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

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

**PART TWO: ADVANCED APPLICATIONS AND SPECIAL POPULATIONS (7.5 CE HOURS)**

**Module 5: Advanced Processing Strategies and Cognitive Interweaves**

**Duration: 90 minutes**

**Understanding Complex Processing Patterns**

As clinicians gain experience with EMDR, they encounter increasingly complex processing patterns requiring sophisticated intervention strategies. This module explores advanced techniques for facilitating processing when standard procedures prove insufficient.

**Advanced Assessment of Processing Blocks**

**Types of Processing Blocks:**

1. **Looping:** Same material repeatedly without progression
2. **Numbing:** Emotional shutdown or disconnection
3. **Escalating:** Increasing disturbance without resolution
4. **Switching:** Jumping between unrelated content
5. **Intellectual:** Staying in cognitive channel only

**Sophisticated Block Analysis:**

*Client: "I keep seeing the same image of my father's angry face, over and over."*

*Therapist: [Internal assessment: Looping pattern. Consider: blocking belief, feeder memory, or need for interweave]*

*Therapist: "What does that angry face mean to you?"*

*Client: "That I'm bad. I must have done something wrong."*

*Therapist: "How old do you feel right now as you see that face?"*

*Client: "Five... maybe six."*

*Therapist: "What does a five-year-old need when a parent is angry?"*

*Client: "Protection... someone to say it's not their fault."*

*Therapist: "Can you give that to your five-year-old self now? Go with that." [BLS]*

**The Art of Cognitive Interweaves**

Cognitive interweaves are therapist-provided statements or questions that facilitate processing by introducing adaptive information or perspectives.

**Principles of Effective Interweaves:**

1. **Minimal and strategic:** Use sparingly, only when needed
2. **Client-centered:** Based on client's own resources
3. **Socratic method:** Questions rather than statements when possible
4. **Developmentally appropriate:** Match the age of traumatized self

**Categories and Examples of Interweaves:**

**Responsibility Interweaves**

For excessive self-blame or responsibility:

*Client: "I should have stopped him from abusing my sister."*

*Therapist: "How old were you?"*

*Client: "Eight."*

*Therapist: "What's an eight-year-old's job in a family?"*

*Client: "To be a kid?"*

*Therapist: "And whose job was it to protect the children?"*

*Client: "The adults... my parents."*

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

**Safety Interweaves**

For persistent fear despite current safety:

*Client: "He could still find me and hurt me."*

*Therapist: "Where is he now?"*

*Client: "In prison."*

*Therapist: "For how long?"*

*Client: "Twenty more years."*

*Therapist: "And where are you?"*

*Client: "Three thousand miles away with a new name."*

*Therapist: "Notice all the barriers between then and now." [BLS]*

**Developmental Interweaves**

For childhood trauma with adult self-blame:

*Client: "I was so stupid. I should have known better."*

*Therapist: "If you saw a seven-year-old child in that situation today, what would you think?"*

*Client: "That they're innocent. They're being manipulated."*

*Therapist: "Can you see your seven-year-old self through those same eyes?"*

*Client: "Oh... she was just a little girl."*

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

**Advanced Interweave Strategies**

**The Adaptive Information Link:**

Connect to existing adaptive networks:

*Client: "I'm worthless because I couldn't save my friend."*

*Therapist: "Tell me about a time you did help someone."*

*Client: "I saved my neighbor's child from drowning last year."*

*Therapist: "Hold both experiences together—what do you notice?" [BLS]*

**The Resource Interweave:**

Activate internal resources:

*Client: "I have no power."*

*Therapist: "Remember when you stood up to your boss last month?"*

*Client: "Yes, that took courage."*

*Therapist: "Where did that courage come from?"*

*Client: "From inside me."*

*Therapist: "Find that courage now. Go with that." [BLS]*

**Managing Complex Emotional States**

**Working with Shame**

Shame often requires specialized interweaves:

*Client: "I'm disgusting. I didn't fight back."*

*Therapist: "What happens to mammals when they're overwhelmed by a predator?"*

*Client: "They freeze?"*

*Therapist: "It's called tonic immobility—it's evolutionary. Your body was protecting you the only way it could. This was your nervous system's wisdom, not a choice."*

