EMDR THERAPY WORKSHEETS AND RESOURCES
FOR CLINICAL PRACTICE

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October 2, 2021
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**GLOSSARY OF EMDR THERAPY TERMS**

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<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td>EMDR Therapy</td>
<td>EMDR therapy is an integrative treatment approach (distinct from psychodynamic, CBT, experiential, etc.) consisting of eight-phases, compatible with all major psychotherapy orientations. It is a comprehensive approach that addresses the physiological storage of memory and how it informs experience. Change is understood as a byproduct of reprocessing due to the alteration of memory storage and the linkage to adaptive memory networks. Dual attention bilateral stimulation or BLS (eye movements, tactile taps, and auditory tones) is merely one component of EMDR therapy.</td>
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<tr>
<td>Adaptive Information Processing</td>
<td>The distinct information processing model that represents the cornerstone of the EMDR approach to psychotherapy and guides clinical practice.</td>
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<tr>
<td>Bilateral Stimulation (BLS)</td>
<td>Eye movements, tapping or auditory alternating stimulus used as dual attention stimuli (external focus) as client simultaneously focuses on some aspect of the internal experience.</td>
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<td>Channels of Associations</td>
<td>Events, thoughts, emotions, etc., within the memory network that spontaneously arise during reprocessing of the identified target.</td>
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<tr>
<td>Cognitive Interweave</td>
<td>A proactive and interactive strategy used during Reprocessing phases 4-6 when the client’s adaptive reprocessing has stalled.</td>
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<td>Ecologically adaptive</td>
<td>Ecologically adaptive responses are those at a level of resolution (SUD greater than 0 or VOC less than 7) suitable for a given individual, time and situation. Residual disturbance or a positive belief not feeling “completely true” can be considered ecological only after appropriate efforts have been made to continue reprocessing.</td>
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<tr>
<td>Memory Networks</td>
<td>Memories with similar information (senses, thoughts, emotion, body sensations and/or beliefs) are linked by their channels of association. Maladaptive/dysfunctional memory networks are the primary basis of pathology including negative patterns of behavior, affects, sensations and distorted beliefs about self and other. Adaptive memory networks are the primary basis of learning, self-esteem, and other positive resources and behaviors; consisting of associated memories that are processed and integrated.</td>
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<tr>
<td>Negative Cognition (NC) = Negative Belief</td>
<td>A belief about the self that is associated with inadequately processed, maladaptively stored experiences.</td>
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<tr>
<td>Positive Cognition (PC) = Positive Belief</td>
<td>A more adaptive belief about the self that is identified in relation to the negative belief associated with the maladaptively stored negative memory/experience. The positive cognition sets the direction of change by linking the memory with adaptive information.</td>
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<tr>
<td>Presenting Problem</td>
<td>The presenting problem describes a specific context in which the underlying issue is experienced, often with a narrow focus. It may be a past or present problem. E.g., “I feel scrutinized by my boss. Last week I was called into their office and was terrified that I had made some horrible error.” See Underlying Issue.</td>
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<tr>
<td>Return to Target</td>
<td>Having the client redirect their focus of attention to the target memory/experience within a reprocessing session. &quot;When you bring up the memory as you experience it now, what are you noticing?&quot;</td>
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<tr>
<td><strong>Set</strong></td>
<td>During reprocessing: 20 or more <em>round trip passes</em> (left/right) of eye movements or other forms of bilateral stimulation (taps, tones). Slower &amp; shorter sets of 6-8 are used during Preparation and Stabilization Phase for installing Safe/Calm State or other resources.</td>
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<td><strong>State Change</strong></td>
<td>Temporary shift in one’s emotional state facilitated by a change in focus of attention. Example: use of safe state to shift from a state of relative distress to a state of calm.</td>
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<tr>
<td><strong>Subjective Units of Disturbance Scale (SUD 0-10)</strong></td>
<td>Scale used to measure the level of distress associated with a memory where 0 is no disturbance/neutral and 10 is the highest disturbance/distress.</td>
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<tr>
<td><strong>Target Memory</strong></td>
<td>The identified memory that is the focus for reprocessing within a clinical session. This selected memory/node is the focus of the Target Assessment Phase. During reprocessing, channels of associations from other relevant experiences emerge.</td>
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<td><strong>Three-Pronged Protocol</strong></td>
<td>Past Events, Present Triggers, and Future Templates – reprocessing targets of the EMDR approach to psychotherapy that ensures comprehensive clinical effects.</td>
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<td><strong>TICES</strong></td>
<td>The components of memory: Trigger (or Target), Image (or other sensory aspects of the memory), Cognition, Emotion, and Sensation.</td>
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<tr>
<td><strong>Touchstone Memory</strong></td>
<td>The earliest memory or experience a client can identify that represents the formation of the maladaptively stored memory network.</td>
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<tr>
<td><strong>Trait Change</strong></td>
<td>A characteristic pattern of response or shift in experience that is permanent (versus a temporary shift in one’s experience due to the application of a state shift strategy or change in focus).</td>
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<tr>
<td><strong>Underlying Issue</strong></td>
<td>An issue prioritized for treatment based on a collaborative understanding of the presenting problem(s) and clinical themes derived from Phase 1, History Taking and Treatment Planning. The underlying issue may include clinical themes of Responsibility, Safety, Control/Choice, and Connection/Belonging. The underlying issue can show up in a variety of contexts. For example, a client who enters treatment with a presenting problem of feeling scrutinized by their boss may experience a pervasive feeling of inadequacy that is experienced in several contexts (e.g., comparison of oneself in friendships and with family, concerns about appearance, difficulty with compliments and criticism, and avoidance of taking on challenges). The overall underlying issue in this case could be referred to as Low Self Esteem. Careful evaluation of the larger underlying issue is likely to lead to more effective target identification than the narrowly focused presenting problem.</td>
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<tr>
<td><strong>Validity of Cognition Scale (VOC 1-7)</strong></td>
<td>Measurement of how valid or true the positive belief (PC) feels now as one focuses on the Target Memory where 1 feels completely false and 7 feels completely true.</td>
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<tr>
<td>Phase</td>
<td>Purpose</td>
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<tr>
<td><strong>Phase One</strong></td>
<td>Obtain background information.</td>
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<tr>
<td><strong>History Taking</strong></td>
<td>Identify suitability for EMDR treatment.</td>
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<tr>
<td><strong>Treatment Planning</strong></td>
<td>Identify reprocessing targets from positive and negative events in client’s life.</td>
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<td><strong>Phase Two</strong></td>
<td>Prepare appropriate clients for EMDR reprocessing of targets.</td>
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<tr>
<td><strong>Preparation and</strong></td>
<td>Stabilize and increase access to positive states: (Safe/Calm State).</td>
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<tr>
<td><strong>Stabilization</strong></td>
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<tr>
<td><strong>Phase Three</strong></td>
<td>Access the target for EMDR reprocessing by stimulating primary aspects of the memory.</td>
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<tr>
<td><strong>Target Assessment</strong></td>
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<tr>
<td><strong>Phase Four</strong></td>
<td>Reprocess experiences toward an adaptive resolution (0 SUD level).</td>
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<tr>
<td><strong>Desensitization</strong></td>
<td>Fully reprocess all channels to allow a complete assimilation of memories.</td>
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<td>Incorporate templates for positive experiences.</td>
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<td><strong>Phase Five</strong></td>
<td>Increase connections to positive cognitive networks.</td>
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<td><strong>Installation</strong></td>
<td>Increase generalization effects within associated memories.</td>
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<tr>
<td><strong>Phase Six</strong></td>
<td>Complete reprocessing of any residual disturbance associated with the target.</td>
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<td><strong>Body Scan</strong></td>
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<td><strong>Phase Seven</strong></td>
<td>Ensure client stability at the completion of an EMDR session and in between sessions.</td>
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<td><strong>Closure</strong></td>
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<td><strong>Phase Eight</strong></td>
<td>Evaluation of treatment effects.</td>
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<tr>
<td><strong>Reevaluation</strong></td>
<td>Ensure comprehensive reprocessing over time.</td>
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Excluding situations caused by insufficient information/organic deficits, the causes of present dysfunction are physiologically stored memories of past experiences. As memories of past and present are successfully reprocessed, adaptive responses to the future are developed. This integrative, three-pronged protocol requires an orientation to past, present and future.
The following may be treated as a clinical checklist or worksheet:

CLINICAL CONCERNS:

DISSOCIATION AND LONG-STANDING ISSUES

- **OK**
- **PROBLEM**
- **CONSULTATION**

- **OK**: Has been addressed and is appropriate for EMDR therapy.
- **PROBLEM**: Problem/Concern. Wait until completion of Basic Course or until further preparation and stabilization have been achieved.
- **CONSULTATION**: Consultation indicated with EMDR clinician with expertise in area of concern.

Client has been screened for Dissociative Disorder (DD). DD rules out the use of EMDR therapy by Part One-trained clinicians and requires additional training beyond the Part Two training. A Mental Status Exam, and the Dissociative Experiences Scale II (DES) should be used for all clients to determine the degree of dissociation present. Further evaluation for Dissociative Disorders should be conducted with any client about whom you have concerns. See *Clinical Signs of Dissociative Disorders*, the DES-II, Adolescent DES, Child Dissociative Checklist, and *A General Guide to the Use of EMDR Therapy in the Treatment of Dissociative Disorders* in the Appendix. Special preparation and stabilization for DD clients is needed to establish their capacity to maintain dual awareness in order for reprocessing to occur.

Indicators of poor psychic development include but are not limited to:

- Years of unsuccessful psychotherapy
- Minimal or poor responses to psychotropic medications
- Depersonalization and/or derealization
- Dissociative Disorder
- History of hospitalizations
- Somatic symptoms
- Chronic instability at home and/or at work
- Inability to learn from experience
- Previous unsuccessful treatment of addictions and/or compulsions
- Secondary gains to maintaining their symptomatology
ACUTE PRESENTATIONS

- OK □ PROBLEM □ CONSULTATION

The following situations require caution and case consultation:

- Major loss, illness, or injury
- Life threatening substance abuse
- Recent suicide attempt(s)
- Self-mutilation
- Serious assaultive or impulsive behavior
- Psychotic episode

STABILIZATION

- OK □ PROBLEM □ CONSULTATION

- Adequate stabilization/self-control strategies in place
- Client must have a workable means of managing distress as necessary during and between sessions
- Client has adequate life supports (friends, relatives, etc.)
- Systems/issues that might endanger client have been addressed
- Client able to call for help if indicated
- Client is safe at home

MEDICAL CONSIDERATIONS

- OK □ PROBLEM □ CONSULTATION

- General physical health/medical condition/age considered (possible exacerbation with stress)
- Any psychoactive substance; whether prescribed or not: Consider implications on client’s ability to access disturbing material, stay present, engage in the process and integrate learning.
- Inpatient if necessary, to manage danger to client or others
- Eye pain contraindicates EMs until cleared by physician (use alternate forms of stimulation)
- Any neurological impairment or physical complication inappropriate for Weekend 1/Part 1 clinicians
- Pregnancy: first trimester cautions; other complications

TIMING CONSIDERATIONS/READINESS/SETTINGS

- OK □ PROBLEM □ CONSULTATION

- Timing of life events (projects, demands, work schedules, vacations, etc.)
- In-person vs virtual sessions
- Willingness/ability to participate in the treatment plan
- 90-minute sessions (if possible) 50 minutes minimum
ADVERSE CHILDHOOD EXPERIENCE (ACE) QUESTIONNAIRE
Finding your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often**...swear at you, insult you, put you down, or humiliate you? **Or** act in a way that made you afraid that you might be physically hurt?

   Yes____ No____ If yes, enter 1 _______

2. Did a parent or other adult in the household **often**...push, grab, slap, or throw something at you? **or ever** hit you so hard that you had marks or were injured?

   Yes____ No____ If yes, enter 1 _______

3. Did an adult or person at least 5 years older than you **ever**...touch or fondle you or have you touch their body in a sexual way? **Or** try to or actually have oral, anal, or vaginal sex with you?

   Yes____ No____ If yes, enter 1 _______

4. Did you **often** feel that...no one in your family loved you or thought you were important or special? **Or** your family didn’t look out for each other, feel close to each other, or support each other?

   Yes____ No____ If yes, enter 1 _______

5. Did you often feel that...you didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you? **Or** your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

   Yes____ No____ If yes, enter 1 _______

6. Were your parents **ever** separated or divorced?

   Yes____ No____ If yes, enter 1 _______

7. Was your mother or stepmother... **often** pushed, grabbed, slapped, or had something thrown at her? **Or sometimes or often** kicked, bitten, hit with a fist, or hit with something hard? **Or ever** repeatedly hit over at least a few minutes or threatened with a gun or a knife?

   Yes____ No____ If yes, enter 1 _______

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

   Yes____ No____ If yes, enter 1 _______

9. Was a household member depressed or mentally ill or did a household member attempt suicide?

   Yes____ No____ If yes, enter 1 _______

10. Did a household member go to prison?

    Yes____ No____ If yes, enter 1 _______

    **Now add up your “Yes” answers: _______This is your ACE Score.**
    (>3 significant; the higher the score, the greater the impact of life experiences)

    Learn more at https://www.cdc.gov/violenceprevention/aces/index.html
**IMPACT OF EVENT SCALE (Revised)**

**Instructions:** Below is a list of difficulties people sometimes have after stressful life events. Please read each item and then indicate how distressing each difficulty has been for you DURING THE PAST SEVEN DAYS with respect to ________________, how much were you distressed or bothered by these difficulties?

<table>
<thead>
<tr>
<th>Item</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<tbody>
<tr>
<td>1-Any reminder brought back feelings about it.</td>
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<td>2-I had trouble staying asleep.</td>
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<td>3-Other things kept making me think about it.</td>
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<td>4-I felt irritable and angry.</td>
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<td>5-I avoided letting myself get upset when I thought about it or was reminded of it.</td>
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<td>6-I thought about it when I didn’t mean to.</td>
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<td>7-I felt as if it hadn’t happened or wasn’t real.</td>
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<td>8-I stayed away from reminders about it.</td>
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<td>9-Pictures about it popped into my mind.</td>
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<td>10-I was jumpy and easily startled.</td>
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<td>11-I tried not to think about it.</td>
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<td>12-I was aware that I still had a lot of feelings about it, but I didn’t deal with them.</td>
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<td>13-My feelings about it were kind of numb.</td>
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<td>14-I found myself acting or feeling like I was back at that time.</td>
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<td>15-I had trouble falling asleep.</td>
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<td>16-I had waves of strong feelings about it.</td>
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<td>17-I tried to remove it from my memory.</td>
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<td>18-I had trouble concentrating.</td>
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<td>19-Reminders of it caused me to have physical reactions, such as sweating, trouble breathing.</td>
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<td>20-I had dreams about it.</td>
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<td>21-I felt watchful and on-guard.</td>
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<tr>
<td>22-I tried not to talk about it.</td>
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Impact of Event Scale - Revised

Scoring Information

Avoidance Subscale = mean of items 5, 7, 8, 11, 12, 13, 17, 22

Intrusion Subscale = mean of items 1, 2, 3, 6, 9, 16, 20

Hyperarousal Subscale = mean of items 4, 10, 14, 15, 18, 19, 21

Assessing Psychological Trauma and PTSD: A Handbook for Practitioners

Chapter 15: The Impact of Event Scale-Revised
by Daniel S. Weiss, PhD & Charles R. Marmar, MD
Department of Psychiatry, University of California, San Francisco
& PTSD Program, San Francisco VA Medical Center

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In J.P. Wilson, & T.M. Keane (eds.),
Assessing Psychological Trauma and PTSD: A Practitioner’s Handbook
New York: Guilford.
© 1995; Daniel S. Weiss & Charles R. Marmar
Dissociative Experiences Scale II (DES-II)
Eve Bernstein Carlson, PhD and Frank W. Putnam, MD

Directions: This questionnaire consists of twenty-eight questions about experiences that you may have in your daily life. We are interested in how often you have these experiences. It is important, however, that your answers show how often these experiences happen to you when you are not under the influence of alcohol or drugs.

To answer the questions, please determine to what degree the experience described in the question applies to you and circle the number to show what percentage of the time you have the experience.

Date: _______________   Age:________  Gender: __________________

Example:

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

1. Some people have the experience of driving a car and suddenly realizing that they don’t remember what has happened during all or part of the trip. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

2. Some people find that sometimes they are listening to someone talk and they suddenly realize that they did not hear part or all of what was said. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

3. Some people have the experience of finding themselves in a place and having no idea how they got there. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

4. Some people have the experience of finding themselves dressed in clothes that they don’t remember putting on. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

5. Some people have the experience of finding new things among their belongings that they do not remember buying. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

6. Some people sometimes find that they are approached by people that they do not know who call them by another name or insist that they have met them before. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

7. Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something and they actually see themselves as if they were looking at another person. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

8. Some people are told that they sometimes do not recognize friends or family members. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

9. Some people find that they have no memory for some important events in their lives (for example, a wedding or graduation). Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
10. Some people have the experience of being accused of lying when they do not think that they have lied. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

11. Some people have the experience of looking in the mirror and not recognizing themselves. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

12. Some people have the experience of feeling that other people, objects, and the world around them are not real. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

13. Some people have the experience of feeling that their body does not seem to belong to them. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

14. Some people have the experience of sometimes remembering a past event so vividly that they feel as if they are reliving the event. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

15. Some people have the experience not being sure whether things that they remember happening really did happen or whether they just dreamed them. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

16. Some people have the experience being in a familiar place but finding it strange and unfamiliar. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

17. Some people find that when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

18. Some people find that they become so involved in a fantasy or daydream that it feels as though it were really happening to them. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

19. Some people find that they are sometimes able to ignore pain. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

20. Some people find that they sometimes sit staring off into space, thinking of nothing, and are not aware of the passage of time. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

21. Some people sometimes find that when they are alone they talk out loud to themselves. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

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 two different people. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
23. Some people sometimes find that in certain situations they are able to do things with amazing ease and spontaneity that would usually be difficult for them (for example, sports, work, social situations, etc.). Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

24. Some people sometimes find that they cannot remember whether they have done something or have just thought about doing it (for example, not knowing whether they have just mailed a letter or have just thought about mailing it). Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

25. Some people find evidence that they have done things that they do not remember doing. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

26. Some people sometimes find writings, drawings, or notes among their belongings that they must have done but cannot remember doing. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

27. Some people sometimes find that they hear voices inside their head that tell them to do things or comment on things that they are doing. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

28. Some people sometimes feel as if they are looking at the world through a fog so that people and objects appear far away or unclear. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

See a brief discussion of the administration and scoring of the DES-II in "Clinical Signs of Dissociative Disorders" on the following pages.

Clients entering treatment usually do not report having a dissociative disorder unless they were in treatment for it previously. For some clinicians, this can be confusing because clients struggling with dissociative disorders present what can be a range of confusing symptoms. These include symptoms of dissociation, post-traumatic symptoms, Schneiderian symptoms that are usually associated with the presence of a thinking disorder, somatic complaints, a sleep disturbance, and usually affective symptoms. Approximately two-thirds of clients with severe dissociative disorders enter treatment complaining of depression. The profile described below can provide some structure to understanding the dissociative disorder client’s clinical presentation and areas to inquire about during your initial interviews. The presence of severe dissociative symptoms will impact how your client responds to EMDR reprocessing as well as how you organize and structure your EMDR Therapy.

History of years of psychotherapy with little progress (Kluft, 1985; Putnam et al., 1986).
   a. Client has varying diagnoses over the years.
   b. Client may have a history of multiple psychiatric hospitalizations with different diagnoses.

Symptoms of depersonalization and/or derealization (Putnam et al., 1986).
For example, the client:
   a. Doesn't feel like her/himself (e.g., bigger or smaller).
   b. Reports that her/his surroundings do not look the same.
   c. Looks in the mirror and sees something other than typical reflection.
   d. Experiences “floating” alongside or above the body.
   e. Reports that daily environment seems dream-like or as if (s)he is walking in a fog.

Memory lapses (Putnam et al., 1986)
For example, the client:
   a. Does not recall how she/he got to the shopping mall.
   b. Finds unfamiliar items at home and does not recall buying them or how they were acquired.
   c. (S)he cannot offer a coherent narrative history. However, this also may occur because of substance abuse, illness, depression, and dementia. Note that a highly organized DID patient may confabulate and fill in the amnesic “gaps”.

Flashbacks and intrusive thoughts
   a. The client has flashbacks and intrusive thoughts for childhood events or recent traumata.
   b. DID can be conceptualized as resulting from chronic, serial PTSD (Spiegel, 1993).

Schneiderian symptoms (Kluft, 1987; Ross et al., 1990)
Of the 11 first rank Schneiderian symptoms, the client may endorse several of them. For example, the most frequently reported include:
   a. Hearing "audible thoughts" or "voices arguing". However, DID clients usually say that they hear voices in the head, not externally (as in schizophrenia).
   b. Experiencing “made” feelings, i.e., feelings that come out of the “blue” without having a logical way of explaining them.
   c. Having "made" thoughts and behaviors or other of the first-rank symptoms may be reported.

