**EMDR Level 1 Training: A Comprehensive 15-Hour Continuing Education Course**

**Eye Movement Desensitization and Reprocessing: Theory, Practice, and Clinical Application**

**PART ONE: FOUNDATIONS AND INITIAL PHASES (7.5 CE HOURS)**

**Course Introduction and Overview**

**Welcome to EMDR Level 1 Training**

Welcome to this comprehensive 15-hour continuing education course in Eye Movement Desensitization and Reprocessing (EMDR) therapy. This intensive training represents your entry into one of the most extensively researched and empirically validated treatments for trauma and post-traumatic stress disorder (PTSD). EMDR has revolutionized trauma treatment since its development by Dr. Francine Shapiro in 1987, offering hope and healing to millions worldwide.

This course is structured to provide both theoretical understanding and practical application skills necessary for competent EMDR practice. Through detailed instruction, clinical demonstrations, case studies, and supervised practice, you will develop the knowledge and confidence to integrate EMDR into your clinical practice safely and effectively.

**Overall Learning Objectives**

Upon completion of this 15-hour EMDR Level 1 Training, participants will be able to:

1. **Explain** the Adaptive Information Processing (AIP) model and its role in conceptualizing pathology and treatment
2. **Demonstrate** proficiency in all eight phases of EMDR therapy protocol
3. **Apply** appropriate bilateral stimulation techniques across diverse client populations
4. **Identify** and address blocked processing and looping during desensitization
5. **Implement** cognitive interweaves when standard processing stalls
6. **Assess** client readiness and appropriateness for EMDR treatment
7. **Develop** comprehensive treatment plans using the three-pronged protocol
8. **Navigate** special populations and complex presentations requiring protocol modifications
9. **Recognize** and manage abreactions and intense emotional responses
10. **Integrate** EMDR with other therapeutic modalities appropriately

**Module 1: History, Research, and Theoretical Foundations**

**Duration: 90 minutes**

**The Discovery and Evolution of EMDR**

The story of EMDR begins with a serendipitous observation. In 1987, Dr. Francine Shapiro, then a graduate student in psychology, noticed during a walk that disturbing thoughts she was experiencing seemed to lose their emotional charge when her eyes moved rapidly back and forth. This observation led to systematic investigation and the development of what would become one of the most researched psychotherapy treatments.

**Initial Development Timeline:**

1987: Initial discovery and first controlled study 1989: First published research in the Journal of Traumatic Stress 1990: Name changed from EMD (Eye Movement Desensitization) to EMDR 1995: First meta-analysis demonstrating effectiveness 2004: American Psychiatric Association recognition 2013: World Health Organization recommendation for PTSD treatment

**The Adaptive Information Processing (AIP) Model**

The AIP model serves as the theoretical foundation for EMDR therapy. This comprehensive framework explains how the brain processes and stores information, and how trauma disrupts this natural process.

**Core Tenets of the AIP Model:**

1. **Information Processing System:** The brain possesses an inherent information processing system designed to process experiences to adaptive resolution. This system takes disturbing life experiences and processes them, allowing learning to occur and the experience to be stored appropriately in memory networks.
2. **Adaptive Resolution:** When functioning properly, the information processing system:
   * Integrates new experiences with existing memory networks
   * Extracts useful information and discards what's not needed
   * Makes appropriate connections and associations
   * Stores memories in a way that guides future behavior adaptively
3. **Trauma and System Overwhelm:** When an experience is overwhelming, the information processing system becomes disrupted:
   * Information gets "stuck" or "frozen in time"
   * The memory is stored in state-specific, dysfunctional form
   * Contains the emotions, physical sensations, and beliefs from the time of the event
   * Remains unintegrated with other memory networks

**Clinical Example of AIP in Practice:**

*Therapist: "Sarah, when you think about the car accident, you mentioned feeling like it's happening right now, even though it was three years ago. That's because the memory got stored in your brain with all the original emotions, body sensations, and thoughts intact—like a time capsule."*

*Client: "So that's why I panic every time I see a red car?"*

*Therapist: "Exactly. Your brain stored that information—'red car equals danger'—without processing it properly. EMDR helps your brain's natural healing system reprocess this memory so it becomes just a memory of something that happened, rather than something that feels like it's still happening."*

**Memory Networks and Pathology**

**Memory Network Organization:**

The AIP model conceptualizes memory as organized in associative networks containing:

* **Thoughts and beliefs**
* **Emotions**
* **Physical sensations**
* **Sensory information** (sights, sounds, smells)

These networks are connected through associative channels. When one node is activated, related nodes become accessible through these channels.

**Pathological Memory Networks:**

Dysfunctionally stored traumatic memories create isolated memory networks that:

* Cannot connect with adaptive information
* Get triggered by current stimuli
* Produce symptoms (flashbacks, panic, avoidance)
* Maintain maladaptive beliefs ("I'm not safe," "It's my fault")

**Research Foundation and Evidence Base**

EMDR is one of the most thoroughly researched trauma treatments, with over 40 randomized controlled trials demonstrating its effectiveness.