*Client: "So it was automatic?"*

*Therapist: "Completely. Notice that." [BLS]*

**Working with Rage**

Intense anger may need containment before processing:

*Client: "I want to kill him for what he did."*

*Therapist: "That rage makes complete sense. What would happen if you could put all that rage into a container for now—not to get rid of it, but to have it available when you need it?"*

*Client: "I could think clearer maybe."*

*Therapist: "Let's try that. Imagine a strong container for the rage." [BLS]*

*Therapist: "Now, underneath the rage, what else is there?"*

*Client: "Hurt... betrayal."*

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

**The Confusion Technique**

For cognitive rigidity or excessive intellectualization:

*Therapist: "I'm going to ask you something that might seem odd. As you think about the trauma, can you try to make it worse?"*

*Client: "What? Why would I do that?"*

*Therapist: "Just try. Make the image bigger, brighter, more disturbing."*

*Client: "I... I can't. It's actually getting smaller."*

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

**Advanced Processing Strategies**

**The Affect Bridge**

Connecting current symptoms to origins:

*Therapist: "Feel that anxiety in your body. Let it be a bridge taking you back to the very first time you felt this exact feeling. Don't think, just let your body remember."*

*Client: "I'm four. Mom's leaving me at daycare. I'm terrified she won't come back."*

*Therapist: "There's the root. Let's process this." [BLS]*

**Float-Back Technique**

For identifying feeder memories:

*Therapist: "Hold the feeling of 'I'm not good enough' and let yourself float back through time. When is the earliest time you remember feeling this?"*

*Client: "Dad comparing me to my brother. I was maybe six."*

*Therapist: "Let's target that memory first."*

**Flash Technique**

For extremely disturbing memories:

*Therapist: "We're going to process this differently. Think of something pleasant or engaging—not related to the trauma."*

*Client: "Okay, playing with my dog."*

*Therapist: "Good. Now just blink at the trauma memory—don't engage with it—then immediately go back to playing with your dog." [BLS]*

[Repeat until disturbance decreases enough for standard processing]

**Processing Resistant Beliefs**

**The "Yes, But" Phenomenon**

*Client: "I know logically I'm safe, but I don't feel it."*

*Therapist: "Where in your body does the 'but' live?"*

*Client: "My gut."*

*Therapist: "Ask your gut what it needs you to know."*

*Client: "It says danger could return anytime."*

*Therapist: "Thank your gut for trying to protect you. What would help it update its files?"*

**Working with Protective Parts**

*Client: "Part of me won't let go of the anger."*

*Therapist: "Can you dialogue with that part? Ask what it's afraid would happen if the anger left?"*

*Client: "It says I'd be vulnerable again."*

*Therapist: "What if the anger could transform into boundary-setting instead of constant vigilance?"*

*Client: "That feels better."*

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

**Module 5 Quiz**

**Question 1:** When using cognitive interweaves, the most effective approach is: a) Providing detailed explanations of trauma theory b) Using Socratic questions to help clients discover adaptive information c) Giving advice about how to handle trauma d) Avoiding all therapist input

**Answer: b) Using Socratic questions to help clients discover adaptive information** *Explanation: Effective interweaves use Socratic questioning to help clients access their own adaptive information. This approach is more powerful than therapist-provided answers and maintains client autonomy in the healing process.*

**Question 2:** The "float-back" technique is primarily used to: a) Induce relaxation b) Identify earlier feeder memories c) Install positive resources d) Close incomplete sessions

**Answer: b) Identify earlier feeder memories** *Explanation: Float-back helps identify earlier memories (feeder memories) that may be maintaining current symptoms. By processing these root experiences, present-day issues often resolve more completely.*

**Question 3:** When working with shame-based trauma, an effective interweave might include: a) Telling the client they shouldn't feel ashamed b) Explaining the neurobiological basis of trauma responses c) Avoiding the shame entirely d) Encouraging the client to blame others

**Answer: b) Explaining the neurobiological basis of trauma responses** *Explanation: Psychoeducation about automatic neurobiological responses (like freeze/tonic immobility) helps clients understand their reactions weren't choices but evolutionary protective mechanisms, reducing self-blame and shame.*

**Module 6: Recent Traumatic Events and Emergency Response Protocols**

**Duration: 90 minutes**

**EMDR for Recent Trauma: Theoretical Considerations**

Recent traumatic events require modified approaches as the memory consolidation process is still active. The standard EMDR protocol may need adjustment to account for ongoing neurobiological processes and potential continuing threat.