DID patients report more frequent first-rank symptoms than patients having schizophrenia (Ross et al., 1990) The DID patient will show a full range of affect whereas the schizophrenic patient usually will demonstrate blunted affect.

Somatic symptoms (Putnam, 1989, pp. 65-67)
The client may:
   a. Report chronic headaches that are intractable to over-the-counter analgesics.
   b. Have physical complaints and pain that physicians cannot account for and which may be "somatic memories".

Sleep disturbance (Loewenstein, 1991)
The client may report frequent nightmares or night terrors. Note that sleepwalking is usually associated with a dissociative disorder.

Co-Morbidity of Dissociation and Depression
One of the primary complaints of the DID patient is an affective disorder. Frequently, there is a history of suicide attempts or suicidal ideation. (Putnam et al., 1986).
All clients should complete the Dissociative Experiences Scale (DES; Carlson & Putnam, 1993). On the DES, a more conservative cut-off score of 20 is recommended by Ross. (Ross, 1995). For clients scoring greater than that and/or responding positively to the clinical signs outlined above, the clinician should suspect the presence of an underlying dissociative disorder. Administration of the Dissociative Disorders Interview Schedule-DSM-V Version (DDIS-V; Ross, 1997) or the Structured Clinical Interview for DSM-IV-Dissociation Revised (SCID-D Revised; see Steinberg, 1994) or the Multidimensional Inventory of Dissociation (MID; Dell, 2008) can provide a thorough assessment and help to confirm the actual diagnosis.

**Screening for Dissociative Disorders**

**Dissociative Experiences Scale II (Carlson and Putnam, 1993)**

For screening adult clients for dissociative disorders, the DES II is the most widely researched and clinically used instrument. The DES II is to be used with adults older than 18 years of age. It is translated and norms are developed for 16 languages.

The DES II is a screening tool which means that you administer it to all your clients and only those who score above the cut-off score need to have a more thorough evaluation for their dissociative symptomatology. One concern with the DES II is that the client can under-report their dissociative experiences. Usually this may happen because the individual is unaware of the extent that she/he dissociates, is fearful of disclosing their dissociative symptomatology or may not attend sufficiently to the questions. The average score on the DES II in the general population is approximately ten (Ross et al., 1991). So, when an individual scores below that score, it can be useful to discuss with the client their attitude as they completed the DES II. Factor analysis of the DES II has demonstrated that it is measuring three distinct dissociative features. These include absorption (which is a “normal” dissociative process), depersonalization, and amnesia.

**Updated information on Use of the DES II with EMDR Therapy**

Though somewhat inconsistent in the literature, the use of cutoff scores helps to identify those who might have a dissociative disorder or a disorder with a considerable dissociative component. This is discussed in the excerpts from the DES manual (Carlson and Putnam, 1992) that is included in this appendix. Additional information is included in their update (Carlson and Putnam, 1993). The diagnosis of Multiple Personality Disorder (MPD) has since been changed to Dissociative Identity Disorder (DID). As described there, using a test score of 30 or above to identify those who may be severely dissociative will result, on average, in the identification of 74% of those who are MPD/DID and correct identification of 80% of those who are not MPD/DID. In this analysis, 61% of those who scored 30 or above who were not MPD/DID had posttraumatic stress disorder or another disorder that has a highly dissociative component. This means that a proportion of those who score 30 or over will probably have a disorder with a considerable dissociative component, but not DID. A receiver operating characteristics analysis described in Carlson et al. (1993) indicated that 30 was the optimal cutoff score for maximizing the accuracy of predictions.

The DES II is a screening tool, but not a diagnostic tool. The clinician should pay attention to any dissociative behaviors that might interfere with EMDR reprocessing. Further, it is recommended that anyone scoring 15% or higher receive further evaluation using such instruments as the Dissociative Disorders Interview Schedule (DDIS), the Structured Clinical Interview for DSM-IV Dissociation (SCID-D Revised), or the Multidimensional Inventory of Dissociation (MID). See information below.

A 2018 meta-analysis of over 200 publications found the following relationship between diagnosis and mean DES scores (Lyssenko, et. al, 2018):

<table>
<thead>
<tr>
<th>Mean DES Score</th>
<th>Diagnostic Category</th>
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<tbody>
<tr>
<td>Over 35</td>
<td>Dissociative Disorders</td>
</tr>
<tr>
<td>Over 25</td>
<td>PTSD, Borderline Personality Disorder, Conversion Disorder</td>
</tr>
<tr>
<td>15 or higher</td>
<td>Somatic Symptom Disorder, Substance-related and addictive Disorders, Feeding and Eating Disorders, Schizophrenia, Obsessive Compulsive Disorder, most affective disorders, bipolar disorder</td>
</tr>
</tbody>
</table>
**DES-T**

The Dissociative Experiences Scale is based on the conceptualization of dissociation as a continuum ranging from normal dissociative experiences, such as "highway hypnosis," daydreaming, or absorption in a book that one is reading, to pathological dissociation that may involve depersonalization/derealization experiences or amnesia for dissociated experiences. More recently, it is demonstrated that there is a discreet variable or taxon of "pathological dissociation" which is distinct from normal or non-pathological dissociation (Waller et al., 1996; Waller & Ross, 1997).

On the DES, the former, normal dissociative experiences, is illustrated by items such as "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." The latter, pathological dissociation, is illustrated by such items as "Some people have the experience of feeling that other people, objects and the world around them are not real" and "Some people have the experience of finding new things among their belongings that they do not remember buying." This class or taxon of pathological dissociation can be assessed by a subset of eight items on the DES and was named the DES-T (Waller et al., 1996). These items are numbers 3, 5, 7, 8, 12, 13, 22 and 27 on the DES. Because scoring of the DES-T is somewhat complicated, a Microsoft Excel 97 spreadsheet was created by Darryl Perry and is in the public domain. It is available and can be downloaded from the website of the International Society for the Study of Dissociation (http://www.isst-d.org). The Excel spreadsheet will assist in calculating the probability that any given individual or client is a member of the dissociative taxon, i.e. – dissociates pathologically.

While the DES-T can indicate the probability that a particular individual exhibits pathological dissociative symptoms, it provides neither a thorough assessment nor a conclusive diagnosis of the client's dissociative disorder. It will be necessary to evaluate the client more thoroughly to obtain a definitive diagnosis.

**Other Available Screening Instruments Include:**

Somatoform Dissociation Questionnaire - developed by Ellert Nijenhuis. The SDQ is available in a 20-item or a five-item format. Both can be obtained on the developer’s website. http://www.enijenhuis.nl/sdq

Multi-scale Dissociation Inventory (MDI) developed by John Briere. This is available directly from the developer. http://s1097954.instanturl.net/multiscale-dissociation-inventory-mdi/

**Follow-Up Evaluation and Diagnosis for Adults:**

The Dissociative Disorders Interview Schedule-DSM-V Version (DDIS-DSM-V) was developed by Colin Ross. The DDIS is a 132-item structured clinical interview that takes approximately 90 minutes to administer. The items and the manual for scoring are available in his text on Dissociative Identity Disorder (Ross, 1997). Also, the structured interview and the manual for scoring it are available free of charge on Dr. Ross’ website: https://www.rossinst.com/ddis.

The Multidimensional Inventory of Dissociation (MID) was developed by Paul F. Dell. The MID is a 218-item personality inventory that is self-administered, and it will take a client approximately 90 minutes to complete. Like with the DES II, the client is asked to rate the frequency of occurrence of a range of dissociative symptoms from 0% to 100%. By entering the client’s scores for each item into the MID spreadsheet, it will provide a considerable range of clinical information. This will include information regarding dissociative symptoms including the presence of self-states or personality “alters,” Schneiderian First-Rank symptoms, as well as cognitive and behavioral psychopathology. Also, the MID contains Validity Scales that provide some input regarding the client’s test-taking attitude. The MID test item, MID Analysis, and its interpretive manual are available free of charge at http://www.mid-assessment.com/. There are adult and adolescent versions available.

The Structured Clinical Interview for DSM-IV-Dissociative Disorders Revised (SCID-D Revised) was developed by Marlene Steinberg (1999). This is also a structured clinical interview and may take approximately two hours to administer. There is data indicating that screening patients with the DES (cut off score=20) and then administering the SCID-D Revised to all patients scoring higher than the cut off score will provide high levels of specificity and sensitivity.

This will minimize the potential for “false negative” as well as “false positive” diagnoses (Sternberg, 1999). An adolescent version of the SCID-D is available also. The SCID-D Revised can be purchased from the American Psychiatric Association.
For the screening of adolescents and children several resources are available:

The Adolescent Dissociative Experiences Scale (A-DES) is a screening instrument only and is available for children ages 11-18 years old. The A-DES is a 30-item self-report that takes the client about 15 minutes to complete. Item content inquiries about a range of dissociative symptoms including absorption and imaginal involvement, dissociative amnesia, depersonalization and derealization, and lastly, passive influence (Armstrong et al., 1997). The measure and directions for scoring are readily available online. Currently the A-DES is available for download at: http://cw.routledge.com/textbooks/eresources/9780415889957/AppendixE.pdf

The Child Dissociative Checklist (CDC) is available for screening dissociative symptoms in children from five to 11 years old. The CDC is a 20-item measure that is completed by a parent or other adult that has significant contact with the child and takes approximately 15 minutes to complete. Validity and reliability are good (Putnam & Peterson, 1994). The measure and directions for scoring are readily available online. Currently the CDC is available for download at: https://s3.amazonaws.com/PHR_other/child-dissociative-checklist.pdf.

For more information on trauma and dissociation:
Please visit the website for the International Society for the Study of Trauma and Dissociation (www.isst-d.org) where you will find resources for members, non-members and the public.

REFERENCES


EMDR Therapy Dissociative Disorders Taskforce

Purpose

This section offers general guidelines in the application of EMDR to the dissociative disorders, with paramount concern for client safety. The intended audience is the established clinician who is new to the diagnosis and treatment of dissociative disorders. This guide is not intended to define standards of care or specific training requirements or certification guidelines. Furthermore, it is not intended to supersede expert clinical judgment or training in dissociative disorders or hypnosis.

Assumptions

The following are some assumptions underlying this guide:

1. EMDR treatment of those with a dissociative disorder is best imbedded within a total psychotherapeutic approach and does not stand alone as a treatment.
2. There is a high prevalence of undiagnosed dissociative disorder in clinical populations.
3. There is a high cost to patient, therapist, and the therapeutic alliance in failing to adequately consider the possibility of dissociative disorders before first using EMDR in a patient’s treatment.
4. As our understanding continues to develop, these guidelines may need revision.

The following paragraphs are guidelines for therapists in evaluating patients for EMDR and determining whether and at what point EMDR may be safely introduced in a patient’s treatment.

Screening

1. The therapist should screen every patient for the presence of an underlying dissociative disorder regardless of the presenting complaint.

   Screening approaches include the Dissociative Experience Scale II (Carlson & Putnam, 1993), the Somatoform Dissociation Questionnaire (Nijenhuis, 2004), the Multiscale Dissociation Inventory (Briere, 2002), and the Mental Status Examination for Dissociative Disorders (Loewenstein, 1991). The therapist has not conducted sufficient screening if that screening is limited to in-session monitoring for evidence of “switching.”

2. If the index of suspicion for the presence of a dissociative disorder is low after screening, the therapist may proceed with the EMDR protocol, including preparatory steps that are appropriate for the presenting problem.

Clarifying the Diagnosis

If the index of suspicion for a dissociative disorder is high after screening, the therapist should conduct further diagnostic evaluation, using, for example, the Dissociative Disorders Interview Schedule DSM-5 version (DDIS; Ross, rossinst.com) or the lengthier Structured Clinical Interview for DSM-IV Dissociative Disorders—Revised by Marlene Sternberg (1999), or the Multidimensional Inventory for Dissociation, v. 6.0 (Dell, 2004), or obtain appropriate consultation.

When a Dissociative Disorder is Present

If the assessment reveals that a dissociative disorder is present, the decision to proceed with EMDR is best guided by considering both therapist and patient factors, as follows:

Therapist factors:

1. It should be determined whether the therapist is sufficiently trained in the dissociative disorders, as evidenced by the therapist
   a. Having taken formal courses in the area
   b. Having been supervised in the psychotherapy of dissociative patients.
2. It should be determined whether the therapist is sufficiently skilled in the treatment of dissociative disorders, as evidenced by such abilities as
   a. Troubleshooting with hostile alters, child alters, and perpetrator alters
   b. Anticipating and accommodating transferences
c. Recognizing and working with hypnotic and dissociative phenomena
d. Managing crises
e. Determining the need for medical and/or inpatient backup

(3) The therapist should have considerable experience using EMDR on patients without dissociative disorders before attempting it on highly dissociative patients. The therapist needs skill in the "cognitive interweave" interventions and other active interventions described in the EMDR Institute's Level II training.

(4) Unless the aforementioned skills are present, the therapist should either refer the patient or seek additional training in the fields of dissociative disorders and hypnosis before using EMDR with a dissociative patient (see the section "Additional Training").

(5) If the requisite skills and training are present, the therapist may implement EMDR within the context of a thorough treatment plan only if positive patient factors are present (see next section).

**Patient factors:**
Patient factors are important in planning the treatment of patients with dissociative disorder, whether EMDR is used or not. Because of the potential of EMDR for rapid destabilization, however, patient factors directly affect the risks associated with the procedure.

Assess patient suitability for EMDR treatment by ascertaining whether the patient has

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

The following assessment is a necessary element in the evaluation of any dissociative patient for any treatment. With EMDR, however, the risks associated with failing to assess adequately are more serious because of the power of the procedure. Determine whether the patient exhibits the following signs, which tend to contraindicate the use of EMDR:

1. Ongoing self-mutilation
2. Active suicidal or homicidal intent
3. Uncontrolled flashbacks
4. Rapid switching
5. Extreme age or physical frailty
6. Terminal illness
7. Need for concurrent adjustment of medication
8. Ongoing abusive relationships
9. Alter personalities that are strongly opposed to abreaction
10. Extreme character pathology, especially a severe narcissistic, sociopathic, or Borderline disorder
11. Serious dual diagnoses such as schizophrenia or active substance abuse

The presence of these signs may not constitute absolute contraindications. However, the risks and complexities that accrue if the therapist proceeds with EMDR in the presence of these signs are considerable. The potential benefits must outweigh these risks, and safety precautions must be in place. Only therapists who are highly experienced with managing those complications are prepared to proceed with EMDR for patients evidencing these signs.

**Embedding EMDR in the Treatment Plan**
If the aforementioned therapist and patient factors are appropriate, EMDR may be one component in a progressive course of treatment. The total treatment plan is best guided by the accumulated knowledge of the field of dissociation and may include hypnosis, EMDR, behavior therapy, cognitive therapy, and other methods.

**Preparing for EMDR**
The therapist should prepare the patient for EMDR with the intention of minimizing the likelihood and impact of any problems occurring in the middle of EMDR sessions. At the same time, the therapist needs to "expect the unexpected," to use Kluft’s phrase. At a minimum, the therapist should carefully explain the procedure to the client with the intent of achieving sufficient informed consent of the entire system, recognizing that this is not a fully attainable goal. To the degree that the system consents, EMDR reprocessing is likely to proceed smoothly. Suggestions for the entire system to observe, even if parts are reluctant, can prevent surprised alters from aborting the reprocessing.
The therapist’s preparation of the patient for EMDR may be affected by factors such as
(1) System complexity
(2) Informed consent of the relevant portions of the system
(3) Cooperation between parts
(4) Permeability of dissociative barriers
(5) Overall system motivation for change

A straightforward, cooperative, and co-conscious system is easier to prepare for EMDR than one that is hostile, complex, and impermeable. Preparation for EMDR reprocessing may proceed in tandem with other therapeutic activities, including the establishment of rapport and the teaching of affect containment and other skills.

**Early Treatment Phases**

Early in the treatment of a dissociative disorder, therapists should refrain from the use of EMDR reprocessing. Exceptions may exist under extraordinary circumstances, to be defined in consultation.

**Caution**

The use of BLS too early in treatment risks premature penetration of dissociative barriers, which could produce results such as flooding of the personality system, uncontrolled destabilization and increased suicidal or homicidal risk. For crisis intervention, the therapist should attempt BLS only if the risks of failing to intervene are as high without as with the intervention.

**Middle Treatment Phases**

Throughout the Integration Phase of treatment, the therapist may find various uses for EMDR, including, for example,
(1) EMDR’s prototypical application, the reprocessing of traumatic memory
(2) Facilitation of internal dialogue using ego state therapy (Watkins & Watkins, 1997)during EMDR
(3) Restructuring of cognitive distortions used as EMDR targets
(4) Building of alternative coping behaviors using EMDR installations
(5) Ego strengthening through installations
(6) Fusion

**Final Treatment Phases**

In the post-integration and termination stages of treatment, EMDR may have continued application, including
(1) Additional coping skills development
(2) Generalization into new situations
(3) Facilitating the patient in making meaning of life’s trauma, pain, and healing
(4) Resolving remaining obstacles to the achievement of life goals.

**Task Force Members:** The following, in alphabetical order, are the original EMDR Dissociative Disorder Task Force members:
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Gerald Puk, PhD
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Walter Young, MD

**APPENDIX: ADDITIONAL TRAINING**

Clinicians who seek additional training in the diagnosis and treatment of dissociative disorders should contact the International Society for the Study of Trauma and Dissociation (ISSTD), 8201 Greensboro Drive, Suite 300, McLean, VA 22102. phone: (703) 610-9037; website: www.isst-d.org.

International Society for the Study of Trauma and Dissociation (ISSTD) https://www.isst-d.org/
American Society of Clinical Hypnosis (ASCH) https://www.asch.net/
EMDR International Association (EMDRIA) Special Interest Group https://www.emdria.org

**CONSULTATION**

Some individuals may find private consultation with a recognized expert in the field of dissociative disorders to be beneficial.
SUGGESTED READING

The following are a few of the resources available for the study of dissociation:


AIP-INFORMED TREATMENT PLAN
TRACING A MEMORY NETWORK FOR ONE PRESENTING ISSUE

1. PRIORITIZE SPECIFIC ISSUE: Identify treatment issue that will be the focus of this period of treatment.

2. RECENT EXAMPLES (PRESENT TRIGGERS):
Identify specific examples of being triggered by this issue.

3. REPRESENTATIVE EXAMPLE:
Use the recent example that most resonates with the prioritized presenting issue as the point of entry into the memory network.

---

Direct Question
Does this feel familiar? OR
What memories feel like this? OR
When have you felt this way before?

Floatback
As you bring up this recent (example) hold in mind the Image, the negative belief (Cognition), and notice the Emotions, and body
Sensations and let your mind Floatback to an earlier (or the earliest) memory that comes to mind......

Affect Scan
Hold that recent (example), notice the Emotions, you are having right now and notice what you are feeling in your body (Sensation).
Now let your mind scan back to an earlier time when you may have felt like this before and notice any memories that come to mind.....

---

Identify memories in the network:

1-6 past memories (or clusters of memories). Specifically check for a childhood memory and note both the earliest memory and the memory that feels the most charged (worst).

Do not get a SUD or other details of past memories. We do not want to activate past memories at this time.

Past Memories
Touchstone Memory: Youngest memory that emotionally resonates with the recent example. (Ideally age 5-12)

Other Past Memories:
Worst Memory: The memory that currently FEELS most disturbing

Other Present Triggers:
Are there additional people, places, or activities that trigger a similar response?

Desired Future:
How would the client like to respond to these present triggers in the future?

---

From the representative example use Direct Question, Floatback, or Affect Scan to access the memory network.

Alicia Avila, LCSW
This worksheet is designed to identify Past, Present, and Future targets as part of an overall treatment plan for a presenting issue. You will use Direct Questioning and the Floatback Technique, and/or Affect Scan to identify relevant experiences in the client’s memory network that are informing their current symptoms. It will also help you prioritize what memories to reprocess and keep track of them as they resolve.

A. PRESENTING ISSUE:
In clinical practice the Presenting Issue is collaboratively determined by client and clinician.

B. IDENTIFY RECENT EXAMPLE(S) OF THE PRESENTING ISSUE:
“What recent experience(s) (1-3) have you had that represent(s) this issue?”

C. IDENTIFY WHICH RECENT EXAMPLE IS MOST REPRESENTATIVE OF THE ISSUE:
“Which of the recent experiences that you mentioned is the most representative or resonant to you now?”

This is the recent experience you will use to access the dysfunctionally stored network to identify related PAST EXPERIENCES.

D. IDENTIFYING PAST EXPERIENCES:
Use **D1: Direct Questioning, D2: Floatback Technique and/or D3: Affect Scan** as scripted below to identify the past experiences associated with the client’s current difficulties. Optimally elicit a few memories including the youngest or childhood memories according to client’s tolerance. In clinical practice direct questioning often provides a clear network of past targets. If it does not, use Floatback then Affect Scan techniques, depending on the client’s affect tolerance.
D1. DIRECT QUESTIONING: The following are examples of direct questions.