**Major Research Findings:**

1. **Efficacy Studies:**
   * 84-90% of single-trauma victims no longer meet PTSD criteria after 3 sessions
   * 77% of combat veterans free of PTSD after 12 sessions
   * Comparable or superior to other evidence-based treatments
2. **Neurobiological Research:**
   * fMRI studies show changes in brain activation patterns
   * Decreased limbic system hyperactivity
   * Increased prefrontal cortex activation
   * Changes in hippocampal volume
3. **Mechanism Studies:**
   * Working memory taxation hypothesis
   * Orienting response/REM sleep theories
   * Increased interhemispheric communication
   * Dual attention stimulus effects

**International Recognition:**

* **World Health Organization (2013):** Recommends EMDR for children, adolescents, and adults with PTSD
* **American Psychological Association:** Strong research support for PTSD treatment
* **Department of Veterans Affairs/Department of Defense:** Strongly recommended for PTSD
* **International Society for Traumatic Stress Studies:** Effective treatment for PTSD

**Comparison with Other Trauma Treatments**

**EMDR vs. Prolonged Exposure (PE):**

* EMDR: No detailed verbal description required
* PE: Requires repeated detailed narration
* EMDR: No homework required
* PE: Daily homework essential
* Both: Similar efficacy rates

**EMDR vs. Cognitive Processing Therapy (CPT):**

* EMDR: Focus on reprocessing memories
* CPT: Focus on cognitive restructuring
* EMDR: Bilateral stimulation component
* CPT: Written trauma accounts
* Both: Address stuck points/dysfunctional beliefs

**Theoretical Mechanisms of Action**

While the exact mechanism remains under investigation, several theories explain EMDR's effectiveness:

**1. Working Memory Theory:** The dual-task nature (holding traumatic memory while tracking bilateral stimulation) taxes working memory, reducing memory vividness and emotionality.

**2. Orienting Response Theory:** Bilateral stimulation triggers an orienting response that:

* Activates parasympathetic nervous system
* Promotes relaxation response
* Facilitates information processing

**3. REM Sleep Hypothesis:** Eye movements simulate REM sleep patterns involved in:

* Memory consolidation
* Emotional processing
* Integration of daily experiences

**4. Interhemispheric Communication:** Bilateral stimulation increases communication between brain hemispheres, facilitating:

* Integration of cognitive and emotional information
* Access to adaptive information
* Resolution of traumatic memories

**Clinical Applications Beyond PTSD**

While initially developed for trauma, EMDR has shown effectiveness for:

**Anxiety Disorders:**

* Panic disorder
* Specific phobias
* Generalized anxiety disorder
* Social anxiety disorder

**Mood Disorders:**

* Depression
* Bipolar disorder (with caution)

**Other Conditions:**

* Chronic pain
* Addiction
* Eating disorders
* Performance anxiety
* Grief and loss

**Clinical Vignette - Expanding Applications:**

*Client: "I know EMDR is for trauma, but I don't have PTSD. I just can't perform in front of people."*

*Therapist: "Performance anxiety often has roots in earlier experiences where you felt judged or humiliated. We can use EMDR to process those foundational memories. When you think about performing, what's the earliest memory that comes up?"*

*Client: "Oh... the school play in third grade when I forgot my lines and everyone laughed."*

*Therapist: "That sounds like it was really painful. That experience may have created a belief about performing that still affects you today. EMDR can help reprocess that memory and update the beliefs that formed then."*

**Module 1 Quiz**

**Question 1:** According to the Adaptive Information Processing (AIP) model, trauma symptoms occur because: a) The person lacks coping skills b) The memory is stored in a dysfunctional, state-specific form c) The person is avoiding dealing with the trauma d) The brain is permanently damaged

**Answer: b) The memory is stored in a dysfunctional, state-specific form** *Explanation: The AIP model posits that trauma symptoms result from memories being stored in their original, disturbing form with the emotions, sensations, and beliefs from the time of the event. These memories remain unintegrated with other memory networks and continue to be triggered by current stimuli.*

**Question 2:** Research on EMDR's effectiveness shows that for single-trauma victims: a) 50% no longer meet PTSD criteria after 3 sessions b) 84-90% no longer meet PTSD criteria after 3 sessions c) Treatment typically requires 20+ sessions d) EMDR is less effective than medication

**Answer: b) 84-90% no longer meet PTSD criteria after 3 sessions** *Explanation: Multiple studies have demonstrated that 84-90% of single-trauma victims no longer meet PTSD diagnostic criteria after just three 90-minute EMDR sessions, making it one of the most efficient trauma treatments available.*

**Question 3:** Which of the following is NOT considered a primary theoretical mechanism for EMDR's effectiveness? a) Working memory taxation b) Orienting response activation c) Suppression of traumatic memories d) Interhemispheric communication

**Answer: c) Suppression of traumatic memories** *Explanation: EMDR does not work through suppression of memories but rather through reprocessing and integration. The main theoretical mechanisms include working memory taxation, orienting response, REM-sleep-like processes, and increased interhemispheric communication.*

**Module 2: Client Assessment and Preparation**

**Duration: 90 minutes**

**Comprehensive Client Assessment for EMDR**

Before initiating EMDR treatment, thorough assessment ensures client safety and treatment appropriateness. This assessment goes beyond standard intake to evaluate specific factors relevant to trauma reprocessing.

**Clinical History Taking**

**Essential Assessment Areas:**

1. **Trauma History:**
   * Single incident vs. complex trauma
   * Developmental trauma
   * Age of occurrence
   * Duration and frequency
   * Relationship to perpetrator
   * Previous trauma treatment
2. **Current Symptoms:**
   * PTSD symptoms (intrusion, avoidance, cognition/mood, arousal)
   * Dissociative symptoms
   * Somatic complaints
   * Sleep disturbances
   * Substance use
3. **Mental Health History:**
   * Previous diagnoses
   * Hospitalizations
   * Suicide attempts/ideation
   * Medication history
   * Previous therapy experiences
4. **Medical History:**
   * Neurological conditions
   * Seizure disorders
   * Eye problems
   * Pregnancy
   * Chronic pain
5. **Resources and Strengths:**
   * Coping strategies
   * Support system
   * Spiritual/cultural resources
   * Previous successes
   * Resilience factors

