). Eye movement desensitization and reprocessing for depression: a systematic review and meta-analysis. *European Journal of Psychotraumatology, 12*(1), 1894736.

Dominguez, S. K., Matthijssen, S. J., & Lee, C. W., 2021). Trauma-focused treatments for depression, A systematic review and menta-analysis. PLoS One, 16(7), e0254778.

Sepehry, A. A., Lam, K., Sheppard, K., Guirguis-Younger, M., Maglio, A-S. (2021). EMDR for depression: a meta-analysis and systematic review. *Journal of EMDR Practice and Research, 15*(1), 2-17.

Yan, S., Shan, Y., Zhong, S., Miao, H., Luo, Y., Ran, H., Jia, Y. (2021). The Effectiveness of Eye Movement Desensitization and Reprocessing Toward Adults With Major Depressive Disorder: A Meta-Analysis of Randomized Controlled Trials. *Frontiers in Psychiatry* 12:700458. doi: 10.3389/fpsyt.2021.700458

Eating Disorders

Balbo, M., Zaccagnino, M., Cussino, M., & Civiiotti, C. (2017). Eye movement desensitization and reprocessing (EMDR) and eating disorders: A systematic review. *Clinical Neuropsychiatry: Journal of Treatment Evaluation*, *14*(5), 321–329.

Bloomgarden, A., & Calogero, R. M. (2008). A randomized experimental test of the efficacy of EMDR treatment on negative body image in eating disorder inpatients. *Eating Disorders*, *16*(5), 418–427.

Cooke, L. J., & Grand, C. (2009). The neurobiology of eating disorders, Affect regulation skills, and EMDR in the treatment of eating disorders. In R. Shapiro (Ed.), *EMDR solutions II: For depression, eating disorders, performance, and more* (pp. 129–150). WW Norton & Company.

Erguney-Okumuş, F. E. (2021). Integrating EMDR with enhanced cognitive behavioral therapy in the treatment of bulimia nervosa: a single case study. Journal of EMDR Practice and Research, 15(4), 231-243.

Halvgaard, K. (2015). Single case study: Does EMDR psychotherapy work on emotional eating? *Journal of EMDR Practice and Research*, *9*(4), 188–197.

Psychosis

Granier, C. & Brunel, L. (2022). Remission of schizophrenia after an EMDR session, *European Journal of Psychotraumatology, 13*(1). DOI: 10.1080/20008198.2021.2014660

Van den Berg, D. P., de Bont, P. A., van der Vleugel, B. M., de Roos, C., de Jongh, A., Van Minnen, A., et al. (2015). Prolonged exposure vs eye movement desensitization and reprocessing vs waiting list for posttraumatic stress disorder in patients with a psychotic disorder: a randomized clinical trial. *JAMA Psychiatry, 72,* 259–267.

Van den Berg, D. P., de Bont, P. A., van der Vleugel, B. M., de Roos, C., de Jongh, A., Van Minnen, A., et al. (2015). Trauma-focused treatment in PTSD patients with psychosis: symptom exacerbation, adverse events, and revictimization. *Schizophrenia Bulletin, 42,* 693–702.

Adams, R., Ohlsen, S., & Wood, E. (2020). Eye Movement Desensitization and Reprocessing (EMDR) for the treatment of psychosis: a systematic review. *European Journal of Psychotraumatology, 11(1),* 1711349.

- EMDR was associated with reductions in delusional and negative symptoms, mental health service and medication use. Evidence for reductions in auditory hallucinations and paranoid thinking was mixed. EMDR appears a safe and feasible intervention for people with psychosis**.**

Obsessive-Compulsive Disorder

Cuisimano, A. (2018) EMDR in the treatment of adolescent obsessive-compulsive disorder: A case study, *Journal of EMDR Practice and Research, 12*(4), 242-254.