"Have there been other memories that felt like this?"
"Do you remember an earlier time when you felt this way?" (Identify a pattern of response, emotional reaction, or distorted belief.)

Record the client’s memories with brief description and age for each memory:

<table>
<thead>
<tr>
<th>Past Experiences (brief description)</th>
<th>Age/Grade</th>
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<tbody>
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</tbody>
</table>

D2. FLOATBACK: Use with Caution with Complex Trauma Client Presentations.

'I'd like us to go back to that recent experience of ____________________________ (repeat [C] representative recent experience). As you hold it in mind, what is the image that represents the worst part of this recent experience?

What negative thoughts or beliefs are you having about yourself as you bring it up now?

What are the emotions you are experiencing? ____________________________
Where do you feel it in your body?" ____________________________
(If possible, use the client’s actual words/descriptions in this script.)

“As you focus on the image (pause) the negative thought(s) (repeat negative thoughts) you are having about yourself (pause), the emotions (pause) and body sensations (pause), let your mind float back to earlier times in your life when you may have felt this way before and just notice what memory or memories come to mind... (pause). What memories are coming up?” Record the client’s memories on the with a brief descriptions and age or grade for each memory below.

To prompt for additional memories (ideally back to early childhood), repeatedly use the following statement until no new memories are identified. “As you focus on that experience, notice any earlier or other memories that may come to mind...”

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<th>Additional Past Experiences (brief description)</th>
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**Additional option:** If Floatback doesn’t yield results, and if client is sufficiently stable, try the Affect Scan (uses only emotion and body sensation).

**D3. AFFECT SCAN: Use with Caution with Complex Trauma Client Presentations.**

"Let’s go back again to the recent experience of ________________ (repeat [C] representative recent experience). As you hold it in mind, notice the emotions you are having right now and notice what you are 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 any memory or memories that come to mind.”

Record the client’s memories with **brief** description and age for each memory:

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<th>Additional Past Experiences (brief description)</th>
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**NOTE:** Before proceeding to PRESENT and FUTURE, identify and note from the PAST memories the **touchstone** (“first/earliest”) and the **worst** memory.

**E. PRESENT TRIGGERS:**

Now that the client may be in greater touch with the core feeling underlying this memory network, explore any additional present triggers that were not identified earlier.

"Are there other situations, people or places in your current life now that bring up these negative reactions?"

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**F. FUTURE DESIRED RESPONSE: (Future Template)**

"How would you like to be able to handle these situations (present triggers) in the future?"

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**G. EXISTING RESOURCES:**

“What personal qualities do you possess that are sources of strength for you? What people, places or things are valuable resources in your life now?”

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H. NEEDED RESOURCES/PREPARATION FOCUS (Question to the client is optional):

"What qualities do you need (or need more of) as you consider working on this issue?"

I. IDENTIFY TARGET MEMORY SELECTED FOR FIRST REPROCESSING SESSION:

Based on the AIP model and the assessment of client’s affect tolerance, the clinician makes a recommendation about which memory should be reprocessed first and offers the rationale. Consider suggesting the earliest memory if client can tolerate that, since touchstone memories are foundational and are more likely to generalize and less likely to get blocked. If necessary due to intrusions from another memory or there are risks to starting with the touchstone consider another past memory. Discuss it with the client and make a final decision.

"Based upon what you have shared with me today and what we know about EMDR therapy, let’s discuss which memory we should reprocess first. I recommend we reprocess:

(Identify the specific first, worst OR other from the past experiences listed previously.)

Because:

(Clinician provides rationale for the choice, e.g., touchstone is the foundational memory; more generalizable and less likely to get blocked.)

How does that sound to you?"

Clinician proposes a neutral label for the memory:

In order to refer to this memory later, I suggest giving this memory a “label.” I suggest ___________________________ (proposed neutral label.)

Does that work for you?

Record the label for the agreed upon memory with the client’s age/grade:

Redirect client’s focus of attention to the Safe/Calm State using their cue word (no BLS) as you close the session:

“Now focus your attention on your Safe/Calm State using your cue word (repeat cue word).”

Clinician: Transfer the information gained in the Target Identification Worksheet into the Target Identification Summary to organize and track Past/Present/Future targets. You will be referring to and adding to the list of targets throughout treatment of this presenting issue.
PHASE ONE: TARGET IDENTIFICATION SUMMARY

Presenting Issue # ___

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<th>Age/Grade</th>
<th>Brief Description or Label</th>
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Past Memories

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<tr>
<th>Present Trigger (examples)</th>
<th>Desired Future Response (for each present trigger)</th>
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Target Identification Summary
1. Presenting Problems, Symptoms and Goals

**Presenting Problems:**
- Describes a specific context in which the presenting issue is experienced, often with a narrow focus.
- Problem areas in daily living such as affect regulation, self-esteem, relationship issues, and socioeconomic stressors.
- Includes why they came to treatment and what are their goals.

**Symptoms:**
- Complex presentations often include multiple symptoms and may be acute or chronic and are often interconnected.
- Dysfunctional traits, behaviors, beliefs, affects, body sensations are manifestations of inadequately processed memories.

**Client Goals:**
- What are their goals?
- Why now?

2. Underlying Issues Including Clinical Themes of Responsibility, Safety, Control and Connection

- Drive the presenting problems.
- There may be multiple and interconnected underlying issues which are uncovered through history taking and case conceptualization.
- An issue prioritized for treatment is based on a collaborative understanding of the presenting problem(s) and clinical themes.
- Clinical themes are often pervasive across various life contexts.
- Each of these themes has a situational component and will likely also have a core developmental aspect.
- All are overlapping and interactive and will evolve through treatment.
- Clinician attends to the client’s narrative with these themes in mind

**Clinical Considerations:**
- Identify prominent themes in the client’s presentation.
- When themes overlap or coexist, consider starting with:
  - the one that is less defended, more approachable, or
  - the one causing most disruption or highest risk, or
  - the one that is most core or pervasive in multiple areas.
3. Adaptive Memory Networks (Internal/External)
   Adaptive memory networks contain positive experiences and early learning, including adaptive information, positive feeling resource states, affect regulation skills and a sense of safety, appropriate responsibility, control/choices and a sense of connection/belonging.

   **Existing Resources:**
   - Identify available resources the client has that can be utilized throughout the course of treatment.
   - Identified in History Taking Phase, reinforced throughout treatment.

   **Needed Resources (Preparation Focus/Stabilization Needs):**
   - Identify needed resources in History Taking Phase to be developed in the Preparation Phase by tailoring it to the specific needs of the client.

4. Case Conceptualization
   Case conceptualization is the overall view of the client’s presentation, clinical factors and a basis for the working hypothesis that guides treatment planning.

   Consists of clinical information about the client including:

   - **Therapeutic Relationship:** how do the perceived similarities or differences affect treatment and the therapeutic relationship and attunement?
   - **Stability and Resources:** stability and current resources, developmental holes, readiness and if not, what is needed?
   - **Three-Pronged Approach:** experiential contributors, presenting symptoms, client desired responses and treatment goals.

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<td>Childhood</td>
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<td>Adult-onset</td>
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   - **Additional Relevant information:** secondary gain factors, prioritize initial focus of treatment, protocols and procedure to be used, factors informing your decision?

5. Treatment Planning
   Evaluates the entire clinical picture and identifies relevant memories to be reprocessed; the order of priority is determined by client readiness for reprocessing as well as needed symptom relief, time constraints and imminent life challenges.

   - Memories identified for reprocessing address current symptoms.
   - Adult-onset trauma versus childhood trauma.
   - Focused reprocessing versus full reprocessing.
   - Follow-up resolution of Present Triggers with Future Templates.
PHASE ONE: AIP INFORMED CASE
CONCEPTUALIZATION AND TREATMENT PLANNING
FOR COMPLEX CLINICAL PRESENTATIONS

CLIENT:

1. Presenting Problem, Symptoms, and Goals
   
   **Problem:** __________________________________________________
   
   _____________________________________________________________
   
   _____________________________________________________________
   
   **Symptoms:** ________________________________________________
   
   _____________________________________________________________
   
   _____________________________________________________________
   
   **Client Goals:** _____________________________________________
   
   _____________________________________________________________
   
   _____________________________________________________________

2. Underlying Issues Including Clinical Themes of Responsibility, Safety, Control, and Connection

   _____________________________________________________________
   
   _____________________________________________________________
   
   _____________________________________________________________
   
   _____________________________________________________________

3. Adaptive Memory Networks
   
   **Existing Resources (Internal/External):**
   
   _____________________________________________________________
   
   _____________________________________________________________
   
   _____________________________________________________________
   
   **Needed Resources (Preparation Focus/Stabilization Needs):**
   
   _____________________________________________________________
   
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   _____________________________________________________________
4. Case Conceptualization

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5. Treatment Planning

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In person sessions:
- Please review the description of how to guide eye movements and alternate forms of bilateral stimulation on pages 60 - 65 of Dr. Francine Shapiro’s 2018 text. Your hand movements should be a straight line (not an arc), and broad enough to guide full range of the client’s eye movements. Generally, avoid having your fingers crossing your face to avoid client being distracted by you.
- Also: Elan Shapiro: Shapiro, E. (2011). Suggestions for Teaching the Application of Eye Movements in EMDR. Journal of EMDR Practice and Research, 5(2), 73. (Full text download at https://connect.springerpub.com/content/sqremdr/5/2/73)
- A video demonstrating face to face BLS created by April Minjarez, PhD: https://youtu.be/kxNfGhd-wQY
- The above resources provide information that can be adapted to virtual settings.

Virtual sessions:
- For expanded guidance in the use of EMDR therapy in the virtual environment, including apps that may be used to guide eye movements by video: https://www.emdria.org/publications-resources/practice-resources/coronavirus-clinical-resources/
- 30-minute video demonstrating BLS virtually created by Alicia Avila, LCSW: https://youtu.be/mE1iBALWDNU
- To offer eye movements (EM) outside of the zoom screen:
  - Use sticky notes or objects in the client’s room or a natural horizontal line (e.g., window frame, junction of wall and ceiling or floor). Make sure their EMs are broad enough.
  - When needed, provide an auditory prompt to set the speed/pace of the EMs (e.g., voice, tapping pen or using an app like Soundbrenner metronome).
  - Coach as needed. Remember that one left/right “pass” will be two tones or taps.
- To offer eye movements (EM) tracking guidance on screen
  - Only effective for clients with a wide enough screen.
  - Ask your client to “pin” your video and hide their own screen.
  - The client’s screen width determines the distance their face must be from their screen, (14” screen = face 14-16” from screen.)
  - The video conferencing window with your image must fill their screen.
  - Using your fingers or an object, start in middle (of your screen) and reach back/forth to the edges of your own screen. Monitor your movements and client’s EMs. Coach as needed.
- Alternative forms of BLS
  - Tactile/tapping via butterfly hug or tapping on knees, table.
  - May combine eye movement with taps by following the left/right tapping with their eyes. (See Elan Shapiro’s article, cited above.)
  - Auditory. There are many resources offering bilateral tones. See EMDRIA resource.
- Whatever form of BLS is used, visually observe the client’s response. Coach as needed.
- Speed: (Shapiro, 2018)
  - Slow and just a few for Calm Safe State and resourcing interventions (Ph 2).
  - Fast and long (20+ bidirectional) sets for all reprocessing phases (Ph 4: Desensitization; Ph 5: Installation; Ph 6: Body Scan).
**PHASE TWO: PREPARATION CHECKLIST**

Check □ when completed:

**Explanation of EMDR Therapy**
- □ AIP/REM
  
  "When a disturbing event occurs, it can get locked in the brain with the images, sounds, thoughts, feelings and body sensations. EMDR seems to stimulate the information and allows the brain to process the experience. That may be what is happening in REM or dream sleep - the eye movements (tones, tactile) may help to process the material. It is your own brain that will be doing the healing and you are the one in control.

**EMDR Seating Position for in person and virtual:** “Let’s discuss how we will do this ....”
- □ For in person setting: Seating arrangement (ships passing).
- □ For virtual setting:
  - □ Client and clinician can “pin” each other. Having client “hide” their own video can avoid distraction.
  - □ Take time to establish the best position for the clinician and the BLS in the visual frame.
- □ BLS: “Let me show you how we can do the bilateral stimulation...”

**Eye Movements:**
- □ Comfortable distance from client’s face. (For more information, see appendix page 134.)
- □ Speed (horizontal EMs) (Demonstrate slow and fast with minimal sets to avoid activation).
- □ Alternative directions (- / \).

**Alternative Bilateral Stimulation (to be used only as clinically indicated)**
- □ Tapping.
- □ Auditory.

**Reprocessing Aids**
- □ Metaphor (train/movie)
  
  "In order to help you ‘just notice’ the experience, imagine riding on a train or watching a video and the images, feelings, thoughts, etc., are just passing by."
- □ Virtual Metaphor: Online photo or video apps that demonstrate images moving, disappearing or changing.
- □ Stop signal. “Show me a nonverbal stop signal that you will use if you need to stop for any reason.”
**PHASE TWO: PROCEDURAL STEPS FOR CREATING A SAFE/CALM STATE**

| INSTRUCT CLIENT TO USE AS NEEDED | Use with or without eye movements. *(If without BLS, substitute breathing.)* Clarify with client that this is a **positive exercise** designed to create a positive memory.  

**Note:** If the experience elicits negative associations, the client could be asked to put that negative material in their container and/or the Safe/Calm State resource can be modified or changed. If this does not work, another stabilizing measure should be explored. Discontinue BLS sets if the client reports any disturbance. Use other coping skills if more appropriate (containment or other resource).  

*"The Safe/Calm State exercise is designed to help you create a state of mind that you can use as an internal resource when you need to access a calm state."*

| IMAGE | *"Please bring up an image or sense that gives you a feeling of safety and calm. (pause) What is it? (pause) Describe what you see."*

| EMOTIONS AND SENSATIONS | *"As you notice it now what do you see, hear, and feel? (pause) What emotions are you noticing? (pause) What sensations do you have in your body?"*

| ENHANCEMENT | *"Focus on it and notice any sights, sounds, smells, and sensations. (pause) Tell me more about what you are noticing."*

| EYE MOVEMENTS | *"Bring up the image or sense and concentrate on what you are feeling and where you feel the pleasant sensations in your body and allow yourself to enjoy them. (pause) Concentrate on those feelings and sensations as you start eye movements. (4-8 slow BLS) What are you noticing now?"*  

If positive: *“Focus on that. (BLS) What do you notice now?”* (If necessary, add up to 4 sets of BLS to strengthen it as long as it remains positive.)  

If negative: Redirect attention away from the image or sense, setting aside any negative parts and return to the positive, if possible. If successful, then *“Focus on that. (BLS) What do you get now?”* If not successful, then identify another calm or safe state making sure there are no associations with people or, instead, shift to a mindfulness or breathing exercise.

| CUE WORD | *"Is there a word or phrase that represents this image or sense? Think of ________ and notice the positive feelings and sensations you are having when you think of that word. Concentrate on those sensations and the word/phrase ________ as you start eye movements. (4-8 slow BLS) (pause) What are you noticing now?"* (Pause for a response.) Repeat and enhance positive feelings with sets of BLS as long as the experience continues to strengthen.

| SELF-CUEING | *“Now say that word_________ and notice how you feel."* (pause) *"What are you noticing?"*  

Note: No more BLS from here on out.

| CUEING WITH DISTURBANCE | *“Now imagine a minor annoyance, not what brought you into therapy, but some minor annoyance perhaps something that annoyed you this morning or on your way here, (1 or 2 out of 10) and notice how you feel. (pause) Bring up the cue word(s)_________ and notice any shifts in your experience. (pause) What do you notice?”*

| SELF-CUEING WITH DISTURBANCE | *“Now think of a little bit more annoying incident (2 or 3 out of 10), notice how you feel, (pause) then bring up that word__________ by yourself, especially noticing any changes in your body when you focus on your cue word.”*
PHASE TWO:
RESOURCE DEVELOPMENT AND INSTALLATION (RDI)

Resources appropriate for RDI are associated with positive affects (confidence, competency, mastery, interest, excitement, enjoyment, pride, triumph) and adaptive responses that the client already possesses, but in other contexts. Appropriate resources are based in adaptive states.

Resources can also include *cultural wealth* (Yosso, 2005) such as any positively associated cultural experiences that highlight the assets of the person as a member of a community. (An array of knowledge, skills, abilities and contacts possessed and used by a community.)

Identify client resources within three broad domains of experience in the order presented:

1. **Mastery Resources** (internal to the client) include:
   - The client’s own experiences of mastery; previous coping responses to challenging situations or experiences associated with relevant positive affect states (e.g., strength, self-compassion, confidence, competency, pride, triumph, etc.).
   - A physical stance or movement that evokes the capacity to act with agency on one’s own behalf.

2. **Relational Resources** include:
   - Positive role models who have demonstrated capacities the client would like to incorporate such as courage, persistence, boundary setting, or truth telling. People the client knows or knows of that embody the resource the client wants to develop. Can be real life heroes or public figures, characters from books, stories, cartoons, movies, TV.
   - Memories of supportive others including caregivers, relatives, teachers, authority figures, religious figures, community leaders, peers, or pets who have provided soothing, care, affection, protection, or other desired qualities.

3. **Symbolic Resources** include:
   - Any animal or element from the natural world such as an eagle, a mountain stream, a rock or a tree that symbolizes a specific resource. Religious, cultural, archetypal, totemic and transpersonal symbols or rituals.
   - An image of a positive goal state or future self that represents the outcome of being successful in attaining their goal.
   - Figures or symbols from dreams or imagination which express the client’s capacity for adaptive functioning or inspiration.
IDENTIFY A SITUATION OR CHALLENGE WHERE THE RESOURCE IS NEEDED

A situation in which the client is triggered in the present (e.g., speaking up in meeting, or walking into a room of strangers) or a circumstance when the client lacks the needed resource (e.g., lacks courage/strength to reprocess traumatic experiences, lacks patience with overtired children, or lacks confidence to set boundaries).

“In what situation or circumstance do you need additional resources?”

IDENTIFY NEEDED RESOURCE

This resource can be a positive affect (i.e., strength, courage, confidence, motivation), a positive belief, or an adaptive response (i.e., patience, assertiveness, self-care) that is necessary, but lacking for the client in the identified situation/circumstance above.

“What resource do you need or need more of as you consider managing or responding in the ________________?” (restate the identified situation/circumstance above)

OR,

“How would you like to be able to FEEL in the challenging situation?”

IDENTIFY THE EXPERIENCE OR ENTITY THAT EMBODIES THE RESOURCE

This is a memory, image or entity that represents one of three broad domains of experience: mastery memories, relational experiences and symbols.

“Can you remember a time when you experienced this resource? If the client answered “yes,” ask: “When was it?”

ONLY if the client answered “no” or gave no response, ask: Have you seen it demonstrated by or experienced it from someone else? If the client answered “yes,” ask, “Who and what was it?”

ONLY if the client answered “no” or gave no response, ask: “Is there an entity or symbol that represents or characterizes this resource, such as something in nature (mountain or large oak tree), or a cultural tradition or ritual, or religious figure? If the client answered “yes,” ask: “What is it?”

ELABORATION OF RESOURCE (Mastery memory, relational experience or symbol)

The clinician asks for an elaboration of the resource to enable the client’s felt sense of the experience.

“Tell me about it.”
**IMAGE**
The clinician asks the client to identify an image that represents the resource.

*What image represents this resource?*

---

**EMOTIONS AND SENSATIONS**
The clinician asks the client to identify what emotions and sensations they are experiencing now.

*As you bring up ____________ (restate the resource or the experience of the resource) and your experience of it now, what are you feeling? What emotions are you having? What sensations are you noticing in your body?*

---

**ENHANCEMENT OF THE FULL EXPERIENCE**
The clinician encourages the client to fully experience their positive feelings, body sensations and to acknowledge any adaptive responses they are noticing as they focus on the memory, image or entity.

*Focus on this positive experience.... what you see, hear, and notice in your body right now. Take a moment to be with your experience. (Pause.) Tell me anything new you notice about it now.*

---

**REINFORCE EXPERIENCE OF RESOURCE WITH BLS**
The clinician reminds the client of the positive and adaptive attributes of the resource, and strengthens the association with several slow, short sets of BLS. If the resource becomes contaminated, start over with a different memory, image or entity or switch to a different domain of experience.

*Bring up the image (restate the image) of this resource. Notice your feelings of ____________ (restate emotions) and where you feel those sensations in your body and allow yourself to experience them fully. Concentrate on the experience as you start eye movements. (Add 8-10 passes of slow BLS.) How does it feel to you now?*

---

If positive: *Focus on that (short, slow BLS) What do you notice now?“* Repeat with several sets of BLS until the resource is fully internalized.

If negative: Redirect attention to another experience associated with that resource; or consider another resource.

---

**CUE WORD**
The clinician asks the client to come up with a word, phrase or positive belief that is associated with the resource and strengthen it with several short, slow sets of BLS.