**Clinical Interview Example:**

*Therapist: "I'd like to understand your full history to ensure EMDR is the right approach for you. Let's start with what brings you to therapy now."*

*Client: "The nightmares are unbearable. I haven't slept through the night in two years since the assault."*

*Therapist: "I'm sorry you're experiencing that. Before we talk more about the assault, I need to gather some background. Have you experienced any other traumatic events in your life?"*

*Client: "Well, my parents divorced when I was seven, and my father was pretty absent after that."*

*Therapist: "Thank you for sharing that. These earlier experiences can sometimes connect to current symptoms. We'll explore those connections as we work. Now, tell me about your current support system."*

**Indications and Contraindications**

**Strong Indications for EMDR:**

* PTSD (single incident or complex)
* Trauma-related anxiety
* Specific phobias with known origin
* Depression with trauma history
* Complicated grief
* Performance anxiety
* Chronic pain with psychological components

**Relative Contraindications Requiring Modification:**

* Active substance abuse (require stabilization first)
* Severe dissociative disorders (need specialized training)
* Active psychosis (wait for stabilization)
* Severe suicidality (address safety first)
* Ongoing trauma (establish safety first)
* Unstable medical conditions

**Absolute Contraindications:**

* Unwillingness to experience temporary distress
* Inability to maintain dual awareness
* No identified targets
* Court-involved cases where memory accuracy is crucial

**Assessing Dissociation**

The Dissociative Experiences Scale (DES) should be administered to screen for dissociative disorders:

**DES Score Interpretations:**

* 0-10: Low dissociation
* 10-30: Moderate dissociation (proceed with awareness)
* Above 30: High dissociation (requires modified approach)

**Clinical Assessment of Dissociation:**

*Therapist: "Some people who've experienced trauma describe feeling disconnected from themselves or their surroundings. Have you ever felt like you were watching yourself from outside your body?"*

*Client: "Sometimes when things get really stressful, I feel like I'm floating above myself."*

*Therapist: "How often would you say this happens?"*

*Client: "Maybe once or twice a week, especially if something reminds me of the trauma."*

*Therapist: "This is called dissociation, and it's your mind's way of protecting you. We'll work on grounding skills before starting EMDR to help you stay present during processing."*

**Developing the Treatment Plan**

**Three-Pronged Protocol:**

1. **Past:** Process memories that laid the foundation for pathology
2. **Present:** Process current triggers
3. **Future:** Install future templates for adaptive behavior

**Target Sequencing Strategies:**

**Chronological Approach:**

* Start with earliest trauma
* Work forward in time
* Addresses foundational issues first

**Worst First Approach:**

* Target most disturbing memory
* Provides immediate relief
* Builds confidence

**Progressive Approach:**

* Start with less disturbing memories
* Build tolerance and skills
* Move to more difficult targets

**Treatment Planning Dialogue:**

*Therapist: "Based on our assessment, I see three main areas to address: the childhood bullying, the car accident at 16, and the recent assault. How would you like to approach these?"*

*Client: "I think the assault is the worst, but I'm scared to start there."*

*Therapist: "That's understandable. We could start with the car accident—it's significant but less overwhelming. This would let you experience EMDR with something manageable first. How does that sound?"*

*Client: "That feels more doable."*

**Phase 1: History Taking and Treatment Planning**

**Developing the Problem List:**

Components of comprehensive problem formulation:

* Presenting symptoms
* Triggers in current life
* Historical contributors
* Negative beliefs
* Desired outcomes

**Creating the Targeting Sequence Plan:**

*Example Treatment Plan:*

1. Stabilization and resource development (2-3 sessions)
2. Process car accident at age 16 (2-3 sessions)
3. Process childhood bullying (3-4 sessions)
4. Process recent assault (3-4 sessions)
5. Process present triggers (2 sessions)
6. Install future templates (1-2 sessions)
7. Closure and integration (1 session)

**Phase 2: Preparation**

The preparation phase establishes the therapeutic framework and develops necessary resources for processing.

**Key Components of Preparation:**

1. **Psychoeducation about EMDR:**

*Therapist: "EMDR helps your brain process stuck memories. Think of it like a splinter—your body wants to heal, but the splinter prevents it. EMDR removes the emotional splinter so natural healing can occur."*

*Client: "So the memory won't go away?"*

*Therapist: "No, you'll still remember what happened, but it won't have the same emotional charge. It becomes a story about your past rather than something that feels current."*

1. **Explaining Bilateral Stimulation:**

*Therapist: "We'll use eye movements, similar to what happens during REM sleep when your brain naturally processes daily experiences. I'll move my fingers back and forth, and you'll follow with your eyes while thinking about the memory."*

*Demonstration of different BLS options*

*Therapist: "Some people prefer tapping or audio tones. Let's try each to see what feels most comfortable for you."*

1. **Establishing Stop Signal:**

*Therapist: "You're in control throughout the process. If you need to stop, simply raise your hand like this [demonstrates]. We'll stop immediately, no questions asked initially."*

1. **Metaphors for Processing:**

Common helpful metaphors:

* Train journey: "Watching scenery pass by"
* Movie screen: "Observing from the audience"
* Clouds passing: "Thoughts and feelings drift through"
* Healing wound: "Natural process of repair"

**Resource Development and Installation (RDI)**

Before processing trauma, clients need adequate resources:

**Safe/Calm Place Installation:**

*Therapist: "Think of a place where you feel completely safe and calm. It can be real or imaginary."*

*Client: "My grandmother's kitchen when I was little."*

*Therapist: "Beautiful. Notice what you see there... what you hear... any smells... how your body feels. What emotion comes up?"*