Marr, J. (2012). EMDR treatment of obsessive-compulsive disorder: preliminary research. *Journal of EMDR Practice and Research, 6*(1), 2-15.
Marsden, Z. (2016). EMDR treatment of obsessive-compulsive disorder: three cases. *Journal of EMDR Practice and Research, 10*(2), 91-103.
Nazari, H., Momeni, N., Jariani, M., & Tarrahi, M. J. (2011). Comparison of eye movement desensitization and reprocessing with citalopram in treatment of obsessive-compulsive disorder. *International Journal of Psychiatry Clinical Practice*, *15*, 270–274.
Talbot, D. (2021). Examination of initial evidence for eye movement desensitization and reprocessing as a treatment for obsessive-compulsive disorder. *Journal of EMDR Practice and Research. 15*(3), 1-7.

Analysis of six case studies and three group studies indicated that EMDR therapy resulted in significantly reduced OCD symptoms from baseline. Also, EMDR may be as effective as exposure response prevention, and more effective than selective serotonin reuptake inhibitors, in treating OCD.

Pain Management

Abdi, N., Malekzadeh, M., Fereidouni, Z. et al. (2021). Efficacy of EMDR therapy on the pain intensity and subjective distress of cancer patients*. Journal of EMDR Practice and Research, 15*(1), 18.
Mazzola, A., Calcagno, M. L., Goicochea, M. T., Pueyrredòn, H., Leston, J., & Salvat, F. (2009). EMDR in the treatment of chronic pain. *Journal of EMDR Practice and Research, 3*(2), 66-79.
Suárez, N., Pérez, J. M., Hogg, B. M., Gardoki-Souto, I., Guerrero, F. G., Cabrera, S. J., Bernal, D. S., Amann, B. L., & Moreno-Alcázar, A. (2020). EMDR versus treatment-as-usual in patients with chronic non-malignant pain: a randomized controlled pilot study. *Journal of EMDR Practice and Research, 14*(4), 190-205.
Tesarz, J., Leisner, S., Gerhardt, A., Janke, S., Seidler, G. H., Eich, W., et al. (2014). Effects of eye movement desensitization and reprocessing (EMDR) treatment in chronic pain patients: A systematic review. *Pain Medicine, 15,* 247–263.

Panic Disorder

Faretta, E. (2012). EMDR and cognitive-behavioural therapy in the treatment of panic disorder: a comparison. *Rivisita di Psichiatria, 47,* 19–25.
Leeds, A. M. (2012). EMDR treatment of panic disorder and agoraphobia: Two model treatment plans. *Journal of EMDR Practice and Research, 6*(3), 110-119.

Personality Disorders

Hafkemeijer, L., de Jongh, A., van der Palen, J. & Starrenburg, A. (2020). Eye movement desensitization and reprocessing (EMDR) in patients with a personality disorder. *European Journal of Psychotraumatology, 11*(1), 1838777.
In a randomized-controlled trial of outpatients with a personality disorder as main diagnosis, five sessions of EMDR therapy (ninety minutes each) yielded significant improvements compared to a waiting list control group after treatment and at 3 month follow up for psychological symptoms, psychological distress, and personality functioning.

Phobias

Doering, S., Ohlmeier, M. C., de Jongh, A., Hofmann, A., & Bisping, V. (2013). Efficacy of a trauma-focused treatment approach for dental phobia: a randomized clinical trial. *European Journal of Oral Science, 121,* 584–593.

Meentken, M. G., van der Mheen, M., van Beynum, I. M. et al. (2020). EMDR for children with medically related subthreshold PTSD: short-term effects on PTSD, blood-injection-injury phobia, depression and sleep**.** *European Journal of Psychotraumatology, 11*(1), 1705598.

Triscari, M. T., Faraci, P., D'Angelo, V., Urso, V., & Catalisano, D. (2011). Two treatments for fear of flying compared: cognitive behavioral therapy combined with systematic desensitization or eye movement desensitization and reprocessing (EMDR). *Aviation Psychology and Applied Human Factors*, *1*: 9–14.

Sex Offenders and Other Perpetrators

Ricci, R. J. (2006). Trauma resolution using eye movement desensitization and reprocessing with an incestuous sex offender: An instrumental case study. *Clinical Case Studies, 5*, 248– 265.