*Is there a word, phrase or positive belief that represents this resource?*

---

*Bring up _____ (restate the word, phrase or belief) and notice the positive feelings and where you feel them in your body when you think of it now. Concentrate on those sensations and the word _____ (restate the word, phrase or belief) as you start eye movements. (8-10 slow BLS). How do you feel now?“* Repeat with several slow, short sets of BLS until it is fully strengthened.
SELF-CUING
The clinician encourages the client to use the cue word to access the resource outside of session.

"Now, I'd like you to know that you can do this on your own when you need it. Take a moment to bring up the cue word on your own now and notice how it feels. When finished, ask: What do you notice?"

FUTURE REHEARSAL USING POSITIVE RESOURCE
The clinician instructs the client to imaginally rehearse using the resource in the situation/circumstance initially identified. After running a movie appropriately using the resource, add sets of slow BLS while the client reruns the movie.

"Now imagine ___________ (restate the situation/circumstance initially described) and see yourself using your resource. How are you managing or responding more effectively?"

If the client affirms a positive/adaptive response, instruct the client to: “Run a movie of using your resource effectively in that situation/circumstance in the future and tell me when you’re finished. When finished, ask: What do you notice?"

If it remains positive/adaptive, strengthen it by instructing the client: “Now run the movie again with BLS and tell me when you are finished.”

Add several sets of slow BLS until the desired scenario has been firmly established. Length of sets can vary, depending on the client’s ability to stay with the desired response without activating a negative association. It may also be beneficial to enhance and install one segment of the experience at a time to minimize possible contamination.

CHALLENGE SITUATION (Optional)
"Now imagine a challenge situation that could arise. Run a movie of your desired response to this situation using your resource. What do you notice?"

PRACTICE
Instruct the client to practice using this resource in situations that are stressful or hard to manage.

NOTE: Evaluate utility of resource in subsequent sessions. Adjust as needed to optimize effectiveness. This process may be repeated for each of the qualities the client wants to develop and strengthen, and with each of the specific images/positive associations generated by the client. Use BLS to reinforce positive experiences of successfully applying the resource. You can add a corresponding positive belief.

PHASE TWO: CONTAINER

In EMDR therapy, containment strategies help to shift focus of attention and regulate affect. A container can be used when needed during and at the end of sessions or as a coping strategy between sessions. Two resources are offered here:

**Murray, Katy.** (2011). Clinical Q&A: Container. *Journal of EMDR Practice and Research, 5*(1), 29. This four-page article describes the value of Container imagery in EMDR therapy and provides a script for guiding clients in building and testing a Container. The full text article can be downloaded at no charge at https://doi.org/10.1891/1933-3196.5.1.29

**Container Exercise – Mark Nickerson**

**Purpose:**
To be able to put aside and safely contain disturbing memories until the person is ready to face them. It can also be used to contain matters that distract a person from their desired focus within EMDR therapy sessions and at other times.

**Instructions:**
*In a moment, I’d like you to design an imaginary container that could be used to store disturbing or distracting thoughts, feelings or memories until you determine you are ready to face them. This is not designed to permanently ignore powerful things that have happened to you. But it is designed to help you have more control over when you choose to face and come to terms with these issues.*

Your container should have the following characteristics:
- **Strong enough to hold what you put in it**
- **Not something you use in your life for other purposes**
- **Something with a door/valve so that you can determine when you want to put something in or take it out**
- **Whatever feels right for you and remember, you can change it if needed**

*Now, take a moment and tell me when you can picture your container.* (Help clarify their container if needed.)

*Now, I’d like you to take a moment to do your best to allow anything you would like to go into your container. You can place it in, pour it in, or let it be drawn into the container in any way your imagination wants to. Take some deep breaths as you do this exercise and I’ll allow you some time to let as much go into the container as possible. Wait about 20 seconds and say, Are things going into the container? Problem solve if needed. When things are going into the container say, Take as long as you need to allow this to happen. Let me know when as much as possible is in the container or if you are having trouble with the exercise.*

When person has completed this say, *Now take a moment to be sure you have sealed up the container.*

*I want you to notice how you feel now that you have been able to put as much as you did in that container. Compared to before, you might feel more relieved, more relaxed, more in control, or something else. Take some more time to appreciate that this is how you are able to feel now.*

*Consider that there may be a time and place to bring something out of the container to face it and come to terms with it. Until that time, know that you can use the container to help you manage disturbance or distractions. Is there a “cue” word you could use to remind you of your container?*
When working with highly dysregulated and dissociative clients, it is helpful to have a repertoire of grounding techniques to assist clients with stabilization during any of the 8 phases. It is preferable to allow the client to reprocess material unimpeded during Phases 4-6, including reprocessing through of high levels of emotion and sensations, as much as can be tolerated. However, some clients may have difficulty staying within their “Window of Tolerance” (Siegel, 1999) while reprocessing.

These clients may show signs of overwhelm or freezing and may be unable to continue to track their experience. Others get panicky and can get disoriented, and have difficulty responding to your voice when attempting to reorient them to the current conditions of safety. Still others may start to go into flashbacks where suddenly the past becomes present and they are unable to observe their reactions, but rather are “in it.” All of these signs indicate that the client is having difficulty regulating their experience and are unable to maintain dual attention between past and present. When a client is unable to self-regulate and stay within their “window of tolerance,” the clinician needs to intervene to ground the client, reorienting them to present reality. The following are some simple stabilization techniques that can be utilized when needed, in increasing order of directedness; (use the strategies listed first):
1. **Reorienting to the Clinician’s Face and Voice**  
   You can say to the client (some or all of the following): "Come back to me (or to being here in the room). I’m right here with you. Notice that you’re in my office and you’re safe. Notice the familiarity of this space. Can you see me here with you? Can you feel me here with you? Look around and remember that you’re here with me, safe and sound. Notice it’s only a memory now.”

2. **Breathing/Posture**  
   Remind the client to breathe from the diaphragm, slowly and deliberately. Breathe with them, coaching them to simultaneously orient to you and to the room (see above). Invite them to straighten or lengthen his/her spine and to feel the support of chair/coach against his/her back and the bottom of their feet on the ground.

3. **Comparison of Textures**  
   Ask the client to feel the surface of the couch or chair and describe; or feel his/her feet on the floor, or key ring or clothing, and describe the differences in textures.

4. **Pillow Toss**  
   Play “catch” with a soft object, such as a small pillow, stuffed animal or balled-up tissue.

5. **Use of Anti-Gravity Muscles**  
   Have the client stand and raise his/her arms above their head, and move their arms up and down, as if flapping wings; or rise up on their toes; or do deep knee bends.

6. **Simple Arithmetic Tasks:**  
   Ask the client to count up or down by 3’s, 4’s etc. The idea is to create a task that is challenging enough to get his/her attention, but without being overly frustrating.

7. **“5 times 5”**  
   Ask the client to identify 5 items seen around the therapy office and describe each one (visual); then to identify 5 smells and describe (olfactory); then 5 sounds (auditory); then 5 textures. (kinesthetic); then 5 tastes, if necessary. If more time is needed to ground the client, the clinician can move to 4 new items of each sense. If more is required, however, it is suggested that the client may need more sophisticated stabilization methods.

All of these interventions require the client to shift states from an affective focus to a cognitive/perceptual/sensory focus, to attend to these tasks. They can help the client to feel more present in the room and dually aware, grounding them in the reality of their current conditions of safety. Note: it is important to resume reprocessing as soon as the client feels ready and sufficiently resourced to do so, whether in the same session or in a subsequent session. If these strategies are not sufficient, use a containment strategy by asking them to take the memory or aspects of it and put it in a container of their choosing to be brought out at a later time, and/or the Safe/Calm State as an additional stabilization strategy.
PHASE TWO:
STABILIZATION AND STRESS MANAGEMENT STRATEGIES
For use during sessions, to bring closure to incomplete reprocessing sessions, or additional stabilization between sessions.

LIGHT STREAM TECHNIQUE
Shapiro, 2018 page 251-252 and Weekend One Manual

ASK: Client to concentrate on upsetting body sensations.
IDENTIFY: “If it had a ________, what would it be?” (Ask about each: shape, size, color, temperature, texture, sound - high or low pitch)
ASK: “What is your favorite color you associate with healing?”
SAY: “Imagine that this favorite-colored light is coming in through the top of your head and directing itself at the shape in your body. Let’s pretend that the source of this light is the cosmos so the more you use, the more you have available. The light directs itself at the shape and resonates, vibrates in and around it. And as it does, what happens to the shape, size or color?”
REPEAT: If client gives feedback that it is changing in any way, continue repeating a version of the underlined portion and ask for feedback until the shape is completely gone. This usually correlates with the disappearance of the upsetting feeling. After it feels better, bring the light into every portion of the person’s body and give client a positive statement for peace and calm until the next session.
ASK: Client to become externally aware at count of five.

SPIRAL TECHNIQUE
Weekend One Manual

Ask client to bring up a disturbing memory and concentrate on the body sensations that accompany the disturbance. Tell client this is an imaginal exercise and there are no right or wrong responses.

“When you bring up the memory, how does it feel from 0-10?”

“Where do you feel it in your body?”
Ask client to concentrate on body sensations.

“Concentrate on the feeling in your body. Pretend the feelings are energy... If the sensation was going in a spiral, what direction would it be moving in, clockwise or counterclockwise?”

Whatever the client answers, respond with “Good” and instruct them to move the spiral in the opposite direction. “Now with your mind, let’s change direction and move the spiral (state clockwise or counterclockwise to indicate the opposite direction). Just notice what happens as it moves in the opposite direction.”
Ask, “What happens?”

If the technique works, the client will report that moving in the opposite direction causes the feelings to dissipate and the SUD to drop. Teach it to the client for self-use. If the client says the spiral doesn’t change, doesn’t move, or nothing happens—choose another technique.
BREATHING SHIFT
Shapiro, 2018 pages 252-253 and Weekend One Manual

Ask the client to bring up a good, happy or positive memory.
(Try to use whatever affect is most useful.)

Ask client to notice where their breath is starting and put their hand over that location on their body.
(Let them breathe a moment or two and instruct them to notice how it feels.)

Now ask them to bring up a memory with a low level of disturbance and notice how their breath changes.
(Ask them to put their hand over that location on their body.)

Now ask client to change their hand to the previous location and deliberately change their breathing pattern accordingly.
(This should cause the disturbance to dissipate. Teach it to the client for self-use.)

DIAPHRAGMATIC BREATHING
Weekend One Manual

Ask the client to take a deep breath and fill their lungs completely so they get the most out of breathing.

You may suggest they scoot forward in their chair and place one hand over their abdomen and the other over their chest. (Demonstrate for client.)

"Start by exhaling and then breathe in all the way with our abdomen for a count of 2 and then breathe in all the way with your chest for a count of 2."

"Hold that for a count of 7 and then breathe out all the way with your abdomen for a count of 4 and breathe in with our chest for a count of 4."

Demonstrate for the client and/or do it together.
Repeat sequence 4 times.
**PHASE THREE: TARGET ASSESSMENT WORKSHEET**

**Prepare client and environment for reprocessing (i.e., seating or pin video, and method of BLS)**

**TARGET MEMORY**
(Past or Present)

"We have decided to reprocess the memory of: ____________________________ to help you with _____________________________________. If a neutral label has not been established: In order for us to refer to this memory later, let’s give it a label. I suggest _____________________________. Does that work for you?" Record agreed upon label for the memory:

**INSTRUCTIONS**

"After we activate the memory, we will be doing sets of eye movements (tones, tactile). Between the sets I will check in with you about what you are experiencing. Please tell me what you are noticing each time we pause. Sometimes things will change and sometimes they won’t. There are no ‘supposed to’s’ in the process. So just give me feedback as to what is happening, without judging whether it should be happening or not. Let whatever happens, happen. Remember you have a stop signal should you need to use it."

**IMAGE**

“What picture represents the worst part of this experience now?”

[If no picture: "As you bring up the experience, what is the worst part of it now?”]

**NEGATIVE COGNITION**

“What words go best with that picture that express your negative belief about yourself now?” [If needed, ask “What does that say about you as a person now?”]

The NC is negative, irrational, self-referencing, distortion, not a description, generalizable, feels true when thinking of the memory.

**POSITIVE COGNITION**

“When you bring up that picture (or experience), what would you prefer to believe about yourself instead?” [If needed, ask “What does that say about you as a person now?”]

The PC is positive, self-referencing, generalizable, feels relatively untrue when thinking of the memory, and fits the theme of the NC.

**VALIDITY OF COGNITION (VOC)**

“When you bring up that picture (or experience), how true do the words ____________________________ feel to you now on a scale of 1-7, where 1 feels completely false and 7 feels completely true?”

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<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completely false</td>
<td>Completely true</td>
<td></td>
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**EMOTIONS/FEELINGS**

“When you bring up that picture (or experience) and the words ____________________________ feel to you now, what emotions do you feel now?”

**SUBJECTIVE UNITS OF DISTURBANCE (SUD)**

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

<table>
<thead>
<tr>
<th>0</th>
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<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
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<tbody>
<tr>
<td>No disturbance</td>
<td>Highest disturbance</td>
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**LOCATION OF BODY SENSATIONS**

“Where do you feel that in your body?”

Proceed immediately to the script to “Begin Reprocessing” at the top of Phase 4.
PHASES 4-7: REPROCESSING & CLOSURE WORKSHEETS

PHASE FOUR - Desensitization: Track channels of associations as they emerge about the memory and other experiences:

BEGIN REPROCESSING ON THE TARGET MEMORY: "Now bring up that picture (or worst part), those negative words (repeat the Negative Cognition), notice where you are feeling it in your body, and let it go wherever it needs to go as you start eye movements." BLS generally 20 or more passes customized to the client’s needs, as fast as the client can tolerate.

**TO RESUME REPROCESSING AN INCOMPLETE TARGET MEMORY:**
(See “Phase 8: Resuming Reprocessing of an Incomplete Target Memory” script to activate the memory and then resume reprocessing.)
"Bring up the experience, the emotions and sensations you’re having now, and let it go wherever it needs to go as you start a set of eye movements."

A. REPROCESS:
"Let it go; take a breath. What are you noticing now?" (pause for a response) Go with that." (Set of BLS are generally 20 - 30 or more passes. After a few sets, customize to the needs of the client.) Repeat: "Let it go; take a breath. What are you noticing now?" (pause for a response) Go with that.” Repeat step A with sets of BLS as long as the client reports changes or new information.

Do as many sets of BLS as necessary until the client stops reporting change for two consecutive sets of BLS, then go to B.

B. RETURN TO TARGET MEMORY:
"When you bring up the memory as you experience it now, what are you noticing?" (pause for a response) Go with that." Continue with sets of BLS (using A, above) as long as the client reports changes or new information.

NOTE: When the client brings up the Target Memory and reports NEUTRAL or NO CHANGE after two consecutive sets of BLS, proceed to C below to check SUD. However, if the lack of change is due to blocked processing (or looping) use strategies for blocked processing.

C. CHECK SUD:
"When you bring up the memory as you experience it now, on a scale of 0 to 10, where 0 is neutral or no disturbance and 10 is the highest disturbance you can imagine, how disturbing does the memory feel to you now?" (pause for a response) Go with that.” As long as the client reports changes or new information, go back to A.

If the SUD is 1 or 2, ask, "Where do you feel it in your body? Go with that." As long as the client reports changes or new information, go back to A.

If the SUD is reported as a 0, continue with at least one set of BLS, then ask, "What are you noticing now?" Proceed to the next phase.

REPEAT Steps A, B, and C until SUD is 0 (or an ecologically adaptive 1). Proceed to Phase 5 Installation.
PHASE FIVE - Installation: Linking the desired Positive Cognition with the target memory/experience:

**BLS** is long and fast as this is still a reprocessing phase with the goal of trait change.

A. “*As you bring up the memory, do the words* (repeat the PC) *still fit, or is there another positive statement that fits even better?*”
   
   Note original or updated PC: ____________________________

B. “*Bring up the memory and those words* (repeat the selected PC). *From 1 completely false to 7 completely true, how true do they feel to you now?*” Note current VOC: ____________

C. “*Hold the memory and the words* (repeat PC) *together.*” (Apply **BLS**).

D. “*Let it go; take a breath. What are you noticing now?* (pause for response) *Notice that.*” (Apply **BLS**)

E. Continue sets of BLS as long as the material is related to the target memory, and becoming more positive/adaptive, or residual disturbance is being reprocessed. 

**CLINICAL CHOICE POINT:** Use your clinical judgment on when to continue to follow the associations and when to return to the target memory and PC (C & D).

F. Check **VOC** adding sets of BLS until the VOC no longer strengthens. “*Bring up the memory and those words* (repeat the selected PC). *From 1 completely false to 7 completely true, how true do they feel to you now?*”

G. Once the VOC=7 (or ecological) and is no longer getting stronger, add another set of BLS and elicit feedback as usual. Then proceed to Phase 6-Body Scan.

H. If the client reports a 6 or less, check the appropriateness of the PC. Identify and address any blocking belief (i.e., “*What prevents it from being a 7?*”).

**NOTE:** If running out of time, set aside the blocking belief to be addressed at a later time and proceed to closure for incomplete target memory.

PHASE SIX - Body Scan:

**BLS** is long and fast as this is still reprocessing with the goal of trait change.

“*Close your eyes and bring up the memory as you experience it now and the words* (repeat the selected PC). *Then bring your attention to the different parts of your body, starting with your head and working downward. Any place you find any tension, tightness or unusual sensation, tell me.*”

If any sensation is reported, do sets of **BLS**. If discomfort is reported —continue sets of BLS until the discomfort subsides or is ecologically adaptive. Repeat the body scan until it is clear or ecologically adaptive.

If a positive/comfortable sensation, do sets of **BLS** to strengthen the positive feeling.

Repeat the body scan until it is clear or ecologically adaptive.

**If time allows, “Let’s return to the treatment plan and consider our next steps.”** (e.g., next target or stabilization exercise.)

Phase Seven - Closure instructions are on the next page.
PHASE SEVEN - Closure:

**INCOMPLETE TARGET MEMORY SESSION (SUD>0, VOC<7, no clear Body Scan)**

An incomplete target is one in which a client’s material is still unresolved, i.e., the client is still reporting distress, the SUD is greater than 0, the VOC is less than 7, or Body Scan is not clear.

1. Tell client it is time to bring closure to the processing:
   
   “We are almost out of time and will need to close. I appreciate the effort you’ve made.”

2. DO NOT take SUD, check PC, take VOC or Body Scan as they may activate processing.

3. Assess need for stabilization: “How are you doing?”
   
   a. If needed, offer a containment exercise:
   
   “I would like to suggest we do a containment exercise before we stop. I would like you to imagine taking what remains of this experience and put it in a container of your choosing until the next time we meet.”
   
   b. Shift state by eliciting their Safe/Calm State, grounding, or relaxation exercise.

4. Debrief once stabilized:
   
   a. Offer validation: “You have done some good work today.”
   
   b. Get client’s feedback and offer feedback on the session with special attention to orienting the client to the present and their use of coping strategies between sessions.
   
   “As you consider your experience today, what positive statement can you make that expresses how you feel OR, what you have learned or gained?” (no BLS)

5. Go to “Instructions for Closing ALL Sessions” at the bottom of this page.

**COMPLETED TARGET MEMORY SESSION (SUD=0, VOC=7, clear Body Scan)**

1. Acknowledge resolution of the Target Memory.

2. Offer validation: “You have done very good work today. How are you feeling?”

3. “As you consider your experience today, what has been most useful from the session OR, what you have learned or gained?” (no BLS)

4. Debrief using ”Instructions for Closing All Sessions”.

**INSTRUCTIONS FOR CLOSING ALL SESSIONS**

Instruct client to observe any changes and use their self-soothing strategies as needed, as the processing can continue between sessions. Assure client of your availability.

“The processing we have done today may continue after our session. You may or may not notice new insights, thoughts, memories, physical sensations, or dreams. Please briefly jot down whatever you notice. We will talk about it at our next session. Remember to use one of your coping skills as needed.”
**PHASE EIGHT: REEVALUATION WORKSHEET**

**Issue/Focus of Current Treatment Plan:** __________________________
(Have seating and BLS method ready)

**GENERAL ISSUE/PROBLEM (Brief Check In)**
Ask specific questions about the symptoms and behaviors being addressed.

"*Related to __________________________ (name of the issue/problem) that we have been working on, tell me what you have noticed that is new or different in your life since our last session.*"

"Have you noticed any changes in your thoughts, feelings, dreams or behavior?"

"*Do you have any new memories or insights as you think about this issue (problem) today?*

**TARGET (Memory Specific): ______________________ (label for the memory)**

"*When you bring up the memory of __________________________ (label) we were working on in our last session, what are you noticing now?*

Optional if more information is needed:

"*What has changed or is different about the experience?*

"*Any new insights or thoughts?*

"*When you bring up the memory as you experience it now, on a scale of 0 to 10, where 0 is neutral or no disturbance and 10 is the highest disturbance you can imagine, how disturbing does the memory feel to you now?*

**Completed Target:**
If reprocessing was **complete in the last session** (SUD 0, VOC 7, Clear Body Scan) and the **SUD is still 0**, review the **Target Identification Summary** to determine the next memory to be reprocessed. Reprocess the next memory using Phases 3-7.