*Client: "Peaceful. Safe. Loved."*

*Therapist: "Give this feeling a word or phrase."*

*Client: "Grandma's love."*

*Therapist: "Hold that image and those words 'Grandma's love' while following my fingers." [Provides short set of BLS]*

*Therapist: "How does that feel now?"*

*Client: "Even stronger. More peaceful."*

**Additional Resources to Install:**

* Protective figure
* Nurturing figure
* Wise figure
* Spiritual resources
* Mastery experiences
* Positive achievements

**Assessing Client Stability**

**Indicators of Readiness:**

* Can maintain dual awareness
* Has functional coping strategies
* Demonstrates affect tolerance
* Able to self-soothe
* Has adequate support system
* No active crisis
* Substance use stable/managed
* Medical conditions stable

**Red Flags Requiring Additional Preparation:**

* Severe anxiety about process
* Inability to identify safe place
* Active self-harm
* Current abusive relationship
* Overwhelming life stressors
* Poor therapeutic alliance

**Stabilization Dialogue:**

*Therapist: "Before we process memories, I want to ensure you have solid coping skills. How do you typically calm yourself when upset?"*

*Client: "I don't really have good ways. Usually I just drink wine or zone out watching TV."*

*Therapist: "Let's spend time developing healthier coping strategies first. EMDR can bring up intense emotions, and I want you to have tools to manage them both in session and between sessions."*

**Container Exercise**

For clients with multiple traumas or overwhelming emotions:

*Therapist: "Imagine a strong container—a safe, trunk, vault—anything that can hold things securely. What comes to mind?"*

*Client: "A big steel safe with a complex lock."*

*Therapist: "Perfect. Now imagine putting any disturbing thoughts, feelings, or memories that might interfere with your daily life into this safe. You can lock them away and know they'll be there when we're ready to work on them in session."*

*Client: "I'm putting all the memories in there."*

*Therapist: "Good. Now lock it securely. You have the only key. These memories are contained until you choose to work with them." [Adds BLS to strengthen container]*

**Module 2 Quiz**

**Question 1:** Which of the following would be considered an absolute contraindication for EMDR? a) History of multiple traumas b) Current anxiety disorder c) Active psychosis with inability to maintain dual awareness d) History of dissociation

**Answer: c) Active psychosis with inability to maintain dual awareness** *Explanation: Active psychosis that prevents maintaining dual awareness (knowing you're in the present while processing the past) is an absolute contraindication. The other conditions may require modifications but don't prevent EMDR treatment entirely.*

**Question 2:** The "three-pronged protocol" in EMDR treatment planning refers to: a) Using three types of bilateral stimulation b) Processing past, present, and future c) Working with thoughts, emotions, and sensations d) Addressing three traumatic memories

**Answer: b) Processing past, present, and future** *Explanation: The three-pronged protocol addresses: 1) Past memories that laid the foundation for pathology, 2) Present triggers and disturbances, and 3) Future templates for adaptive behavior. This comprehensive approach ensures thorough treatment.*

**Question 3:** During the preparation phase, installing a "Safe/Calm Place" serves to: a) Avoid processing traumatic material b) Provide a resource for self-soothing during and between sessions c) Replace the traumatic memory d) Test if the client can follow eye movements

**Answer: b) Provide a resource for self-soothing during and between sessions** *Explanation: The Safe/Calm Place is a crucial resource that clients can access when processing becomes overwhelming or when they need self-soothing between sessions. It's installed with BLS to strengthen the positive association and make it more readily accessible.*

**Module 3: Phases 3-6: Assessment Through Body Scan**

**Duration: 120 minutes**

**Phase 3: Assessment**

The Assessment Phase activates the memory network to be processed and establishes baseline measurements. This structured approach ensures all components of the memory are accessed.

**Identifying the Target Memory**

**Components of Target Identification:**

1. **Image:** The worst part or most disturbing aspect
2. **Negative Cognition (NC):** Core negative belief
3. **Positive Cognition (PC):** Desired belief
4. **Validity of Cognition (VoC):** How true PC feels (1-7 scale)
5. **Emotions:** Current emotions when thinking of memory
6. **Subjective Units of Disturbance (SUD):** Disturbance level (0-10)
7. **Body Sensations:** Physical location of disturbance

**Clinical Example of Assessment Phase:**

*Therapist: "When you think of the car accident, what image represents the worst part?"*

*Client: "The moment I saw the other car coming at me and knew I couldn't avoid it."*

*Therapist: "As you hold that image in mind, what negative belief about yourself goes with it?"*

*Client: "I'm going to die."*

*Therapist: "That's what you thought then. What negative belief about yourself do you have now when you look back at that picture?"*

*Client: "I'm helpless. I can't protect myself."*

*Therapist: "When you think of that incident, what would you like to believe about yourself instead?"*

*Client: "I'd like to believe I'm safe now."*

*Therapist: "When you think of the accident and the words 'I'm safe now,' how true do those words feel on a scale of 1 to 7, where 1 is completely false and 7 is completely true?"*

*Client: "Maybe a 2. I know it logically, but I don't feel it."*

*Therapist: "When you bring up that image and the words 'I'm helpless,' what emotions do you feel now?"*

*Client: "Fear... anger... frustration."*

*Therapist: "On a scale of 0 to 10, where 0 is no disturbance and 10 is the worst disturbance you can imagine, how disturbing does it feel now?"*

*Client: "About an 8."*

*Therapist: "Where do you feel it in your body?"*

*Client: "My chest is tight, and my stomach is in knots."*

**Understanding Negative and Positive Cognitions**

**Categories of Negative Cognitions:**

1. **Responsibility/Defectiveness:**
   * "It's my fault"
   * "I should have done something"
   * "I'm bad"
   * "I don't deserve good things"
2. **Safety/Vulnerability:**
   * "I'm in danger"
   * "I'm not safe"
   * "I can't trust anyone"
   * "I'm going to die"
3. **Power/Control:**
   * "I'm powerless"
   * "I'm out of control"
   * "I'm helpless"
   * "I can't handle it"