Ricci, R. J., Clayton, C. A., & Shapiro, F. (2006). Some effects of EMDR on previously abused child molesters: Theoretical reviews and preliminary findings. *Journal of Forensic Psychiatry and Psychology, 17*, 538–562.

Ricci, R. J., Clayton, C. A., Foster, S., Jarero, I., Litt, B., Artigar, L., & Kamin, S. (2009). Special applications of EMDR: Treatment of performance anxiety, sex offenders, couples, families, and traumatized groups. *Journal of EMDR Practice and Research, 3*(4), 279-288.

Social Anxiety Disorder

Lafmejani, A. Q., Biniaz, D. S., & Rezaei, S. (2020). The effectiveness of eye movement desensitization and reprocessing (EMDR) on fear of negative evaluation (FNE) and social adjustment in female students with social phobia. *International Journal of Psychology, 14*(1), 192-226.

Appendix F: Essential Terms & Definitions

Abreaction – "The re-experiencing of the stimulated memory at a high level of disturbance" (Shapiro, 2018, p. 88). During an abreaction, the emotions and physical sensations are particularly strong, perhaps almost as strong as they were during the original event (Shapiro, 2018, p. 121).

BL-DAS – bi-lateral dual-attention stimulus, also referred to as DAS (dual-attention stimulus), BLAS (bi-lateral alternating stimulus), eye movements, or taps. Often administered in sets during EMDR resourcing and reprocessing protocols.

Memory–
Implicit Memory – includes nonverbal, nondeclarative, somatosensory, or procedural. Involves skills or attitudes that have become second nature or relatively automatic (e.g., riding a bike) or unconscious.
Explicit Memory – includes verbal or declarative. Involves information that is consciously available regarding past experience, including free recall of facts or lists, concept of time, and is predominantly verbal or visual-spatial. There are two main categories of explicit memory:

- **Episodic Memory** – the memory of autobiographical events (times, places, emotions, and who, what, when, where, why) that can be explicitly stated as personal experiences that occurred at a particular time and place.
- **Semantic Memory** – a structured record of facts, concepts and skills acquired throughout life via episodic memory (e.g., general knowledge about the world)

Target Memory– the experience, incident, or representative real or composite (may be at least partially imagined) experience which is the subject of EMDR Phases IV-VIII.

Pass – (aka *saccade*) one "round trip" of BL-DAS. In eye movements, one "pass" looks like this:

Eyes looking straight ahead, at fingers of clinician or other object (wand, lightbar, etc.).	*Eyes tracking fingers or object to the left, without moving head/neck.*	*Eyes tracking to Right…*	*Eyes tracking center, looking straight ahead…*

Reprocessing – refers to Phases IV-VI of EMDR therapy, during which the target memory and associated material is accessed, desensitized to no disturbance or neutral, a positive self-referencing cognition is selected to represent the adaptive resolution, checked for validity, and a body scan is completed to ensure all emotional, cognitive, and somatic aspects of the memory are resolved.

Resourcing – primarily refers to protocols such as Calm/Safe Place utilized in Phase II / Preparation of EMDR therapy, similar protocols to access and strengthen adaptive material, and other strategies to support regulation, stabilization, containment, and state shifting within EMDR therapy.

Set – a series of BL-DAS, typically comprised of 3-12 passes during resourcing protocols, and 24+ passes in reprocessing protocols.

Trauma – Can include DSM-5 Criterion A events and /or the experience of neglect or abuse that undermines an individual's sense of worth, safety, ability to assume appropriate responsibility for self or other, or limits one's sense of control or choices. EMDR and the AIP Model conclude that a person experiences an event or pattern as "traumatic" when it cannot be adequately or adaptively processed by their nervous system. Said differently, trauma is any experience that an individual is not (by virtue of internal or external resources or adaptive material) prepared to handle.

Appendix G: References

From Recommended Screening Tools:

Armstrong, J., Putnam, F. W., Carlson, E., Libero, D., & Smith, S. (1997). Development and validation of a measure of adolescent dissociation: The Adolescent Dissociative Experience Scale. *Journal of Nervous and Mental Disease, 185*, 491–497.