**Incomplete Target:**
- If SUD is > 0, follow instructions for “Resuming Reprocessing of an Incomplete Target Memory.”
- If in the prior session the VOC was not checked or was <7, go to Phase 5: Installation.
- If Body Scan was not cleared in the prior session, go to Phase 6: Body Scan.
PHASE EIGHT: RESUMING REPROCESSING OF AN INCOMPLETE TARGET MEMORY

If the SUD is greater than 0, activate the memory with the following questions and then resume Desensitization Phase 4:

**Memory**

"Bring up the memory we have been working on. What is the image that represents the worst part of it now?"

**Emotions**

“What emotions are you experiencing now?”

**SUD**

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

**Body Location**

“Where do you feel it in your body?”

**Reprocessing**

Resume Desensitization by starting with the Phase 4 script “To Resume Reprocessing”

If the Target Memory is a SUD=0, and in the prior session the VOC of the Positive Cognition was not checked or was <7, go to Phase 5 Installation to link the Positive Cognition to the memory. Follow procedural steps through Body Scan.

If the Target Memory is SUD=0, the Positive Cognition for the Target Memory is VOC=7, but the Body Scan was not cleared, go directly to Body Scan (Phase 6).

Continue until Phases 4-6 are completed (SUD=0 VOC=7, clear Body Scan).

ONCE TARGET IS FULLY REPROCESSED

- Review Treatment Plan: See Target Identification Summary to determine what memories still need to be reprocessed using Phases 3-6.
- To begin reprocessing another memory or present trigger go to Phase 3.
- Only if the completed target is a present trigger, proceed to a Future Template.

CLOSURE

Use Closure (Phase 7) procedures at the end of every session (whether target is complete or incomplete).
PHASE EIGHT: TREATMENT PLANNING CONSIDERATIONS

TREATMENT PLAN CONSIDERATIONS:

1. Target Memory is complete (SUD=0, VOC=7, clear Body Scan).

2. Check remaining experiences identified during History Taking and Treatment Planning as well as associations that emerged during reprocessing:

   **Past**
   Reprocess past experiences that are still disturbing.
   Apply standard procedures for Phases 3-6 until fully reprocessed.

   **Present**
   Reprocess present triggers that are still disturbing.
   Apply standard procedures Phases 3-6 for each trigger that did not generalize from reprocessing past experiences.

   **Future Templates**
   After a present trigger is reprocessed, proceed to Procedural Steps for Developing Future Templates.
THREE PRONGED APPROACH: PAST, PRESENT, & FUTURE TARGETS

One Presenting Issue

![Diagram showing the three pronged approach: PAST, PRESENT, & FUTURE TARGETS]

Example of a Complex Case with Three Issues

**Note:** With complex cases, there are multiple dysfunctional memory networks which need to be identified and reprocessed. For each issue you will work through a specific treatment plan with past, present, and future targets.
PROCEDURAL STEPS FOR DEVELOPING FUTURE TEMPLATES

INTRODUCTION
"You have just completed work on a present trigger ________ and came to that positive belief of (repeat the PC) _________. Can you imagine a time in the future when this positive belief might be useful in the same type of situation we have just worked on?"

STEP 1: IDENTIFY DESIRED OUTCOME
Identify a future situation (similar to the reprocessed present trigger) where a more adaptive response is needed. Ensure the client has the skills needed to implement it.

"What is the future situation?"

________________________________________________________
Address skill building as needed.

"Do the words (repeat PC from present trigger) fit?" (If not, identify preferred PC.)

Note the PC: ____________________________________________

"How would you like to feel in that future situation?" (e.g., calm, confident, grounded, etc.)."

Note desired feeling or state:

__________________________________________________________________

STEP 2: IMAGINE THE FUTURE SCENE
Ask the client to imagine that future scene/image of the experience while holding in mind the Positive Cognition (PC) and the desired feeling.

"I’d like you to imagine yourself responding effectively with that situation in the future. With the new positive belief (repeat the PC) ________________, and a feeling of (repeat desired feeling or state) ________________ imagine stepping into this scene. Notice how you are handling the situation and what you are thinking, feeling, and experiencing in your body."

After a sufficient pause ask: "What are you noticing?"

Step 2 continued on next page
FUTURE TEMPLATE STEP 2 continued

A. If the client's response is POSITIVE:

- Reinforce the scene/image and strengthen with sets of BLS (one or two sets – long/fast as used in reprocessing).

- Use script below to install the Positive Cognition (PC):

  PHASE FIVE - Installation: Linking the desired Positive Cognition with the future template:

  - “Bring up the future situation and those words (repeat the selected PC). From 1 completely false to 7 completely true, how true do they feel to you now?” Note VOC: ________________

  - “Hold the situation and the words (repeat PC) together.” (Apply BLS)

  - “Let it go; take a breath. What are you noticing now? (pause for response) Notice that.” (BLS)

  - Continue sets of BLS as long as the material is related to the future situation, and becoming more positive/adaptive, or residual disturbance is being reprocessed. CLINICAL CHOICE POINT: Use your clinical judgment on when to continue to follow any associations and when to return to the future situation and the PC.

  - Check VOC adding sets of BLS until the VOC no longer strengthens. “Bring up the future situation and those words (repeat the selected PC). From 1 completely false to 7 completely true, how true do they feel to you now?”

- Once the VOC=7 (or ecological) and no longer getting stronger, add another set of BLS and elicit feedback. Then **SKIP B and go directly to Step 3** on the next page.

B. If client’s response is NEGATIVE or uncertain, explore and address as needed:

- Is the disturbance related to appropriate hesitancy due to unfamiliarity or needed skills? Identify any difficulties, problem solve, teach relevant skills and/or strengthen resources. Then generate a desired response and process the future scene as above by returning to the beginning of Step 2.

- In other cases, blocks, anxieties or fears can be reprocessed directly by sets of BLS until neutral. Then generate a desired response and reprocess as above (Step 2).

- If disturbance isn’t clearing, identify if there is another present trigger that needs to be reprocessed first. Reprocess with Phases 3-6. Then generate a desired response and reprocess as above (Step 2).

- If, after these strategies the Future Template remains blocked, explore for Feeder Memories or Blocking Beliefs. Once identified, use Phases 3-6 to reprocess the associated past memories, present triggers, and/or memories related to a negative or blocking belief. Once reprocessing of the contributory experience(s) is complete, generate a desired response and reprocess as above by returning to the beginning of Step 2 on preceding page.

Future Template, page 2 of 4
STEP 3: RUN A MOVIE

Ask the client to run a MOVIE of the sequence from start to finish (without BLS) responding adaptively to the situation, holding in mind the Positive Cognition (PC), and noticing the feelings and sensations.

"Now I would like you to run a movie of dealing effectively with this situation, holding in mind the positive belief (state PC) ______________ you have about yourself and noticing the positive feelings and sensations." After sufficient pause, ask "What are you noticing?"

A. If the client’s response is POSITIVE:
   - Add BLS as the client runs the movie again to strengthen the positive feelings.
   - Use script below to install the Positive Cognition (PC):
     - PHASE FIVE - Installation: Linking the desired Positive Cognition with the future template:
       - "Bring up the future situation and those words (repeat the selected PC). From 1 completely false to 7 completely true, how true do they feel to you now?" Note VOC: ______________
       - "Hold the situation and the words (repeat PC) together." (Apply BLS)
       - "Let it go; take a breath. What are you noticing now?" (pause for response) Notice that. (BLS)
     - Continue sets of BLS as long as the material is related to the future situation, and becoming more positive/adaptive, or residual disturbance is being reprocessed. CLINICAL CHOICE POINT: Use clinical judgment on when to continue to follow any associations and when to return to the future situation and the PC.
     - Check VOC adding sets of BLS until the VOC no longer strengthens. "Bring up the future situation and those words (repeat the selected PC). From 1 completely false to 7 completely true, how true do they feel to you now?"
   - Once the VOC=7 (or ecological) and no longer getting stronger, add another set of BLS and elicit feedback. Then SKIP B.

B. If the client hits any blocks, apply additional sets of BLS until neutralized. Run the desired movie from start to finish until the client achieves a sense of confidence and satisfaction.

STEP 4: GENERATE A CHALLENGE SITUATION When time allows and if appropriate for your client:

Create a scenario where there is an unanticipated or undesirable challenge and generate an adaptive response to that situation. Process and install PC to VOC of 7 (or ecologically adaptive) for each situation. Offer example(s) ONLY if client cannot generate them:

"I'd like you to imagine that very same situation, but this time a challenge occurs. What would the challenge be?"

Implement Steps 2 and 3 (see prior pages) for the same situation – now with the added challenge. You may choose to generate multiple challenge situations if time allows.

Use Closure (Phase 7) procedures at the end of every session.
**PHASE SEVEN – Closure following Future Template.**

Closure script is modified for the Future Template.

**INCOMPLETE TARGET MEMORY AND/OR FUTURE TEMPLATE SESSION**

1. Tell client it is time to bring closure to the processing:
   
   “We are almost out of time and will need to close. I appreciate the effort you’ve made.”

2. Assess need for stabilization: “How are you doing?”
   
   a. If needed, offer a containment exercise:
      
      “I would like to suggest we do a containment exercise before we stop. I would like you to imagine taking what remains of this experience and put it in a container of your choosing until the next time we meet.”
   
   b. If needed, shift state by eliciting their Safe/Calm State, grounding or relaxation exercise.

3. Debrief once stabilized:
   
   a. Offer validation: “You have done some good work today.”
   
   b. Get client’s feedback and offer feedback on the session with special attention to orienting the client to the present and their use of coping strategies between sessions.

   “As you consider your experience today, what positive statement can you make that expresses how you feel OR, what you have learned or gained?” (no BLS)

4. Go to “Instructions for Closing ALL Sessions” at the bottom of this page.

**COMPLETED TARGET MEMORY and/or FUTURE TEMPLATE SESSION**

1. Acknowledge resolution of the Target Memory and/or Future Template.

2. Offer validation: “You have done very good work today. How are you feeling?”

3. “As you consider your experience today, what has been most useful from the session OR, what you have learned or gained?” (no BLS)

4. Debrief using “Instructions for Closing All Sessions”.

**INSTRUCTIONS FOR CLOSING ALL SESSIONS**

Instruct client to observe any changes and use their self-soothing strategies as needed, as the processing can continue between sessions. Assure client of your availability.

“The processing we have done today may continue after our session. You may or may not notice new insights, thoughts, memories, physical sensations, or dreams. Please briefly jot down whatever you notice. We will talk about it at our next session. Remember to use one of your coping skills as needed.”
RECENT TRAUMATIC EVENTS

ADAPTIVE INFORMATION PROCESSING

Recent traumatic events (occurred within approximately the last 3 months) have not fully consolidated as a single memory. Therefore, it is necessary to reprocess each aspect of the traumatic event separately.

Each frame of the event is assessed and reprocessed individually (Phases 3-5).

Once the client is able to imagine the entire sequence of events with no disturbance, an overarching PC is identified and installed (Phase 5) & Body Scan (Phase 6) of the entire experience is completed.

PURPOSE

To reprocess a disturbing event that occurred within the last three-months.

HISTORY TAKING AND PREPARATION

➢ Use standard preparation and client readiness checklist.

➢ Obtain a narrative of the event, beginning before the event occurred until after it was over.

➢ Narrative can come from others in addition to the client.

➢ Identify the sequence frame by frame of the entire event, noting if there is a “worst” frame.

➢ Once reprocessing begins, you’ll start with the worst frame first.

➢ If there is no worst frame, reprocess each frame chronologically.
REPROCESSING SEQUENCE

A. Reprocess the worst (or first) part of the experience using Phase 3 (Target Assessment), Phase 4 (Desensitization), and Phase 5 (Installation).
   **Do not do** Phase 6 (Body Scan).

B. Reprocess each of the remaining frames in chronological order using Phase 3 (Target Assessment), Phase 4 (Desensitization), and Phase 5 (Installation).
   **Do not do** Phase 6 (Body Scan).

C. Have client visualize the entire event with eyes closed. Have the client open their eyes and apply BLS to any frame that is still disturbing until neutralized.

D. Repeat until the entire event can be visualized from start to finish without disturbance.

E. Full Phase 5 (Installation) on the entire memory: Install an overarching positive belief (PC) for the entire event and have the client visualize the event from start to finish with eyes open using BLS.

F. As an additional check, review the entire event with eyes closed holding in mind the PC to ensure that the **VOC** is at a 7 for the entire event (each frame). If not, reprocess that frame until **VOC** is 7. Repeat procedure until the entire event is linked with the PC and the **VOC** is 7.

G. Apply Body Scan holding in mind the event and the Positive Cognition.

H. Reprocess any present triggers associated with the recent event.

I. Apply Future Template of desired response(s) after resolution of each trigger.
Focused reprocessing (EMD and Restricted Reprocessing) is a strategy used to limit content accessed by the client. The clinician may choose to move back and forth between focused reprocessing and full EMDR reprocessing as needed to restrict or allow spontaneous associations.

When to consider focused reprocessing to limit spontaneous associations:

- When the client cannot tolerate full reprocessing.
- When there is limited time or resources for an imminent challenge or pressing issue.
- To facilitate reduction of overwhelming symptoms and/or increase stability.
- When the clinician needs to more actively manage the pace or scope of reprocessing.
- Sometimes helpful in the recent events protocol (See Appendix).
ADAPTIVE INFORMATION PROCESSING
Access memory or part of a memory as it is currently stored so that it can be desensitized.

Accessing the Target Memory activates the distressing emotional states.

The dual attention between past and present, combined with BLS, facilitates a de-arousal effect. Returning to target after each set limits the associative reprocessing for containment purposes.

ORIGINALLY DEVELOPED AND RESEARCHED BY DR. SHAPIRO IN THE 1980s

For a more thorough discussion please refer to Pages 220-222 of Dr. Shapiro’s 2018 text in which she differentiates between the EMD procedures used in the original (1989) research and how EMD has evolved in clinical practice.

REPLACED BY EMDR THERAPY AS A MORE COMPREHENSIVE TREATMENT

PURPOSE

To be used in circumscribed situations to reduce arousal and increase stability.

For the reduction of symptoms stemming from a memory or part of a memory while minimizing spontaneous associations to other experiences.

For use in initial stages of treatment for more debilitated clients and/or in emergency situations to increase the client’s ability to stay present and incorporate a greater sense of mastery.

For selected clients who can easily get emotionally overwhelmed and dysregulated.

Once the client is sufficiently stabilized, standard EMDR reprocessing can be used.

EMD PROCEDURAL STEPS ON FOLLOWING PAGE
EMD PROCEDURAL STEPS:

“The disturbing memory can be treated by requiring the client to maintain in awareness one or more of the following: (1) an image of the memory, (2) the negative self-statement or assessment of the event, and (3) the physical sensations. However, the procedures below were tested in the first RCT (Shapiro, 1989), and appeared to be both effective in desensitizing an identified adverse event and successfully limiting associations. EMD can also be used to target an isolated sensory experience such as a sound or smell. Intrusions can be treated by focusing only on the image.” (Shapiro, 2018 p. 221).

A. Identify the memory or part of memory.

B. Use the standard Phase 3 – Target Assessment Phase identifying the components of the experience.

C. In Phase 4 - Desensitization, apply short sets of fast BLS, (12-20), increasing the number of repetitions as needed. After each set, instruct the client to "Let it go; take a breath. (pause) What are you noticing now?" If positive, these can be reinforced with sets of eye movement.

D. If other associations arise, shorten subsequent sets. Use a containment strategy and return to target.

E. Return to target after each set until the desired shift has occurred.

   **Note:** In clinical practice, the procedure is to return to the target after every set, while checking the SUD occasionally. In Shapiro’s early research on single incident trauma survivors the procedure is to return to the Target Image and Negative Cognition after each set and take a SUD.

F. Once the desired treatment effect has been achieved, begin Phase 5 - Installation: install the selected PC until VOC is 7 or as strong as ecologically adaptive.

G. Note that Phase 6 - Body Scan is **skipped**.

H. Phase 7 - Closure: As usual, as in general practice apply a state shift strategy.
EMD WORKSHEET

PURPOSE
Desensitizing a single event or part of an event, limiting access to associated channels of memories.

PHASE THREE – Target Assessment:
Prepare client and environment for reprocessing (i.e., seating or pin video, BLS method).

Specific Instructions:
"After we activate the memory, we will be doing sets of eye movements (tones, tactile). Between the sets I will check in with you about what you are experiencing. Please tell me what you are noticing each time we pause. Sometimes things will change and sometimes they won’t. There are no ‘supposed to’s’ in the process. So just give me feedback as to what is happening, without judging whether it should be happening or not. Let whatever happens, happen. Remember you have a stop signal should you need to use it.”

Target Memory or part of a memory:

**Image:** (Most disturbing) **“What picture represents the worst part of the experience?”**

If no picture: **“As you bring up the experience, what is the worst part of it now?”**

**Negative Cognition:** **“What words go best with that picture (or worst part) that express your negative belief about yourself now?”** [If needed, ask “What does that say about you as a person now?”]

**Positive Cognition:** **“When you bring up that picture (or experience), what would you prefer to believe about yourself instead?”** [If needed, ask “What does that say about you as a person now?”]

**Validity of Cognition (VOC):** **“When you bring up that picture (or experience), how true do the words (repeat the Positive Cognition) feel to you now on a scale of 1 to 7, where 1 feels completely false and 7 feels completely true?”**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completely false</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Completely true</td>
</tr>
</tbody>
</table>

**Emotions:** **“When you bring up that picture (or experience) and the words (repeat the NC) _____ what emotions do you feel now?”**
SUD: "On a scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does the memory feel to you now?"

1  2  3  4  5  6  7  8  9  10
No disturbance                        Highest disturbance

Location of Body Sensation: "Where do you feel it in your body?"

---

PHASE FOUR - Desensitization:

"Bring up the picture (or worst part), those negative words (repeat the Negative Cognition), and begin a set of eye movements." (12-20 repetitions or shorter of fast BLS in order to limit access to associations.)

After each set: "Let it go. Take a breath." (pause) "What are you noticing now?"

Return to the Target after each set, choosing wording 1 or 2 as scripted below:

1. "Bring up ______ (the memory or that part of the memory) and begin another set of eye movement."

Return to Target after each set, occasionally taking a SUD:

"When you bring up the (memory or that part of the memory) on a scale of 0 to 10, where 0 is neutral or no disturbance and 10 is the highest disturbance you can imagine, how disturbing does it feel to you now?"

OR

2. "When you bring up the picture or (worst part) and those negative words, on a scale of 0 to 10, where 0 is no disturbance and 10 is the highest disturbance you can imagine, how disturbing does it feel to you now?"

Note: If associations to other memories arise, return to target and shorten sets and if needed, contain other memories or associations. If bringing up the image (or worst part) and NC evokes more distress, then ask only for the SUD after each set. If the NC no longer matches the image (or worst part) then focus only on the image (or worst part) and emotion.

Continue with additional sets of BLS and return to the target after each set until the disturbance is as low as the client can go or it is ecologically adaptive under the current circumstances. If stalled in high disturbance, options include adjusting the BLS (direction, speed, length of set, modality), offering a cognitive interweave, or asking the client to scan for other disturbance (e.g., image, sound, smell, body sensation).

Once the SUD has stopped decreasing, move to Phase 5 - Installation.
PHASE FIVE - Installation:

“As you bring up the memory, do the words (repeat the PC) still fit, or is there another positive statement that fits even better?” Note the original or updated PC.

“Bring up the memory and the words (repeat the selected PC). From 1 completely false to 7 completely true, how true do they feel to you now?”

“Hold the memory and the words (repeat PC) together.” Apply BLS: fast as this is still reprocessing. “How true do those words feel to you now when you think of the original experience on a scale of 1-7 where 1 is untrue and 7 is absolutely true?”

Continue Installation as long as the material is becoming more adaptive.

DO NOT DO PHASE 6 – Body Scan when using EMD.

PHASE SEVEN - Closure:

Procedure for Closing Incomplete Target Memory Session:

An incomplete target is one in which a client’s material is unresolved, i.e., they are still experiencing some distress or confusion about the memory or related associations. The following is a suggested procedure for closing down an incomplete target memory. The purpose is to validate the client’s efforts and help them shift states in order to help them feel grounded before they leave.

Steps:

1. Inform the client that it is time to stop and explain the reason. “We are almost out of time and we will need to stop soon.”

2. DO NOT take SUD, check PC, take VOC or Body Scan as they may activate processing.

3. Assess the need for stabilization. “How are you doing?”

   a. Offer a containment exercise, if needed:

      “I would like to suggest we do a containment exercise before we stop. I would like you to imagine taking what remains of this experience and put it in a container of your choosing until the next time we meet.”

   b. Shift state by eliciting their Safe/Calm State, a resource, grounding, or a relaxation exercise.