**Developing Effective Positive Cognitions:**

Positive cognitions should be:

* **Present-tense** ("I'm safe now" not "I was safe")
* **Self-referencing** ("I did the best I could" not "It wasn't my fault")
* **Possible and realistic** ("I can learn to feel safe" not "Nothing bad will ever happen")
* **Generalizable** (applicable beyond single incident)

**Common NC-PC Pairs:**

* NC: "I'm powerless" → PC: "I have choices now"
* NC: "I'm damaged" → PC: "I'm whole and complete"
* NC: "I should have known better" → PC: "I did the best I could"
* NC: "I'm not good enough" → PC: "I'm good enough"

**Refining Cognitions Dialogue:**

*Client: "My positive belief is 'It wasn't my fault.'"*

*Therapist: "That's about the situation. What would you like to believe about yourself?"*

*Client: "That I'm not to blame?"*

*Therapist: "Let's make it more positive. Instead of what you're not, what are you?"*

*Client: "I'm... innocent? I did the best I could?"*

*Therapist: "How does 'I did the best I could' feel?"*

*Client: "Yes, that feels right."*

**Phase 4: Desensitization**

Desensitization is the core processing phase where bilateral stimulation facilitates the reprocessing of traumatic memories.

**Initiating Processing**

**Standard Instructions:**

*Therapist: "I'd like you to bring up that picture of seeing the car coming at you, the negative belief 'I'm helpless,' and notice where you feel it in your body. Just let whatever happens, happen. Follow my fingers."*

[Therapist provides set of 24+ bilateral movements]

*Therapist: "Take a breath. What are you noticing now?"*

**Types of Processing**

**Processing Patterns:**

1. **Channels of Association:**
   * **Image channel:** Visual memories change
   * **Cognitive channel:** Insights and realizations
   * **Emotional channel:** Feelings shift
   * **Somatic channel:** Body sensations change
   * **Behavioral channel:** Remembering actions taken
2. **Adaptive Processing Indicators:**
   * Decreasing disturbance
   * Shifting perspectives
   * Making connections
   * Accessing adaptive information
   * Spontaneous insights

**Clinical Example - Channels of Processing:**

*After BLS Set 1:* *Client: "I see myself getting out of the car. I forgot I was able to walk away."* (Image/Behavioral)

*After BLS Set 2:* *Client: "I'm feeling angry instead of scared now."* (Emotional)

*After BLS Set 3:* *Client: "The tightness in my chest is loosening."* (Somatic)

*After BLS Set 4:* *Client: "I'm realizing the other driver was drunk. It really wasn't my fault."* (Cognitive)

**Managing Blocked Processing**

**Indicators of Blocked Processing:**

* No change after multiple sets
* Increasing disturbance without resolution
* Looping (same material repeatedly)
* Numbing or dissociation

**Strategies for Blocked Processing:**

1. **Change the bilateral stimulation:**
   * Alter speed (faster/slower)
   * Change direction
   * Switch modality (eyes to taps)
   * Adjust distance
2. **Return to target:**

*Therapist: "Let's go back to the original incident. What are you noticing now?"*

1. **Check for blocking beliefs:**

*Therapist: "Is there a part of you that doesn't want to let this go?"*

*Client: "If I let go of the fear, I might not be careful enough."*

*Therapist: "So there's a belief that fear keeps you safe. Let's go with that." [BLS]*

**Cognitive Interweaves**

When processing remains stuck, cognitive interweaves provide adaptive information to jumpstart processing.

**Types of Interweaves:**

1. **New Information:**

*Therapist: "You know you survived, right? You're here now."*

1. **Perspective Shift:**

*Therapist: "If this happened to your best friend, what would you tell them?"*

1. **Metaphor/Analogy:**

*Therapist: "It's like you've been carrying a heavy backpack from that day. What would happen if you set it down?"*

1. **Socratic Questions:**

*Therapist: "Whose responsibility is it when someone drives drunk?"*

**Clinical Example - Effective Interweave:**

*Client: [Stuck in loop] "I keep seeing his face. I should have fought back."*

*Therapist: "How old were you?"*

*Client: "Seven."*

*Therapist: "What does a seven-year-old child need to do when an adult hurts them?"*

*Client: "Survive... get through it."*

*Therapist: "And did you?"*

*Client: "Yes..."*

*Therapist: "Go with that." [BLS]*

*Client: [After set] "I was just a little kid. I did survive. That was actually brave."*

**Managing Abreactions**

Abreactions involve intense emotional release during processing. They're not necessary for healing but may occur naturally.

**Supporting Abreactive Responses:**

*Client: [Crying intensely during BLS]*

*Therapist: [Continues BLS, speaking calmly] "That's it. Just notice. You're doing great. I'm right here with you. Let it move through."*

[Continues until intensity peaks and begins to decrease]

*Therapist: "Take a breath. What's coming up?"*

*Client: "All the grief I never let myself feel. It's finally moving."*

**Phase 5: Installation**

Once the SUD reaches 0-1, install the positive cognition to strengthen adaptive neural networks.