Bernstein, E. M., & Putnam, F.W. (1986). Development, reliability, and validity of a dissociation scale. *Journal of Nervous Mental Disorders, 174*(12), 727–35.

Carlson, E. B., & Putnam, F. W. (1992). *Manual for the Dissociative Experiences Scale.* Lutherville, MD: Sidran Foundation.

Carlson, E. B., & Putnam, F. W. (1993). An update on the Dissociative Experience Scale. *Dissociation, 6,* 16-27.

Carlson, E. B., Putnam, F. W., Ross, C.A., Torem, M., Coons, P., Bowman, E. S., et al. (1993). Predictive validity of the Dissociative Experiences Scale. *American Journal of Psychiatry, 150,* 1030-1036.

Dalenberg, C., & Carlson, E. (2010, November). *New versions of the Dissociative Experiences Scale: The DES-R (revised) and the DES-B (brief).* Paper presented at the 26th annual meeting of the International Society for Traumatic Stress Studies, Montreal, Quebec.

Dell, P .F. (2006). Multidimensional Inventory of Dissociation (MID). A comprehensive measure of pathological dissociation. *Journal of Trauma & Dissociation, 7*, 77-106.

Felitti, V. J., & Anda, R. F. (2014). The lifelong effects of adverse childhood experiences. In D. L. Chadwick, A. P. Ciardino, R. Alexander, J. D. Thackeray, & D. Esernio-Jessen (Eds.), *Chadwick's childhood maltreatment: Sexual abuse and psychological maltreatment (*Vol. 2, pp. 203-216). Saint Louis, MO: STM Learning.

Gratz, K. & Roemer, L. (2004). Multidimensional Assessment of Emotion Regulation and Dysregulation: Development, Factor Structure, and Initial Validation of the Difficulties in Emotion Regulation Scale. *Journal of Psychopathology and Behavioral Assessment*, *26*(1), 41-54.

Ippen, C. G., Ford, J., Racusin, R., Acker, M., Bosquet, M., Rogers, K., et al., (2002). *Traumatic Events Screening Inventory - Parent Report Revised.* Available at http://www.ptsd.va.gov/professional/pages/assessments/assessment-pdf/TESI-C.pdf

Kate, M.-A., Jamieson, G., Dorahy, M. J., & Middleton, W. (2020). Measuring dissociative symptoms and experiences in an Australian college sample using a short version of the multidimensional inventory of dissociation. *Journal of Trauma & Dissociation*, 1-23. doi:10.1080/15299732.2020.1792024

Nijenhuis, E. R. S., Spinhoven, P., Van Dyck, R., Van der Hart, O., & Vanderlinden, J. (1996). The development and the psychometric characteristics of the Somatoform Dissociation Questionnaire (SDQ 20). *Journal of Nervous and Mental Disease, 184,* 688–694.

Nijenhuis E. R., Spinhoven P, van Dyck R, van der Hart O, & Vanderlinden J. (1997). The development of the somatoform dissociation questionnaire (SDQ-5) as a screening instrument for dissociative disorders. *Acta Psychiatrica Scandanavica, 96*(5), 311-318.

Nijenhuis, E. R. S., Van der Hart, O., & Kruger, K. (2002). The psychometric characteristics of the Traumatic Experiences Questionnaire (TEC): First findings among psychiatric outpatients. *Clinical Psychology and Psychotherapy, 9*(3), 200-210.

Price, C. J., & Thompson, E. A. (2007). Measuring Dimensions of Body Connection: Body Awareness and Bodily Dissociation. *Journal of Alternative & Complementary Medicine, 13*(9), 945–953.

Putnam, F. W., & Peterson, G. (1994). Further validation of the *Child Dissociative Checklist*. *Dissociation: Progress in the Dissociative Disorders, 7*(4), 204-211.

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Wherry, J. N., Jolly, J. B., Feldman, J., Adam, B., Manjanatha, B. S., Shalini, M. (1994). The Child Dissociative Checklist. *Journal of Child Sexual Abuse, 3,* 51-66.

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