4. Debrief once stabilized:

   a. Offer validation: “You have done some good work today.”

   b. Get client’s feedback and offer feedback on the session with special attention to orienting the client to the present and their use of coping strategies between sessions.

      “As you consider your experience today, what positive statement can you make that expresses how you feel OR, what you have learned or gained?” (no BLS)

5. Go to “Instructions for Closing ALL Sessions” on the next page.
Instructions for Bringing Closure to A Completed Target Memory Session:

1. Acknowledge resolution of the Target Memory.
2. Offer validation: "You have done very good work today. How are you feeling?"
3. "As you consider your experience today, what has been most useful from the session OR, what you have learned or gained?" (no BLS)
4. Debrief using “Instructions for Closing All Sessions”.

Instructions for Closing All Sessions:

Instruct client to observe any changes and use their self-soothing strategies as needed, as the processing can continue between sessions. Assure client of your availability.

"The processing we have done today may continue after our session. You may or may not notice new insights, thoughts, memories, physical sensations, or dreams. Please briefly jot down whatever you notice. We will talk about it at our next session. Remember to use one of your coping skills as needed."

PHASE EIGHT – Reevaluation:

Check in with the client on how they have been able to respond or manage the challenging situation related to the memory or part of the memory that was desensitized. Check for additional intrusive thoughts, startle responses and other symptoms. Check the SUD of the original experience – if you only desensitized a part of the memory, consider full EMDR reprocessing of the entire experience for complete resolution.
Inadequately processed memories are stored without access to information needed for adaptive resolution, resulting in distortions about the integrity of self versus other, past versus present, internal versus external locus of control, sense of exclusion versus inclusion. These distortions manifest in negative emotions and beliefs about the self. Pervasiveness of these distortions helps identify clinical themes. Negative beliefs are organized into categories of experience that reflect the informational plateaus/clinical themes and nature of clients’ distortions about themselves.

**RESPONSIBILITY: DEFECTIVENESS/ACTION**

- Distorted conclusions about self, i.e., "I am the cause of the problem."
- Confusion about self versus other.
- Inability to differentiate between standards for an adult versus standards for a child.
- Clinical challenge is to designate appropriate responsibility.

<table>
<thead>
<tr>
<th><strong>Self-Worth/Shame</strong></th>
<th><strong>Action/Guilt</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;I am bad.‖</td>
<td>&quot;It’s my fault.‖</td>
</tr>
<tr>
<td>&quot;I’m not good enough.&quot;</td>
<td>&quot;I should have done something.”</td>
</tr>
<tr>
<td>&quot;I don’t matter.”</td>
<td>&quot;I am unforgiveable.”</td>
</tr>
<tr>
<td>&quot;I am incompetent.”</td>
<td>&quot;I am horrible person.”</td>
</tr>
<tr>
<td>&quot;I don’t matter.”</td>
<td>&quot;I’m inadequate/weak.”</td>
</tr>
</tbody>
</table>

**SAFETY/VULNERABILITY**

- Continued confusion about current conditions of safety after the threat has passed.
- High level of fear or conversely numbness due to thwarted fight/flight response that gets triggered under certain conditions in the present.
- Clinical challenge is to differentiate past vs. present conditions of safety.

| "I am vulnerable.”  | "I can’t trust….” |
| "I am going to die.” | "I’m in danger.” |
| "I am not safe.”    | "I am helpless/powerless.” |

**CONTROL/CHOICES**

- Continues to be confused about locus of control in the present.
- Continues to feel/believe themselves to be powerless/helpless due to experiences of powerlessness/helplessness in the past.
- Clinical challenge is to shift locus of control from external to internal.

| "I am helpless/powerless.” | "I can’t handle it.” |
| "I’m trapped.”             | "I am out of control.” |
| "I am not in control.”     | "I cannot trust myself/my judgment” |

**CONNECTION/BELONGING**

This new distinct theme was added to the original three themes (Shapiro, 2018) to reflect the fundamental human need for attachment, interpersonal and social connection and belonging. Many psychological theorists have recognized this core need including Maslow in his hierarchy of needs. Negative beliefs listed in this category are examples of a pattern of resonant NCs identified in the reprocessing of traumatic and adverse experiences which have violated a person’s sense of connection and belonging. These traumatic experiences include social and culturally linked exclusion associated with stigmatization, discrimination, oppression and marginalization. In addition, these internalized beliefs often resonate with other experiences of interpersonal rejection, loneliness and isolation.

- Internalized pain and/or identity confusion/ambivalence associated with being excluded/mistreated by social/societal forces.
- Feel/believe themselves to be defined as they were treated.
- Clinical challenge is to restore dignity, inherent social worthiness, and desire for rewarding social connection.

| "I don’t belong.” | "I’m different and that’s not okay.” |
| "I can’t connect.” | "I’m alone.” |
| "I am invisible.” | |

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**INFORMATIONAL PLATEAUS/CLINICAL THEMES AND NEGATIVE BELIEF CATEGORIES**

EMDR Institute EMDR Therapy Basic Training

EMDR Therapy Worksheets and Resources for Clinical Practice

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Digital copy provided solely for attendees of the EMDR Institute and Trauma Recovery/EMDR-HAP Basic Training. Not for distribution.
### EXAMPLES OF NEGATIVE AND POSITIVE COGNITIONS

This is a listing of possible negative and positive cognitions related to the memory to be reprocessed. This list is not to be handed to the client; it is for the clinician to use as a reference when assisting the client in putting words to the possible distorted thoughts or beliefs that arise from the memory. If the client struggles, the clinician can offer 1-2 options from each category on this list. We have grouped the cognitions into the four themes. “...(T)here are nuances to many of the cognitions, whereby they overlap or are a combination of two or more categories. The selection should be one that resonates most for the individual, one that articulates the dysfunctional affect that pervades the person when (they) think of the event.” (Shapiro, 2018, p. 443.)

<table>
<thead>
<tr>
<th>THEME/CATEGORY</th>
<th>NEGATIVE COGNITIONS</th>
<th>POSITIVE COGNITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RESPONSIBILITY:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DEFECTIVENESS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Worth/Shame</td>
<td>I am bad.</td>
<td>I am good.</td>
</tr>
<tr>
<td></td>
<td>I am unlovable.</td>
<td>I am lovable.</td>
</tr>
<tr>
<td></td>
<td>I’m not good enough.</td>
<td>I am good enough.</td>
</tr>
<tr>
<td></td>
<td>I am incompetent.</td>
<td>I am competent.</td>
</tr>
<tr>
<td></td>
<td>I don’t matter.</td>
<td>I do matter.</td>
</tr>
<tr>
<td></td>
<td>It’s my fault.</td>
<td>It’s not my fault. (I’m innocent.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>RESPONSIBILITY:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ACTION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action/Guilt</td>
<td>It’s my fault.</td>
<td>I learned/can learn from it.</td>
</tr>
<tr>
<td></td>
<td>I should have done something.</td>
<td>I did the best I could.</td>
</tr>
<tr>
<td></td>
<td>I am unforgiveable.</td>
<td>I can forgive myself and move on.</td>
</tr>
<tr>
<td></td>
<td>I am a horrible person.</td>
<td>I’m okay, in spite of my mistake.</td>
</tr>
<tr>
<td></td>
<td>I’m inadequate/weak.</td>
<td>I am adequate/strong.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SAFETY/VULNERABILITY</strong></td>
<td>I am vulnerable.</td>
<td>I can (learn to) protect myself.</td>
</tr>
<tr>
<td></td>
<td>I am going to die.</td>
<td>I survived.</td>
</tr>
<tr>
<td></td>
<td>I am not safe.</td>
<td>I am safe now.</td>
</tr>
<tr>
<td></td>
<td>I can’t trust anyone.</td>
<td>I can choose whom to trust.</td>
</tr>
<tr>
<td></td>
<td>I’ m in danger.</td>
<td>It’s over, I can move beyond it.</td>
</tr>
<tr>
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</tr>
<tr>
<td><strong>CONTROL/CHOICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I am helpless/powerless.</td>
<td>I have choices now.</td>
</tr>
<tr>
<td></td>
<td>I’m trapped.</td>
<td>I’m free.</td>
</tr>
<tr>
<td></td>
<td>I am not in control.</td>
<td>I’m in control now.</td>
</tr>
<tr>
<td></td>
<td>I can’t handle it.</td>
<td>I can handle it.</td>
</tr>
<tr>
<td></td>
<td>I am out of control.</td>
<td>I’m in control of my reactions.</td>
</tr>
<tr>
<td></td>
<td>I cannot trust myself/my judgment ...</td>
<td>I can (learn to) trust myself/my judgment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CONNECTION/BELONGING</strong></td>
<td>I can’t connect.</td>
<td>I can connect/I am connected.</td>
</tr>
<tr>
<td></td>
<td>I don’t belong.</td>
<td>I do belong/I worthy of belonging.</td>
</tr>
<tr>
<td></td>
<td>I am invisible.</td>
<td>I deserve to be seen.</td>
</tr>
<tr>
<td></td>
<td>I’m different, and that’s not okay. ..</td>
<td>I am myself/unique, &amp; that’s okay.</td>
</tr>
<tr>
<td></td>
<td>I’m alone.</td>
<td>I’m not alone. (I’m connected.)</td>
</tr>
</tbody>
</table>

See Shapiro 2018, pages 443-444 for additional examples of Negative & Positive Cognitions.
TREATMENT SUMMARY NOTES
For Record-Keeping Purposes
(Optional)

CIRCLE APPROPRIATE ITEMS:

NAME ___________________________ DATE ___/___/____

PRESENTING ISSUE: ________________________________

_____________________________________________________________________

TARGET MEMORY:

_____________________________________________________________________

Past Present Trigger Future Template

Target Memory Status: Complete Incomplete

Stabilization Exercise used at the end of the session? Yes/No

Safe State Light Stream Breathing Other ______________________

Client Stability when leaving session:

Poor Fair Good Excellent

Treatment Summary Notes:

Issues/associations that arose during processing to be re-evaluated at a later time:
PHASE 1: EMDR Therapy Psychosocial Interview
Agenda Client Readiness Criteria Checklist for Children

The following may be treated as a clinical checklist or worksheet:

□ OK – Has been addressed and is appropriate for EMDR therapy.

□ PROBLEM – Problem/Concern. Wait until completion of Basic Course or until further preparation and stabilization have been achieved.

□ CONSULTATION – Consultation indicated with EMDR clinician with expertise in the area of concern.

CLINICAL CONCERNS:

DISSOCIATION AND LONG-STANDING ISSUES

□ OK □ PROBLEM □ CONSULTATION

Client has been screened for Dissociative Disorder (DD). DD rules out the use of EMDR therapy by Part One-trained clinicians and requires additional training beyond the Part Two training. A Mental Status Exam, and the Dissociative Experiences Scale II (DES) should be used for all clients to determine the degree of dissociation present. Further evaluation for Dissociative Disorders should be conducted with any client about whom you have concerns. See Clinical Signs of Dissociative Disorders, the DES-II, Adolescent DES, Child Dissociative Checklist, and A General Guide to the Use of EMDR Therapy in the Treatment of Dissociative Disorders in the Appendix. Special preparation and stabilization for DD clients is needed to establish their capacity to maintain dual awareness in order for reprocessing to occur.

Indicators of poor psychic development include but are not limited to:

□ Years of unsuccessful psychotherapy
□ Minimal or poor responses to psychotropic medications
□ Depersonalization and/or derealization
□ Dissociative Disorder
□ History of hospitalizations
□ Somatic symptoms
□ Chronic instability at home and/or at work
□ Inability to learn from experience
□ Previous unsuccessful treatment of addictions and/or compulsions
□ Secondary gains to maintaining their symptomatology

Specific to Children and Adolescents:

□ Frequent aggression or destruction of property
□ Consistent refusal to cooperate with parents and teachers
ACUTE PRESENTATIONS

- OK □ PROBLEM □ CONSULTATION

The following situations require caution and case consultation:
- Major loss, illness or injury
- Life threatening substance abuse
- Recent suicide attempt(s)
- Self-mutilation
- Serious assaultive or impulsive behavior
- Psychotic episode

STABILIZATION

- OK □ PROBLEM □ CONSULTATION

- Adequate stabilization/self-control strategies in place
- Client must have a workable means of managing distress as necessary during and between sessions
- Client has adequate life support (friends, relatives, etc.)
- Systems/issues that might endanger client have been addressed
- Client (or parent/caregiver) able to call for help if indicated
- Medical marijuana use
- Client is safe at home

MEDICAL CONSIDERATIONS

- OK □ PROBLEM □ CONSULTATION

- General physical health/medical condition/age considered (possible exacerbation with stress)
- Medications
- Inpatient if necessary, to manage danger to client or others
- Eye pain contraindicates EMs until cleared by physician (use alternate forms of stimulation)
- Any neurological impairment or physical complication inappropriate for Weekend 1/Part 1 clinicians
- Pregnancy: first trimester cautions; other complications

TIMING CONSIDERATIONS/READINESS

- OK □ PROBLEM □ CONSULTATION

- Timing of life events (projects, demands, work schedules, vacations, etc.)
- Availability of both clinician and client for continuity of sessions, support, and follow-up
- Willingness/ability to participate in the treatment plan
- 90-minute sessions (if possible) 50 minutes minimum.
- Children often need less time, usually less than 50 minutes
PHASE 1:
Child Target Identification Worksheet

This worksheet is designed to help you take an AIP-informed history and develop a treatment plan specific to a presenting issue. You will practice using the Floatback Technique (or Affect Scan) as well as direct questioning to identify relevant experiences in the client’s memory network that are informing their current symptoms. It will also help you prioritize what memories to process and keep track of them as they resolve.

Presenting Complaint:

“What do you want to work on?”
(Consider what the adult suggests, however, the child ultimately decides.)

Recent Example of Presenting Complaint:

“Has anything happened lately that is like what you said?”

“Are there any other things that have happened lately that are like that too?”

Past Experiences:

Use direct questioning or the Floatback Technique as scripted below to identify the past experiences associated with the client’s current difficulties. Use the most disturbing experience from the recent events described above. Children may not be able to come up with past incidents because they are more present oriented and trauma specific.

“When you think of that thing that just happened__________, what is the picture you see? What is the bad (yucky/upsetting) thought (about yourself) you have? Notice the feelings you have and how your body feels and think back to an earlier time you might have felt this way before. What are you thinking or feeling (noticing)?”

After each association:

“What else do you think or feel?”
If Floatback doesn’t yield results or is too demanding, try Affect Scan:

“When you think about that thing that happened, notice how you feel and your body feels now. Can you remember an earlier time that you felt like that before?”

Repeat instructions having the client focus on each association briefly until s/he can’t access any more associations:

“Anything else? Keep going and see if there are other things.”

Continue to Floatback and notice what else emerges.

Identify the first and worst experiences in the memory network. Record the client’s experiences using headlines, taking note of the first and the most disturbing experiences:

<table>
<thead>
<tr>
<th>Experiences</th>
<th>Age</th>
</tr>
</thead>
<tbody>
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<td></td>
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<td></td>
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</tbody>
</table>

Present Triggers:

“Are there other things that bring up these yucky/bad/upsetting thoughts (or behaviors) and feelings?”

Future Template:

“How to you want to be in this situation in the future?”
(with children be specific about their desired behavior and the time frame)

Redirect Client’s focus of attention to Safe/Calm Place, shifting state to end clinical session.

Treatment Plan Summary:

Target Memory selected for the first reprocessing session:

Touchstone Memory  Worst  Other Past Experience
PHASE 2: Child Preparation Checklist

☐ Check when completed

Explanation of EMDR Therapy

- AIP/REM

“When something bad happens, it can get stuck in your brain with a picture, sounds, your thoughts, feelings and how your body feels. This EMDR thing helps your brain to feel better about what happened. We think it is like dream sleep because sometimes dreams can help us with stress. The eye movements (sounds or tapping) help us with the stress over the bad thing that happened and other things that might be connected to it. It is your own brain that will be doing the healing and you are the one in control.”

(The younger the child the more the explanation should be shortened.)

EMDR Seating Position

- Seating arrangement (ships passing). Working virtually may be different.

Eye Movements

- Comfortable distance from child’s face
- Comfortable speed (horizontal EMs)
- Alternative directions (\ /)

Alternative Bilateral Stimulation (to be used only if necessary)

Tapping

- Auditory
- Bilateral stimulation (BLS)
  - Stabilization and Resourcing (BLS slower, 4-8 passes)
  - Reprocessing Phases-Desensitization, Installation, Body Scan (BLS faster,
    - 20 or more passes or customized to need of client)

Children

- Experiment with eye movements for younger children as they may or may not be able to track eye movements.
- Children of all ages benefit from having toys or creative tools to follow.
- Changing creative tools either with eye movements, tactile or auditory movements throughout processing to keep children interested. (Examples: puppets, wands, drums, feathers, clapping, stomping).
- Tactile and auditory
- Introduce options
- Use only when necessary
- They may prefer these methods to keep engaged
- They often like the tactile or auditory modes fast
Bilateral stimulation speed and sets

- Stabilization and Resourcing (BLS slower, 4-8 passes and young children even fewer passes 2-4)
- Reprocessing Phases-Desensitization, Installation, Body Scan (BLS faster, 20 or more passes or customized to need of client)

Client Stability/Coping Strategies

- Metaphor (train/video)
  
  “In order to help you ‘just notice’ the experience, imagine riding on a train or watching a video and the images, feelings, thoughts, etc., are just passing by.”

- Stop signal
  - Stop signal/keep going signal
  - In-session/between sessions for state change as needed
    - Containment (see appendix for container exercise examples)
    - Safe/Calm State
    - Relaxation exercises or other stress reduction strategies
## Child Procedural Steps for Creating A Safe/Calm State

### Instruct to use with or without eye movements.

**Client to Use as Needed**

**Use other coping skills if more appropriate** (containment or other resource).

<table>
<thead>
<tr>
<th><strong>Image</strong></th>
<th>“Think about a place, real or imaginary, past or present that when you think about it makes you feel safe, calm or happy. Something like a beach or mountain. What picture do you see?”</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emotions and Sensations</strong></td>
<td>“When you think of that place, what do you see, hear and feel? What does your body feel?”</td>
</tr>
<tr>
<td><strong>Enhancement</strong></td>
<td>“Think about that Safe/Calm (or happy) Place and notice how it looks, sounds, smells and feels. Tell me what it is like.”</td>
</tr>
</tbody>
</table>
| **Eye Movements** | “Think about the picture. Feel how good your body feels and follow my fingers (or other BLS, 2-4 slowly). What is that like?”  
If positive: “Notice that. (BLS) What is it like now?”  
If negative: “Notice that. (BLS) What is it like now?” |

If not successful, then identify another calm or safe experience making sure there are no associations with people, or shift to a mindfulness or breathing exercise.

| **Cue Word** | “Think of a word or a sentence that reminds you of your Safe/Calm Place. When you think about your Safe/Calm Place and that word _____ notice the good feelings you have. Think about the good feelings and follow my fingers (or other BLS, 2-4 times) (Pause.) What is it like now?” |

(Pause for a response.) Repeat and enhance positive feelings with sets of BLS as long as the experience continues to strengthen. This can be shortened for younger children to keep them engaged. Also, it can be done as a visualization to prevent moving into reprocessing.

| **Self-Cueing** | OPTIONAL for young children.  
“Now say that word_____ and notice how you feel.” |
| **Cueing with Disturbance** | OPTIONAL for young children.  
“Think about something small that bothers you (SUD 1-2, the therapist can use a drawing or use hands to demonstrate intensity.) Now bring up the good word_____. Does anything feel different? What do you notice?” |

| **Self-Cueing with Disturbance** | OPTIONAL for young children.  
“Think about something else small that bothers you (SUD 2-3, or use drawing or hands), notice how you feel, think of that good word_____, notice how your body feels when you think about that good word.” |
Principles and Procedures for Enhancing Current Functioning with EMDR Resource Development and Installation (RDI) in Complex Posttraumatic Stress Disorder (Adapted from Korn & Leeds, 2002)

Adapted for Children

Purpose

• To develop and strengthen specific qualities or attributes needed to address specific challenges.
• To increase access to adaptive memory networks.
• To increase capacity to tolerate affects, both positive and negative.
• To strengthen ability to shift from one state to another.

Types of Resources

Resources appropriate for RDI are associated with positive affects (confidence, competency, mastery, interest, excitement, enjoyment, pride, triumph, belonging) and adaptive responses that the child already possesses, but in other contexts. Identify resources within three broad domains of experience in the order presented:

1. Mastery Resources (internal to the client) include:

   • The child’s own experiences of mastery; previous coping responses to challenging situations or experiences associated with relevant positive affect states (e.g., strength, self-compassion, confidence, competency, pride, triumph, etc.).