**Installation Process:**

*Therapist: "When you think of the original incident, does the positive belief 'I'm safe now' still fit, or is there a better one?"*

*Client: "Actually, 'I'm stronger than I knew' feels more true."*

*Therapist: "Think of the original incident and hold the words 'I'm stronger than I knew.' How true does that feel from 1 to 7?"*

*Client: "About a 5."*

*Therapist: "Hold the memory and those words together." [BLS]*

[After set]

*Therapist: "How true does 'I'm stronger than I knew' feel now, from 1 to 7?"*

*Client: "It's a 6."*

*Therapist: "Let's continue." [BLS]*

[Continue until VoC reaches 7 or stops increasing]

**Strengthening Installation:**

When VoC won't reach 7:

*Therapist: "What prevents it from being a 7?"*

*Client: "Well, I don't feel strong all the time."*

*Therapist: "How about 'I can be strong when I need to be'?"*

*Client: "Yes, that's completely true—a 7."*

*Therapist: "Let's install that." [BLS]*

**Phase 6: Body Scan**

The body scan ensures complete processing of all somatic components.

**Body Scan Procedure:**

*Therapist: "Close your eyes and think of the original incident together with the words 'I'm stronger than I knew.' Then scan your body from head to toe. Tell me if you notice any tension, tightness, or unusual sensations."*

*Client: [After scanning] "There's still a little tension in my shoulders."*

*Therapist: "Focus on that tension." [BLS]*

*Client: "It's releasing... my shoulders are dropping... relaxing."*

*Therapist: "Scan your body again."*

*Client: "Everything feels calm now. Neutral."*

*Therapist: "Hold the original incident and the positive belief while I do one more set to strengthen this." [BLS]*

**Integration and Ecological Check**

**Ensuring Ecological Validity:**

*Therapist: "As you think about having processed this memory, how does that feel in relation to your life now?"*

*Client: "It feels like a weight has been lifted. Like I can move forward."*

*Therapist: "Is there any part of you that has concerns about this change?"*

*Client: "No, it all feels right. I feel like myself again, but stronger."*

**Module 3 Quiz**

**Question 1:** When developing a Positive Cognition (PC), which characteristic is MOST important? a) It should deny the traumatic event happened b) It should be phrased in present tense and be self-referential c) It should blame someone else for the trauma d) It should be exactly opposite of the negative cognition

**Answer: b) It should be phrased in present tense and be self-referential** *Explanation: Effective positive cognitions are present-tense ("I'm safe now"), self-referential ("I did my best"), realistic, and generalizable. They don't deny reality but reflect adaptive beliefs about oneself in the present.*

**Question 2:** During desensitization, if a client reports the same content repeatedly without change (looping), the therapist should: a) Stop EMDR immediately b) Continue with the same approach indefinitely c) Consider strategies like changing BLS speed or using cognitive interweaves d) Tell the client they're resisting

**Answer: c) Consider strategies like changing BLS speed or using cognitive interweaves** *Explanation: Looping indicates blocked processing. Effective interventions include changing BLS parameters (speed, direction, modality), returning to target, checking for blocking beliefs, or using cognitive interweaves to provide adaptive information.*

**Question 3:** The purpose of the Body Scan phase is to: a) Relax the client before ending the session b) Ensure all somatic components of the memory have been processed c) Teach body awareness skills d) Check for medical problems

**Answer: b) Ensure all somatic components of the memory have been processed** *Explanation: The body scan ensures complete processing by checking for any residual somatic disturbance related to the target memory. Any remaining sensations are processed with additional BLS until the body feels neutral or calm.*

**Module 4: Phases 7-8 and Session Management**

**Duration: 120 minutes**

**Phase 7: Closure**

Closure ensures client stability at session end, regardless of whether processing is complete. This phase is crucial for maintaining client safety and therapeutic alliance.

**Complete vs. Incomplete Sessions**

**Complete Session Closure:**

* Target fully processed (SUD = 0)
* Positive cognition installed (VoC = 6-7)
* Clear body scan
* Client feels settled

*Therapist: "Excellent work today. You've fully processed the accident memory. How are you feeling?"*

*Client: "Tired but good. Like I've finished something important."*

*Therapist: "Between now and our next session, keep a log of any dreams, thoughts, or memories that come up. Also notice any positive changes. We'll review these next time."*

**Incomplete Session Closure:** When processing isn't complete:

*Therapist: "We've done important work today, but we haven't finished processing this memory. That's perfectly normal—some memories take multiple sessions. How are you feeling right now?"*

*Client: "Still activated. The image isn't as bad, but it's still there."*

*Therapist: "Let's make sure you're stable before you leave. Let's go to your safe place." [Guides safe place exercise]*

*Therapist: "Remember, processing continues between sessions. Your brain will keep working on this. If things feel overwhelming, use your container exercise and coping skills we practiced. You can call me if you need support."*

**Stabilization Techniques for Closure**

**Closing Incomplete Sessions:**

1. **Safe Place Visualization:**
   * Return to previously installed resource
   * Strengthen with additional BLS
   * Ensure client can access independently
2. **Container Exercise:**
   * Place unfinished material in container
   * Seal until next session
   * Reinforce client control
3. **Grounding Techniques:**
   * 5-4-3-2-1 sensory awareness
   * Breath work
   * Progressive muscle relaxation
   * Bilateral stimulation for calming

**Clinical Example - Incomplete Closure:**

*Therapist: "We need to stop for today. I know the memory still has some charge. Let's put it in your container."*

*Client: "But it's still at a 4. I want to finish."*

*Therapist: "I understand that frustration. Processing continues between sessions—your brain keeps working on it. Right now, let's ensure you're stable. Imagine your strong safe with the complex lock."*

*Client: "Okay, I see it."*

*Therapist: "Place what's left of this memory inside. You have the only key. You decide when to take it out again."*