   • Parents can be helpful in identifying the child/teen’s experiences of mastery. Ask the parents to talk about times when the child exhibited a skill, achieved something they were aiming for, or when the child/teen showed maturity. Utilizing parents for assistance with positive resources can also improve the parent-child/teen relationship.

   • A physical stance or movement that evokes a feeling of strength for the child (e.g., standing like Superman or Wonder Woman).

2. Relational Resources include:

   • Positive role models who have demonstrated capacities the child/teen would like to have such as courage, persistence, boundary setting, or truth telling. People the child knows or knows of that embody the quality they wants to develop. Can be real life heroes or public figures; characters from books, stories, cartoons, movies, TV or video games.

   • Memories of supportive others including caregivers, relatives, teachers, authority figures, coaches, religious figures, peers, or pets who have provided soothing, care, affection, protection, or other desired qualities.

3. Symbolic Resources include:

   • Any animal or element from the natural world such as an eagle, a mountain stream, a rock or a tree that symbolizes a specific quality. Religious, archetypal, totemic and transpersonal symbols.

   • An image of a positive goal state or future self (such as seeing oneself in the future working as a teacher or a coach.)

   • Figures or symbols from dreams or imagination which express the child’s capacity for adaptive functioning or inspiration.
Principles and Procedures for Enhancing Current Functioning with EMDR Resource Development and Installation (RDI) in Complex Posttraumatic Stress Disorder Worksheet

Adapted for Children

Identify Needed Quality

“What ability or feeling would you like to make stronger on the inside? What ability or feeling would help you?”

Identify the Experience of the Resource

“Can you remember a time when you had that good feeling inside (or when you seemed to have that ability)?

Image

“Tell me all about it.” (Pause-wait for a response.) “What is the picture you have in your mind about it?”

Emotions and Sensations

“Picture that right now. Tell me, how does it make you feel?”

Enhancement

“Think about what you see in that picture, what you hear, anything you can smell. (Pause) Now how do you feel?”
Reinforce Experience of Resource with BLS

“When you think about the good picture and the sounds, smells, and feelings, watch my fingers. (4-6 slow BLS) How does it feel to you now?”

If positive:

“See if you can think of the good picture one more time.” (Short, slow BLS.) With younger children and children with a shorter attention span, one or two sets of BLS is adequate.

If negative:

Redirect attention to another experience associated with that resource; or, consider another resource.

Cue Word (Optional for Younger Children)

“Is there a word or a phrase that represents this good memory?”

“Think of a word or a sentence that reminds you of this good picture. When you think about the good picture and that word(s)__________notice the good feelings you have. Think about the good feelings and follow my fingers” (2-4 slow BLS).

“How do you feel now?” Repeat as needed.

Self-Cueing

“Now bring up the good word(s)__________. How do you feel?”

Future Rehearsal Using Positive Resource (Optional for Younger Children)

“Can you think of a situation that is hard for you? “Now bring up the good picture along with the good word(s). Notice your good feelings. Now tell me about how you would like to handle that hard thing.”

Add short sets of slow BLS until desired scenario has been firmly established. Length of sets can vary, depending on the child’s ability to stay with the desired response without activating a negative association. Can also install one segment of the experience at a time to minimize possible contamination.
Creative Containers for Children

In EMDR therapy, containment strategies help to shift focus of attention and regulate affect. A container can be used when needed during and at the end of sessions or as a coping strategy between sessions. Here are two resources:

**Containing the Bad Stuff Script:** "We worked on some stuff today that you may not want to think about until we see each other again in our next session so let's draw a picture (or use a sandtray, or create a box from craft material, or from toys or items in the office) and put that stuff in the box for next time. (Allow enough time for the child to create a box.) Now I'd like you to pretend to take anything that you don't like to think about or feel from our session and shrink it down and lock it in your box. Then I'd like you to pretend to put it somewhere far away or really safe. When we get together next time, we can decide how to take it out. If any of it bothers you before our session pretend to shrink it and send it back to the box. Ok?” Adapted from; *EMDR and the art of psychotherapy with children: infants to adolescents*, by Adler-Tapia, R. L., & Settle, C. S. (2017) New York, NY: Springer Publishing.

**Containing the Bad Stuff Script No. 2:** “Before we talk about any of that stuff that happened, let’s figure out a special place where you can send your memories later, so you don’t have to think about them during the rest of the week. The special place could be something that’s already right here inside my office. I’ll hold onto your memories here in my office during the rest of the week so that you can go home and play and not worry about that stuff. Do you see any place in my office that might work? (Allow time for the child to look around the office and choose a container, such as a desk drawer, cupboard, or a file cabinet.) OK, great choice. Look at how solid and strong this cabinet is. Now at the end of our session, you’ll be able to use your imagination to send everything you don’t want to think about right in there. During the week, if something else comes up in your mind that bothers you, you’ll be able to send it here, too, from wherever you are. It can stay here with me instead of with you.” Adapted from; *Integrative team treatment for attachment trauma in children*, by Wesselmann, D., Schweitzer, C., & Armstrong, S. (2016) New York, NY: W.W. Norton.
### Instructions

“What we are going to do is take what is bothering you and see if we can make it feel better. I am going to ask you some questions. Then I am going to do the eye movements (tactile or sounds) for a minute or less. I am going to move my fingers back and forth, and you are going to follow with your eyes and just think and feel about the questions I asked you. You are not talking and I am not talking; you are just thinking and feeling. Then after a minute, I am going to stop and say, ‘Take a breath, which means pause, and tell me the last thing you were thinking or feeling. Whatever you say will be okay. Don’t judge it. And I’m going to say, ‘Go with that’, which means keep going. We will do this for a while and then we will stop, and I will ask you how you are doing. But remember that if you want to stop you know the stop sign and I will just stop.”

### Target Memory

**Experience chosen to be reprocessed:**

“We picked what was bothering you and decided to work on the first time it happened. That thing was________________________.”

“Is that still what you want to work on?”

### Image

**Most disturbing:**

“What is the picture you see when you think of what happened?”

**If no picture:**

“As you think of the experience, what is the worst part of it?”

### Negative Cognition

“What is the bad (yucky) thought (about yourself) that goes with the picture when you think about it now?”

### Positive Cognition

“When you think about the picture (or what happened) what would you like to think? Or, What’s the good thought (about yourself)?”
### VOC  
**Validity of Cognition**

“When you think of what happened how true do those good words (repeat PC) feel to you now from 1 to 7 where 1 feels not true and 7 feels true.” (can demonstrate with a drawing or hands spread out).

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completely false</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Completely true</td>
</tr>
</tbody>
</table>

### Emotions/Feelings

“When you think of what happened, what do you feel now?”

### SUD
**Subjective Units of Disturbance**

“When you think about what happened, from 0 - 10 (may use hands or drawing), where 0 is no bother and 10 is the most upset you can imagine, how upsetting is it to you now?”

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No disturbance/neutral</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Highest disturbance</td>
</tr>
</tbody>
</table>

### Location of Body Sensations

“When some kids feel things in their head, some in their tummy and some in their feet. Where do you feel it?”

May demonstrate by pointing to different parts of the body.

### PHASE 4: Desensitization

Track channels of associations as they emerge about the memory and other experiences:

**Begin Processing on the Target Memory:**

“Think about the picture, the bad (yucky) thought (repeat NC), and follow my fingers.” **BLS** generally 20 or more passes customized to the client’s need. Children may need shorter sets, 15 or less.

**Resume Processing on an Incomplete Target Memory**  
(See Reevaluation for instructions on setting up an incomplete session):

“Think about what happened, the feelings and the feelings in your body and follow my fingers.”

### A-Reprocess

“Take a breath. What are you feeling or thinking (noticing) now?”

(Pause for a response.)

“Go with that.” or “Keep going.” **BLS** generally 20 or more passes customized to need of client – less for children as long as client reports change or new information (as many sets of **BLS** as necessary) until the client stops reporting change for two consecutive sets of **BLS**, then go back to target.
### B-Back to Target

“When you go back to the original memory, what are you noticing now?”

(Pause for a response.)

“Go with that.” *(BLS generally 20 or more passes/customized to need of client).*

“Take a breath; let it go. What are you noticing now?”

(Pause for a response.)

“Go with that.” *(set of BLS)*

Continue with sets of BLS as long as client reports change or new information (as many sets of BLS as necessary).

When the client goes back to original target after two consecutive sets of BLS and still reports no change check SUD (see “Check SUD” below).

### C-Check SUD

“When you bring up the original memory, on a scale of 0 to 10, where 0 is no disturbance and 10 is the highest disturbance you can imagine, how disturbing does it feel to you now?” *(Can demonstrate with drawing, hands, etc.)* Go with that.” *(set(s) of BLS)*

If SUD is 1 or 2, ask,

“Where do you feel it in your body? Go with that.” *(set(s) of BLS)*

REPEAT Steps A, B, and C until SUD is 0 (or ecologically sound).

### PHASE 5: Installation

**Linking the desired Positive Cognition with the original memory/experience:**

“Do you still like the words (repeat the PC) Or, are there words you like better?”

1. “Think about what happened and the words (repeat PC). From 1 (not true) to 7 (really true), how true do they feel now?” *(can use a drawing, hands, etc.)*

2. “Think about what happened and the words (repeat PC) together.”

3. “How true do the words (PC) feel to you now on a 1 to 7?” *(Can use drawing, hands, etc.)*

4. Continue sets of BLS until the VOC no longer strengthens. Once the VOC=7 (or ecological), go to Phase 6: Body Scan.

   If client reports a 6 or less, check appropriateness and address blocking belief (if necessary) with additional sets of BLS.

**NOTE:** If running out of time, set aside the blocking belief to be addressed at a later time and proceed to Closure for Incomplete Session.
**PHASE 6: Body Scan**

“Close your eyes, think about what happened and the words (repeat PC). Think about each part of your body from your head down to your toes. Are there any parts of your body that feel tense or uncomfortable (feel bad)?”

If any sensation is reported, do BLS. If a positive/comfortable sensation, do BLS to strengthen the positive feeling. If a sensation of discomfort is reported—reprocess until discomfort subsides.

**PHASE 7: Procedure for bringing closure to incomplete sessions:**

An incomplete session is one in which a client’s material is still unresolved, i.e., the client is still reporting distress, the SUD is greater than 0, the VOC is less than 7, or Body Scan isn’t clear.

Steps:

1. Give the client the reason for stopping.
   
   “We need to stop now because we are almost out of time. How do you feel? (pause) You did a good job! Is there anything good that you learned?”

2. Do a containment exercise:

   “Let’s do our Safe Place exercise (container or relaxation exercise).”

3. Read the “Debrief the Experience” section to the client as scripted below:

   **Closure for all Sessions:**

   Debrief the experience

   “You may continue to think about or have feelings about our session today for the next couple of days. Sometimes kids have dreams about the session that night or the next night but not always. I want you to remember them or write down (or draw a picture of) any of the thoughts, feeling or dreams for me four our next session. Don’t forget to use your Safe/Calm Place (or relaxation exercise) this week.”

   For the parent or caregiver

   “Occasionally kids feel things strongly after EMDR and they may want to rest or have a lot of energy, so give them as much support and space as you can. And, for both of you, if you have any questions about this process give me a call and I will call you back.”
TREATMENT SUMMARY NOTES
For Record-Keeping Purposes
(Optional)

CIRCLE APPROPRIATE ITEMS:

DATE ___/___/___

PRESENTING ISSUE: _______________________________________

TARGET MEMORY:

Past Present Trigger Future Template

Target Memory Status: Complete Incomplete

Stabilization Exercise used at the end of the session? Yes/No

Safe/Calm State Light Stream Breathing Other___________

Client Stability when leaving session:

Poor Fair Good Excellent

Treatment Summary Notes:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Issues/associations that arose during processing to be re-evaluated at later time:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Child Reevaluation Worksheet

Reevaluation (Global)

Ask parent/caregivers,

“Have you noticed any changes in your child’s behaviors or symptoms this week?”

Ask the child,

“What has gone well this week? What parts of the week have been hard?”

Ask parent/caregivers,

“Did you observe your child have any strong reactions to any particular situations this week? Was there anything different about your child’s level of reactivity this week?”

Ask the child,

“Were there any big triggers this week?” or “Were there any situations that made you feel scared, mad, or sad?”

Ask parent/caregivers,

“Did your child have any difficulty sleeping or any bad dreams this week?”

Ask the child,

“How did you sleep this week? Did you have any dreams?”

Target (Memory Specific)

Ask children,

“When you think about what we worked on last time, what do you get now?”

“Is there anything else you want to tell me about it?”

“When you think of what happened, are there any thoughts that pop up?”

“From 0 to 10 where 0 means this doesn’t bother you at all and 10 means it bothers you the most you can imagine (can demonstrate with drawing, hands, etc.), how upsetting is it to you now?”

Note to Clinician:

Remember to review History Taking and Treatment Planning Worksheet (see next page) to determine how to best proceed if Target Memory from previous session has been resolved.
Child Treatment Planning Considerations

Treatment Plan

- Original Target Memory is complete (SUD=0, VOC=7, clear Body Scan).
- Check remaining experiences identified during History-Taking as well as associations that emerged during reprocessing:
  
  Past
  - Reprocess past experiences that are still disturbing.
  - Apply standard procedures for Phases 3-8 until fully reprocessed.

  Present
  - Reprocess present triggers that are still disturbing.
  - Apply standard procedures Phases 3-8 for each trigger that did not generalize from reprocessing past experiences.

Future Templates

- As past experiences and present triggers are resolved, proceed to “Procedural Steps for Installing Future Templates.”
Child Incomplete Target Memory Assessment

**SUD > 0**

Procedures for restarting an incomplete Target Memory.

**Memory**

“What is the picture you see when you think of what happened?”

**Emotions**

“When you think of what happened, what do you feel now?”

“When you think about what happened, from 0 to 10 where 0 means this doesn’t bother you at all and 10 means it bothers you the most you can imagine, how upsetting is it to you now?” (Can demonstrate with drawing, hands, etc.)

“Where do you feel it in your body? Point to different parts of the body and say, Some kids feel things in their head, some in their tummy and some in their feet. Where do you feel it?”

Go to “Resume Processing for Incomplete Session,” on second page in worksheet to continue reprocessing from previous session.

**SUD = 0 VOC < 7**

If the Target Memory is **SUD = 0**, and the Positive Cognition for the Target Memory is **VOC < 7**, go directly to Phase 5 in your Assessment and Reprocessing Worksheet for resuming the Installation Phase. Follow procedural steps through Closure.

**SUD = 0 VOC = 7**

If the Target Memory is **SUD = 0**, the Positive Cognition for the Target Memory is **VOC = 7**, and the Body Scan is not clear, return to Phase 6, Body Scan.
Child Version Procedural Steps for Installing Future Template

Introduction

“We worked on memories from a while back that had bothered you. And we worked on tough situations that commonly upset you. Perhaps today we could help you get really good at handling those tough situations.”

Step 2: Adaptive Response and Skills Assessment

“Can you think of a good way to handle this tough situation next time? Do you think this will be hard or easy to do? _________________. If it seems hard, let’s stop and talk about it. We can even practice it.”

Image and PC

“I’d like you to imagine/role-play this good way of handling the hard situation ________________as if it were happening tomorrow or next week, and remember the good (helpful) thought (PC from the target or trigger) _________________. What feeling would you like to have? _________________. (e.g., calm, confidence). Imagine/pretend you’re there now. Think of those words (PC) ________________and the feeling of _________________ while handling this situation _________________.”

(Pause) NO BLS YET.

After a sufficient pause, ask: “Did it seem hard or easy? Do you have any thoughts or feelings? What is your body feeling?” ________________

Positive Response from Client: Target the scene and reinforce with BLS (one or two sets).

“Let’s do some (eye movements, tapping, etc.) to make the good way of handling the situation seem easier and help you feel really good about it.”

Then install the Positive Cognition (PC) until VOC is 7 (or ecologically valid).

“This time, (imagine/let’s role-play) handling the situation this really good way again and hold in your mind the good thought (PC) ________________.” Add BLS (one or two sets). How true does that good thought (PC) _________________ feel to you now?” (Can point to a 1-7 number scale or use hands to demonstrate.)
Neutral or Uncertain Response from Client:

“What do you think is making it hard? __________________. Should we talk about how to handle this again, or should we practice some more? __________________. After more psychoeducation and/or role play say, Let’s try it again. Imagine this situation tomorrow or next week and your good way of handling it. Remember the good thought (PC) ________________.” Add BLS (one or two sets).

Negative Response from Client:

“Is there something you can think of that might be making this hard? __________________. Let’s problem solve. What do you need? How can I help you? __________________. Now that we have problem-solved, let’s see if you can imagine/pretend handling this now. Does the good thought (PC) ________________ still fit? If not, what would be a better thought? (new PC) ________________ Imagine the situation and imagine/pretend/practice your good way of handling it and think of those words (PC) ________________.” Add BLS (one or two sets).

Step 3: Run a Movie

“Now I would like you to run a movie in your head. Pretend you are in this situation __________ and you handle it the good way we talked about/practiced. Run the movie all the way from the beginning to the end. Remember the good thought (PC) ________________, I will add the eye movements/tapping to make it easier and help you feel really good about it. Add continual BLS until the client tells you that they have finished the movie. Then ask, How do you feel about it? Any thoughts? Anything in your body?”

Process any Disturbance:

If the client hits any blocks, address as above by focusing on the negative experience, problem solve, and then combine the adaptive response with the PC along with one or two sets of BLS until the client is able to play the movie from start to finish with a sense of confidence and satisfaction.

NOTE: If client remains blocked, further processing of past memories may be needed.

Step 4: Generate Challenge Situations

Create multiple scenarios where there is an unanticipated or undesirable outcome and generate an adaptive response to that situation. Process and install PC to VOC of 7 (or ecologically valid) for each situation. “Now let’s imagine another situation like this, but something a little harder. What could it be? ________________. How do you feel when you think about that situation?” Offer example(s) if client cannot generate them.

Target challenging situation starting with the scene of adaptive coping (holding in mind the PC and feeling) and reinforce with BLS if client’s response is positive. “Think of the harder situation ________________ and remember that good way you’re going to handle things. Now think of the words (PC) ________________ and the positive feeling ________________.” Add BLS (one or two sets) and reinforce with more BLS if the response is positive. Then proceed with Installation
of PC. Now think of the situation and how you will handle it and the words (PC) ________________.” Add BLS (one or two sets).

If client’s response is negative: “What is making this hard for you? ________________. Let’s problem solve. What could help you feel better about handling it a good way? Should we talk about it some more or practice some more? ________________. Now that we have problem-solved/practiced more, let’s try it again. What would it be like if you handled this situation the good way? Is the good thought (PC) still best? ________________. If not what would be a better thought (new PC)? ________________. Think of the situation ________________ and how you will handle it and think of those words (PC) ________________.” Add BLS (one or two sets).

Target the scene as above and install PC.

Run Movie Using BLS to Reinforce

Repeat until VOC is 7 or ecologically appropriate and there is an adaptive response throughout.

“Now I would like you to run a movie in your head. Pretend you are in this situation ________________ and you handle it the good way we practiced/talked about. Run the movie all the way from the beginning to the end. Remember the good thought (PC) ________________. I will add the eye movements/tapping to make it easier and help you feel really good about it.” Add continual BLS until the client tells you that they have finished the movie. Then ask, How do you feel about it? Any thoughts? Anything in your body?”

Add continual BLS until the client tells you they have finished the movie.
Child Procedural Steps Outline

PHASE 1: History Taking, Client Screening & Treatment Planning

PHASE 2: Preparation Rapport

Explanation of EMDR therapy (Preparation Phase): Explanation of EMDR therapy is dependent upon age, background, experience, and sophistication of client.

“When something bad happens, it can get stuck in your brain with a picture, sounds, your thoughts, feelings and how your body feels. This EMDR thing helps your brain to feel better about what happened. We think it is like dream sleep because sometimes dreams can help us with stress. The eye movements (sounds, or tapping) help us with the stress over the bad thing that happened and other things that might be connected to it. It is your own brain that will be doing the healing and you are the one in control.”

The younger the child the more the explanation should be shortened.

Establishing Types of Stimulation

Demonstrate all three (eye movements, auditory, tactile taps) so choices are available if needed.

For eye movements determine the appropriate distance and direction of eye movement. (Preparation Phase)

“Where does it feel most comfortable to have my hand?” (Clinician moves hand toward and away from the client’s face and tests the speed of the eye movements).

Set Up

For eye movements, clinician places chair to the side of the client (“ships passing in the night” position). For tactile and auditory tones, it is also preferable for clinicians to place their chair to the side in order to allow clients to keep their eyes open (without directly facing the clinician).

Metaphor to Use

(Offered in the Preparation Phase)

“Remember that it is in the past, so remembering what happened is like watching an old movie on your T.V. set.”

The train or movie metaphor encourages dual awareness and an open, receptive posture to the unfolding of their experience during the Desensitization Phase.
**Review and Check the Safe/Calm Place**  
(If needed)

Check with the client to make sure their safe/calm place is still useful and write down the cue word/phrase. May need to review other resources as well, or instead.