*Client: [After visualization] "It's locked away."*

*Therapist: "Good. Now let's strengthen your calm place before you go."*

**Debriefing and Psychoeducation**

**Standard Debriefing Points:**

*Therapist: "Processing continues between sessions in the form of dreams, insights, memories, or emotions. This is your brain continuing to heal. Think of it like your system doing maintenance work. Keep a log of what you notice, but don't effort to make anything happen."*

**Self-Care Instructions:**

\*Therapist: "For the next 24-48 hours:

* Be gentle with yourself
* Avoid alcohol or substances that might interfere with processing
* Engage in calming activities
* Use your resources if needed
* Remember you can contain any overwhelming material
* Call if you experience any crisis"\*

**Session Log Instructions**

**Teaching the Log Process:**

\*Therapist: "Keep a brief log—just a sentence or two about:

* Any dreams (just note themes, don't analyze)
* Memories that surface
* Insights or 'aha' moments
* Current day triggers
* Positive changes you notice This helps us track your processing and plan next session."\*

**Sample Log Entry:** *"Tuesday: Dream about being in a safe house. Wednesday: Remembered Mom protecting me once—felt grateful. Thursday: Car honked, startled but recovered quickly. Friday: Noticed I drove past accident site without panic."*

**Phase 8: Reevaluation**

Every session begins with reevaluation to assess processing effects and determine the session focus.

**Beginning Subsequent Sessions**

**Reevaluation Protocol:**

*Therapist: "How are you doing since our last session?"*

*Client: "I had some interesting dreams and actually felt calmer overall."*

*Therapist: "Tell me about the dreams first."*

*Client: "I dreamed I was driving a car and completely in control. I even helped someone else who'd had an accident."*

*Therapist: "That sounds like adaptive processing—your mind integrating new perspectives. When you think about the accident now, what comes up?"*

*Client: "It seems more distant. Like something that happened but doesn't define me."*

*Therapist: "What's the SUD level now, 0-10?"*

*Client: "Maybe a 1 or 2."*

*Therapist: "Let's check if any aspects need attention. Bring up the original image."*

**Checking Previous Work**

**Systematic Reevaluation:**

1. **Check original target:**
   * Current SUD level
   * Status of positive cognition
   * Any residual disturbance
2. **Review session log:**
   * Process any new material
   * Address current triggers
   * Integrate insights
3. **Scan for aspects:**
   * Different perspectives of event
   * Related memories activated
   * Present-day triggers

**Clinical Dialogue - Finding Remaining Aspects:**

*Therapist: "The accident itself feels resolved. Are there any other parts that still bother you?"*

*Client: "Well, the aftermath was awful—dealing with insurance, the other driver blaming me."*

*Therapist: "That sounds like a separate aspect to process. What was the worst part of the aftermath?"*

*Client: "Standing in court while his lawyer called me a liar."*

*Therapist: "Let's target that today. What image represents the worst part?"*

**Ecological Checking**

**Assessing Systemic Effects:**

*Therapist: "How are the changes from our work affecting your daily life?"*

*Client: "Mostly positive. I'm driving again. But my partner says I seem different."*

*Therapist: "Different how?"*

*Client: "More confident. Less anxious. They're adjusting to me not needing as much reassurance."*

*Therapist: "Relationships often shift when we heal. How do you feel about these changes?"*

*Client: "Good, but I want to be patient with my partner's adjustment."*

**Determining Completion**

**Indicators Target is Resolved:**

* SUD = 0
* VoC = 6-7
* Clear body scan
* No activating aspects
* Ecological check positive
* Future template installed

**Moving Through Treatment Plan:**

*Therapist: "We've completed the accident memory and its aspects. Looking at our treatment plan, we identified the childhood bullying as the next target. How does that feel to you?"*

*Client: "I'm ready. I actually think it connects to the accident—both times I felt powerless."*

*Therapist: "Good insight. Those connections often help processing move faster. Shall we begin with the worst bullying incident?"*

**Special Considerations in Session Management**

**Managing Multiple Channels**

**When Multiple Memories Emerge:**

*Client: "While processing the accident, I remembered three other times I felt helpless."*

*Therapist: "Your mind is showing you connected memories. For now, just notice them. If they don't resolve with the current target, we'll address them separately."*

**Feeder Memories**

Earlier memories that "feed" current symptoms:

*Client: "Processing the work criticism, I suddenly remembered Dad saying I'd never amount to anything."*

*Therapist: "That earlier memory might be feeding your current sensitivity to criticism. Let's stay with what's coming up." [BLS]*

*Client: "I can see how Dad's words created a template I've been living by."*

**Cluster Processing**

Related memories that process together:

*Therapist: "As we process this rejection, other rejections might also heal. Your brain groups similar experiences."*

*Client: "That makes sense. They all have the same feeling."*

**Time Management in Sessions**

**90-Minute Session Structure:**

* 10 minutes: Check-in and reevaluation
* 60-70 minutes: Active processing
* 10-20 minutes: Closure and debrief

**Managing Processing Time:**

*Therapist: [At 60 minutes] "We have about 20 minutes left. We can continue processing for another 10 minutes, then we'll need time for closure."*

**When to Extend Sessions:**

Consider extending when:

* Client is in active processing
* Close to completion (SUD almost 0)
* Client requests and can tolerate
* Stopping would be destabilizing

*Therapist: "You're moving through important material. Would you like to extend our session by 30 minutes to complete this? We can also stop and continue next time."*

**Documentation Best Practices**

**Session Note Components:**

* Phase of treatment
* Target addressed
* Starting and ending SUD/VoC
* Processing observations
* Interventions used
* Client response
* Homework given
* Next session plan

**Sample Progress Note:**

*"Phase 4 (Desensitization) targeting motor vehicle accident (MVA). Starting SUD: 8, Ending SUD: 1. NC: 'I'm helpless' to PC: 'I'm capable now' (VoC start: 2, end: 6). Processed through image, cognitive, and somatic channels. Used cognitive interweave when client looped on self-blame. Abreaction with appropriate release. Incomplete session—used container and safe place for closure. Client stable at session end. Assigned session log. Plan: Continue MVA processing next session."*

**Module 4 Quiz**

**Question 1:** When a session ends with incomplete processing (SUD still elevated), the therapist should: a) Extend the session until processing is complete b) Tell the client the treatment isn't working c) Use stabilization techniques and ensure client safety before ending d) Start processing a different memory

**Answer: c) Use stabilization techniques and ensure client safety before ending** *Explanation: Incomplete sessions are normal in EMDR. The priority is ensuring client stability through techniques like safe place visualization, container exercise, and grounding. Processing continues between sessions, and the work resumes at the next appointment.*

**Question 2:** Phase 8 (Reevaluation) occurs: a) Only after completing all targets b) At the beginning of each session after the first c) Only if the client reports problems d) Once monthly

**Answer: b) At the beginning of each session after the first** *Explanation: Reevaluation begins every session after the initial session. It assesses the effects of previous processing, checks for new material, and determines the current session's focus. This ensures continuous assessment of treatment progress.*

**Question 3:** "Feeder memories" refer to: a) Memories that have no emotional charge b) False memories created during therapy c) Earlier memories that contribute to current symptoms d) Memories of positive experiences

**Answer: c) Earlier memories that contribute to current symptoms** *Explanation: Feeder memories are earlier experiences that "feed" or maintain current pathology. For example, childhood criticism may feed current sensitivity to workplace feedback. Identifying and processing feeder memories often resolves present-day symptoms more completely.*

**Part One Comprehensive Examination**

**10-Question Assessment for Part One**

**Question 1:** According to the Adaptive Information Processing model, pathology results from: a) Lack of intelligence b) Memories stored in state-specific, dysfunctional form c) Conscious avoidance of trauma d) Chemical imbalances only

**Answer: b) Memories stored in state-specific, dysfunctional form** *Explanation: The AIP model posits that pathology results from memories being inadequately processed and stored with the original disturbing emotions, sensations, and beliefs. These remain isolated from adaptive memory networks.*

**Question 2:** Before beginning EMDR, which screening is essential for determining treatment approach? a) Intelligence testing b) Dissociation assessment c) Personality testing  
d) Career aptitude assessment

**Answer: b) Dissociation assessment** *Explanation: Screening for dissociation (typically using the DES) is crucial as high dissociation levels require modified EMDR approaches. This ensures safe and appropriate treatment planning.*

**Question 3:** A client's Negative Cognition is "I should have saved him." The most appropriate Positive Cognition would be: a) "It wasn't my fault" b) "I did the best I could" c) "He's in a better place" d) "I should forgive myself"

**Answer: b) "I did the best I could"** *Explanation: This PC is present-tense, self-referential, and addresses the core issue of responsibility without denying reality. It's believable and can generalize to other situations.*

**Question 4:** During desensitization, a client reports the same content repeatedly. The BEST intervention is: a) Stop treatment permanently b) Change the speed or type of bilateral stimulation c) Tell them they're doing it wrong d) Skip to a different memory

**Answer: b) Change the speed or type of bilateral stimulation** *Explanation: Looping indicates blocked processing. Changing BLS parameters (speed, direction, or modality) often restarts processing. Other options include returning to target or using cognitive interweaves.*

**Question 5:** The Safe/Calm Place exercise is installed during which phase? a) Assessment b) Preparation  
c) Desensitization d) Closure

**Answer: b) Preparation** *Explanation: Safe/Calm Place is installed during the Preparation phase (Phase 2) to provide resources for self-soothing before beginning trauma processing. It can be accessed during and between sessions.*

**Question 6:** The three-pronged protocol addresses: a) Three different traumas b) Thoughts, feelings, and behaviors c) Past, present, and future d) Child, adult, and parent ego states

**Answer: c) Past, present, and future** *Explanation: The three-pronged protocol comprehensively addresses past memories that created pathology, present triggers, and future templates for adaptive behavior.*

**Question 7:** During installation (Phase 5), the goal is to strengthen the Positive Cognition until the VoC reaches: a) 3-4 b) 5 c) 6-7 d) 10

**Answer: c) 6-7** *Explanation: Installation continues until the Validity of Cognition scale reaches 6-7, indicating the positive belief feels completely or almost completely true when paired with the original memory.*

**Question 8:** An abreaction during EMDR is: a) A sign to stop treatment immediately b) An intense emotional release that can be part of processing c) Always harmful d) Only seen in weak clients

**Answer: b) An intense emotional release that can be part of processing** *Explanation: Abreactions are intense emotional releases that may occur naturally during processing. While not necessary for healing, they're managed by continuing BLS with support until intensity decreases.*

**Question 9:** The body scan phase ensures: a) The client is medically healthy b) All somatic components of the trauma are processed c) The client can relax d) The session can end

**Answer: b) All somatic components of the trauma are processed** *Explanation: Body scan (Phase 6) checks for residual somatic disturbance related to the target memory. Any remaining sensations are processed until the body feels neutral when thinking of the memory with the PC.*

**Question 10:** Reevaluation at the beginning of sessions is important to: a) Fill time b) Assess processing effects and determine session focus c) Avoid processing d) Test the client's memory

**Answer: b) Assess processing effects and determine session focus** *Explanation: Reevaluation (Phase 8) assesses the effects of previous processing, identifies new material that emerged between sessions, and helps determine the current session's focus for continued treatment.*