**Specific Instructions**

“What we are going to do is take the thing that is bothering you and see if we can make it feel better. I am going to say back to you all the things I am going to ask you right now. Then I am going to do the eye movements (tactile or sounds) for a minute or less I am going to move my hand back and forth and you are going to follow it with your eyes and just think and feel about what I said to you. You are not talking and I am not talking, you are just thinking and feeling. When I stop I will ask, ‘What are you thinking or feeling?’ You tell me the last thing you are thinking or feeling. Whatever you say is okay, we don’t judge it. Then I am going to say, ‘Go with that’ which means ‘keep going’. We will do this for a while and then we will stop and I will ask you how you are doing. But remember if you want me to stop you know the stop sign and I will stop.”

**Stop Signal**

“If at any time you feel you have to stop, use your stop signal.”

**PHASE 3: Assessment Target Memory**

**Note:** During the History Taking Phase as well as throughout the course of treatment, relevant experiences, both past and present, related to the client’s issue(s) have been identified. The selection of the Target Memory to be processed has been selected by both clinician and client.

1. **Image**

   “What is the picture you see when you think of what happened?”

   If no image, ask,

   “What is the worst part of the memory?” Or, “When you think of the memory, what comes up now?”

2. **Negative Cognition (NC)**

   The Negative Cognition is a presently held belief that represents the distortion the client continues to have about themself as they relate to the experience in the present. Ask the client to make an “I” statement in the present tense.

   “What is the bad (yucky) thought (about yourself) that goes with the picture when you think about it now?”
3. Positive Cognition (PC)
   The Positive Cognition represents the desired belief about himself/herself. Often, clients acknowledge the intellectual validity of the PC, but emotionally it feels relatively untrue.
   
   “When you think about the picture (or what happened) what would you like to think?”
   Or, “What’s the good thought (about yourself) that you would like to have?”

4. Validity of Cognition (VOC)
   “When you think of what happened, how true do those good words (repeat PC) feel to you now from 1 to 7 where 1 feels not true and 7 feels true” (Can demonstrate with a drawing or hands spread out.)

5. Emotions/Feelings
   Identify emotion(s) the client is experiencing in the present.
   “When you think of what happened, what do you feel now?”

6. Subjective Units of Disturbance (SUD)
   “From 0 to 10 where 0 means this doesn’t bother you at all and 10 means it bothers you the most you can imagine (can demonstrate with drawing, hands, etc.), how upsetting is it to you now?”

7. Physical Sensations
   “Some kids feel things in their head, some in their tummy and some in their feet. Where do you feel it?”

**PHASE 4: Desensitization**

1. “Think about the picture, the bad (yucky) thought (repeat NC), and follow my fingers.”

   Begin the bilateral stimulation (BLS) slowly. Gradually increase the speed as fast as the client can comfortably tolerate the movement. Adjust the speed and length of set to client’s need.

   At least once or twice during each set of BLS, or when there is an observable change, comment to client something like,
   
   “That’s it. That’s right. You’re doing fine.”

   Sometimes, offering supportive comments during the set helps maintain dual awareness, especially if client is upset:

   “That’s it. It’s old stuff. Just notice.”

   You can also use the metaphor(s) the client has chosen to remind them that the distress is temporary and they’re just “passing through.”
2. After a set of bilateral stimulation, say,

   “Take a breath. What are you feeling or thinking now?”

As long as client reports change (i.e., new memories or other associations emerge or changes in images, thoughts, feelings, sensations) say,

   “Go with that.” or “Keep going.”

(Acknowledge the client’s response without repeating their words/statements.)

Some clients may have difficulty “letting whatever happens, happen.” They may report that nothing is happening, or, they’re trying hard to make something happen Say,

   “Think of what happened to start with, but then just notice any thoughts or feelings that come up.”

3. Continue with subsequent sets of BLS until you believe the client is at the end of a channel, e.g., the material reported is neutral or positive with no qualitative change. Go back to Target and ask:

   “When you think about what happened, what are you thinking or feeling (noticing) now? Go with that.”

Whatever the client reports, add a set of BLS.

If new material opens up, continue down that channel of associations with subsequent sets of bilateral stimulation. When you believe the client is at the end of the channel, go back to the Target Memory and ask,

   “Take a breath. What are you thinking or feeling(noticing) now?”

Whatever the client reports, add a set of BLS.

4. If the SUD is 1 or 2, ask where they feel it in their body. Apply BLS until SUD is 0 or ecologically appropriate.

   If the SUD is 0, apply another set of BLS to strengthen. Proceed to Installation Phase.

   Note: If SUD continues to be greater than 0 after multiple sets of BLS, and/or a blocking belief arises, offer a containment strategy for remaining material; then, shift to Safe Place or other relaxation exercise to facilitate state shift.

   Do not proceed to Installation Phase until SUD is 0 or ecologically appropriate. .”

**PHASE 5: Installation of Positive Cognition**

1. Link the desired Positive Cognition with the original memory:

   “Do you still like those words (repeat PC)? Or, are there words you like better?” (Record the new PC if the client changes it.)

   “Think about what happened and the words (repeat PC). From 1 not true to 7 really true, how true do they feel now?” (Can use a drawing, hands, etc.)

2. “Think about what happened and the words (repeat PC) together.”

   Apply another set of BLS, and check the VOC again.

   “How true do the words (PC) feel to you now on a 1 to 7?” (Can use drawing, hands, etc.)

   Continue with subsequent sets of BLS until VOC=7.
Note: If VOC is < 7, explore if it is ecologically appropriate or if there is a blocking belief. If time allows, continue with BLS. Otherwise, set aside the blocking belief to address at a later time, and see if the VOC can strengthen to a 7. If not, proceed to Closure Procedures for Incomplete Session.

PHASE 6: Body Scan Body

Scan

“Close your eyes, think about what happened and the words (repeat PC). Think about each part of your body from your head down to your toes. Are there any parts of your body that feels tense or uncomfortable (feels bad)?”

If any sensation is reported, apply bilateral stimulation. If a positive or comfortable sensation develops, apply one or more sets of bilateral stimulation to strengthen the positive experience. If a sensation of discomfort is reported, apply BLS until discomfort subsides.

PHASE 7: Closure Closure/Debriefing the Experience

“You may continue to think or have feelings about our session today for the next couple of days. Sometimes kids have dreams about the session that night or the next night, but not always. I want you to remember your thoughts or feelings and write them down (or draw a picture) for me for our next session. Don’t forget to use your Safe/Calm Place (or relaxation exercise) this week.”

For the parent or caregiver,

“Occasionally kids feel things strongly after EMDR and they may want to rest or have a lot of energy, so give your child as much support and space as you can. And for both of you-if you have any questions about this process, give me a call and I will call you back.”

Procedure for Closing Incomplete Sessions

An incomplete session is one in which a client’s material is unresolved, i.e. he is still experiencing some distress or confusion about the memory or related associations. OR, the SUD is greater than a 1/2 and/or the VOC is less than 6. The following is a suggested procedure for closing down an incomplete session. The purpose is to validate the client’s efforts and help him shift states in order to help him feel grounded before he leaves.

Steps:

1. Inform the child that it is time to stop and explain the reason.

   “We are almost out of time and we will need to stop soon.”

2. Offer validation for their efforts.

   “We need to stop now because we are almost out of time. How do you feel? (pause) You did a good job! Is there anything good that you learned?”

3. Offer a containment exercise, if needed:

   “Let’s do our Safe Place exercise (container or relaxation exercise).”

4. Review Closure/Debriefing the Experience (see above) with the child.
## EMD Scripted Child Worksheet

### Purpose
- Desensitizing a single event or part of an event, limiting access to associated channels of memories.

**Reminder:** In clinical practice, proceed only after Preparation Phase. The child can access and use Safe Place and the event represents the problem and the image represents the selected event.

| Specific Instructions | “What we are going to do is take what happened and see if we can make it feel a little better today. You and I will figure out the picture or worst part. Then I am going to do the eye movements (tactile or sounds) for a half minute. I am going to move my hand back and forth and you are going to follow it with your eyes and just pay attention to the upsetting picture. You are not talking and I am not talking, you are just noticing. When I stop I will ask, ‘What are you thinking or feeling (noticing) right now’? You tell me the last thing you are thinking or feeling. Whatever you say is okay, we don’t judge it. Then I am going to ask how upsetting it feels now, and you can just show me with your hands (or point to a number on a scale). Then I will say, ‘Notice the picture and follow my fingers again.’ We will do this for a while until it feels better. But remember if you want me to stop you know the stop sign and I will stop.” |

| Target Memory | |

| Image | Most disturbing:  
“What is the picture you see when you think of what happened?”  

If no picture:  
“As you think of the experience, what is the worst part of it?” |

<p>| NC Negative Cognition (optional) | “What is the bad (yucky) thought (about yourself) that goes with the picture when you think about it now?” |</p>
<table>
<thead>
<tr>
<th>Positive Cognition (optional)</th>
<th>“What would you like to think instead?”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Validity of Cognition (optional)</td>
<td>“When you think about what happened, how true does the thought (repeat PC) feel to you now?” (Can point to a 1-7 number scale or use hands to demonstrate.)</td>
</tr>
<tr>
<td>1 2 3 4 5 6 7</td>
<td>Completely false  Complete true</td>
</tr>
<tr>
<td>Emotions/Feelings</td>
<td>“When you think of what happened, what do you feel now?”</td>
</tr>
<tr>
<td>Subjective Units of Disturbance</td>
<td>“From 0 to 10 where 0 means this doesn’t bother you at all and 10 means it bothers you the most you can imagine (can demonstrate with drawing, hands, etc.), how upsetting is it to you now?”</td>
</tr>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td>No disturbance/neutral  Highest disturbance</td>
</tr>
<tr>
<td>Location of Body Sensations</td>
<td>“Some kids feel things in their head, some in their tummy and some in their feet. Where do you feel it in your body?”</td>
</tr>
<tr>
<td>May demonstrate by pointing to different parts of the body.</td>
<td></td>
</tr>
<tr>
<td>Desensitization</td>
<td>“Think about the picture and follow my fingers.” (12-15 repetitions of BLS or shorter in order to limit access to associations.)</td>
</tr>
<tr>
<td>After each set:</td>
<td>“Take a breath. What are you feeling or thinking now?_______ Show me with your hands how upset you feel inside now from 0 to 10, with 10 as the worst you could feel. Or Point to the number to show me how upset you feel right now. Think of the incident and let’s keep going.”</td>
</tr>
<tr>
<td>If the child associates to a different upsetting memory, ask the child to put the memory in his or her container. Return to the original incident and shorten the sets.</td>
<td></td>
</tr>
<tr>
<td>If the child is not responding adequately to the brief EMD method:</td>
<td>• Shift to implementation of the full standard EMDR protocol with longer sets, allowing the child to make associations.</td>
</tr>
<tr>
<td></td>
<td>• Close the session as an incomplete session, using container and safe place, another calming activity, or a playful activity. Evaluate whether the child is missing pertinent adaptive information or needs additional preparation work. Implement the full protocol in a subsequent session.</td>
</tr>
</tbody>
</table>
### Installation

Once the **SUD** has stopped decreasing and appears to be as low as it will go with EMD, ask,

> “What is the most helpful thought or idea you have had about this incident today?”

**PC**

(PC may be something like, “I can handle my feelings,” or, “I can feel safer now that it’s over.”)

Say,

> “Think about what happened and the words (repeat PC) together. How true do those words feel to you now on a 1 to 7?” (Can use drawing, hands, etc.)

Add short sets of **BLS** until **VOC** is 7 or as strong as ecologically appropriate.

### Body Scan

(Only if **SUD** is 0 or 1 and **VOC** is 6-7):

> “Close your eyes, think about what happened and the words (repeat PC). Think about each part of your body from your head down to your toes. Are there any parts of your body that feel tense or uncomfortable (feel bad)?”

### Closure

Debrief the experience.

> “You may continue to think about or have feelings about our session today for the next couple of days. Sometimes kids have dreams about the session that night or the next night but not always. I want you to remember them or write down (or draw a picture of) any of the thoughts, feeling or dreams for me four our next session. Don’t forget to use your Safe/Calm Place (or container or relaxation exercise) this week.”

### Reevaluation

Check in with the child on how he/she has been able to respond or manage the challenge situation related to the memory or part of the memory that was targeted with EMD. Check for intrusive thoughts, startle responses and other symptoms. Check the **SUD** of the original experience.

If you only targeted a part of the memory, or the **SUD** only partially reduced, consider reprocessing the memory with the full standard protocol.
## CHILD EXAMPLES OF NEGATIVE AND POSITIVE COGNITIONS

<table>
<thead>
<tr>
<th>Responsibility/Defectiveness</th>
<th>Negative Cognitions</th>
<th>Positive Cognitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>I'm not good enough</td>
<td>I am good enough/fine as I am.</td>
<td>I am worthy; I am pretty good.</td>
</tr>
<tr>
<td>I don't deserve love.</td>
<td>I deserve love; I can have love.</td>
<td>I got this!</td>
</tr>
<tr>
<td>I am a failure.</td>
<td>I am fine.</td>
<td>I am lovable.</td>
</tr>
<tr>
<td>I am worthless/pathetic.</td>
<td>I am fine.</td>
<td>I am lovable.</td>
</tr>
<tr>
<td>I am disgusting.</td>
<td>I am laudable.</td>
<td>I am fine.</td>
</tr>
<tr>
<td>I am not lovable.</td>
<td>I am fine.</td>
<td>I am lovable.</td>
</tr>
<tr>
<td>I deserve only bad things.</td>
<td>I am good enough/fine as I am.</td>
<td>I am worthy; I am pretty good.</td>
</tr>
<tr>
<td>I am sick.</td>
<td>I am fine.</td>
<td>I am laudable.</td>
</tr>
<tr>
<td>I do not deserve….</td>
<td>I am better.</td>
<td>I am lovable.</td>
</tr>
<tr>
<td>I am small.</td>
<td>I am OK just the way I am.</td>
<td>I am laudable.</td>
</tr>
<tr>
<td>I am a disappointment.</td>
<td>I am OK just the way I am.</td>
<td>I am laudable.</td>
</tr>
<tr>
<td>I deserve to die.</td>
<td>I am fine.</td>
<td>I am laudable.</td>
</tr>
<tr>
<td>I am miserable.</td>
<td>I am fine.</td>
<td>I am laudable.</td>
</tr>
<tr>
<td>I am dumb.</td>
<td>I am fine.</td>
<td>I am laudable.</td>
</tr>
<tr>
<td>I am ugly.</td>
<td>I am fine.</td>
<td>I am laudable.</td>
</tr>
<tr>
<td>I can't do anything right.</td>
<td>It's OK to make mistakes.</td>
<td>I am laudable.</td>
</tr>
<tr>
<td>I am a bad kid.</td>
<td>I am OK just the way I am.</td>
<td>I am laudable.</td>
</tr>
<tr>
<td>I have to be perfect.</td>
<td>I am OK just the way I am.</td>
<td>I am laudable.</td>
</tr>
<tr>
<td>My feelings are bad.</td>
<td>I am OK just the way I am.</td>
<td>I am laudable.</td>
</tr>
<tr>
<td>I don't fit in.</td>
<td>I am OK just the way I am.</td>
<td>I am laudable.</td>
</tr>
<tr>
<td>Nobody likes me. (I am not likable.)</td>
<td>I am liked by some people. (I am likable.)</td>
<td>I am liked by some people. (I am likable.)</td>
</tr>
<tr>
<td>I let people down.</td>
<td>It's OK to make mistakes.</td>
<td>I am laudable.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Responsibility/Action</th>
<th>Negative Cognitions</th>
<th>Positive Cognitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>I should have done something.</td>
<td>I did the best I could.</td>
<td>I did the best I could.</td>
</tr>
<tr>
<td>I did something wrong.</td>
<td>I learned/can learn from it.</td>
<td>I did the best I could/ I can learn.</td>
</tr>
<tr>
<td>I should have known better.</td>
<td>I do the best I can/ I can learn.</td>
<td>I'm fine as I am.</td>
</tr>
<tr>
<td>I am shameful/stupid/bad person.</td>
<td>I am fine as I am.</td>
<td>I did the best I could.</td>
</tr>
<tr>
<td>I am weak.</td>
<td>I am fine as I am.</td>
<td>I am fine as I am.</td>
</tr>
<tr>
<td>I am to blame.</td>
<td>I am fine as I am.</td>
<td>I am fine as I am.</td>
</tr>
<tr>
<td>I should have done more.</td>
<td>I am fine as I am.</td>
<td>I am fine as I am.</td>
</tr>
</tbody>
</table>

*What does this say about you? (e.g., therefore, I am…)*
<table>
<thead>
<tr>
<th>Negative Cognitions</th>
<th>Positive Cognitions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Safety/Vulnerability</strong></td>
<td><strong>Control/Choice</strong></td>
</tr>
<tr>
<td>I cannot trust anyone.</td>
<td>I am not in control.</td>
</tr>
<tr>
<td>I cannot protect myself.</td>
<td>I am not in control.</td>
</tr>
<tr>
<td>I am in danger.</td>
<td>I am powerless/helpless.</td>
</tr>
<tr>
<td>I am not safe.</td>
<td>I cannot get what I want.</td>
</tr>
<tr>
<td>I am going to die.</td>
<td>I cannot stand up for myself.</td>
</tr>
<tr>
<td>It’s not OK (safe) to feel/show my emotions.</td>
<td>I cannot let it out.</td>
</tr>
<tr>
<td>I am not safe.</td>
<td>I am a liar.</td>
</tr>
<tr>
<td>Bad things always happen to me.</td>
<td>I do dumb things.</td>
</tr>
<tr>
<td>Nobody cares about me.</td>
<td>I cannot trust my judgment. I don’t always think right.</td>
</tr>
<tr>
<td>I can’t trust others.</td>
<td>I can’t win/succeed.</td>
</tr>
<tr>
<td>It’s not fair.</td>
<td>I have to be perfect/please everyone.</td>
</tr>
<tr>
<td>I am picked on/weak.</td>
<td>I can’t handle it.</td>
</tr>
<tr>
<td></td>
<td>I can’t do it.</td>
</tr>
<tr>
<td></td>
<td>I never get what I want.</td>
</tr>
<tr>
<td></td>
<td>Nobody listens to me.</td>
</tr>
<tr>
<td></td>
<td>Everyone is mean to me. I am a victim.</td>
</tr>
<tr>
<td></td>
<td>I can handle it.</td>
</tr>
<tr>
<td></td>
<td>I can do many things if I try.</td>
</tr>
<tr>
<td></td>
<td>Some things go my way.</td>
</tr>
<tr>
<td></td>
<td>Others care about what I have to say.</td>
</tr>
<tr>
<td></td>
<td>I stand up for myself.</td>
</tr>
<tr>
<td></td>
<td>I am not in control.</td>
</tr>
<tr>
<td></td>
<td>I now have choices.</td>
</tr>
<tr>
<td></td>
<td>I can get what I want.</td>
</tr>
<tr>
<td></td>
<td>I can stand up for myself.</td>
</tr>
<tr>
<td></td>
<td>I can tell people my feelings.</td>
</tr>
<tr>
<td></td>
<td>I am learning to tell the truth.</td>
</tr>
<tr>
<td></td>
<td>I am learning to do better.</td>
</tr>
<tr>
<td></td>
<td>I can trust my judgment. I’m thinking better.</td>
</tr>
<tr>
<td></td>
<td>I can win/succeed.</td>
</tr>
<tr>
<td></td>
<td>I can be myself/make mistakes.</td>
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<td></td>
<td></td>
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<tr>
<td></td>
<td><strong>Connection/Belonging</strong></td>
</tr>
<tr>
<td>I don’t fit in</td>
<td>I fit in</td>
</tr>
<tr>
<td>I can’t ask for help</td>
<td>I can ask for help</td>
</tr>
<tr>
<td>I’m all alone.</td>
<td>I have others who care about me</td>
</tr>
<tr>
<td>Nobody wants me.</td>
<td>I’m wanted</td>
</tr>
<tr>
<td>I’m left out.</td>
<td>I belong</td>
</tr>
</tbody>
</table>
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- Special Interest Internet Discussion Groups (SIGs)
- Francine Shapiro Library: https://emdria.omeka.net/

TRAUMA RECOVERY (EMDR HUMANITARIAN ASSISTANCE PROGRAMS) - www.emdhrap.org
- Non-profit organization
- Volunteer based
- Disaster response network (Domestic and International)
- Lower fee EMDR therapy trainings for non-profit agencies/organizations
- Bookstore

EMDR FOUNDATION - www.emdrfoundation.org
- Non-profit (501c3) raising funds for EMDR research
- Offers funding to high quality EMDR therapy research worldwide
- Resources and links for researchers
- Translating Research into Practice (TRIP) articles
- EMDR Early Intervention Researcher’s Toolkit
- EMDR Fidelity Rating Scale
- Lists current research projects worldwide on EMDR therapy