**Understanding Memory Consolidation**

**Timeline of Trauma Memory Formation:**

* **0-6 hours:** Immediate encoding, high malleability
* **6-24 hours:** Initial consolidation beginning
* **24-72 hours:** Synaptic consolidation
* **Weeks to months:** Systems consolidation
* **Ongoing:** Memory reconsolidation with each retrieval

**Clinical Implications:**

*Therapist: "Since your assault was yesterday, your brain is still actively processing what happened. EMDR can help guide this natural process toward adaptive resolution rather than traumatic consolidation."*

**Recent Traumatic Event Protocol (R-TEP)**

Developed by Shapiro and Laub, R-TEP adapts standard EMDR for events within the past 3 months.

**R-TEP Modifications:**

1. **Extended preparation:** More emphasis on safety and stabilization
2. **Narrative development:** Chronological processing of event
3. **Google Earth perspective:** Viewing event from distance
4. **Present triggers focus:** Immediate environmental concerns
5. **Future templating emphasis:** Preparing for ongoing challenges

**R-TEP Clinical Application:**

*Therapist: "Since the accident was last week, we'll process this slightly differently. We'll start with you telling me what happened, in order, from just before the accident until you felt safe again."*

*Client: "I was driving to work, normal morning..."*

*Therapist: "As you tell the story, we'll pause at disturbing points for processing. This helps your brain organize the experience properly."*

**Emergency Response Protocol (ERP)**

For immediate intervention (within 24-48 hours):

**ERP Structure:**

*Session Example - 4 hours post-incident:*

*Therapist: "I know you've just experienced something overwhelming. We're going to help your nervous system begin to process this while it's still fresh."*

*Client: "I can't stop shaking."*

*Therapist: "That's your body discharging the trauma energy. Let's work with it, not against it. Follow my fingers while you notice the shaking." [BLS]*

*Client: "The shaking is actually lessening."*

*Therapist: "Your body knows how to heal. We're just helping it along."*

**Group Traumatic Episode Protocol (G-TEP)**

For mass trauma incidents affecting multiple people:

**G-TEP Components:**

1. **Psychoeducation phase** (group)
2. **Individual processing** (within group setting)
3. **Butterfly hug** self-administration
4. **Drawing/artistic expression**
5. **Group resource installation**

**G-TEP Implementation:**

*Group Leader: "Everyone here experienced the earthquake differently. We'll work individually within our group space. Draw your experience first—no words needed."*

[Participants draw]

*Group Leader: "Now, looking at your drawing, notice where you feel it in your body. Everyone do the butterfly hug together." [Demonstrates]*

[Group performs synchronized butterfly hug]

*Group Leader: "Continue until your body feels calmer. Raise your hand when ready."*

**Critical Incident Stress Debriefing Integration**

**Combining EMDR with CISD:**

*Phase 1 - Facts:* *Facilitator: "Let's establish what happened. Just facts, no feelings yet."*

*Phase 2 - Thoughts:* *Facilitator: "What thoughts went through your mind during the worst moment?"*

*Phase 3 - EMDR Processing:* *Facilitator: "Now we'll process these thoughts and feelings using bilateral stimulation."*

**Working with Ongoing Trauma**

When danger continues (domestic violence, war zones, pandemic):

**Safety-First Modifications:**

*Therapist: "I understand you're still living with your abuser. We'll focus on building internal resources and processing only what's safe to address while developing your exit plan."*

**Resource Building Priority:**

1. Safe place (even if only internal)
2. Protective figure installation
3. Courage and strength resources
4. Container for overwhelming emotions
5. Future template for safety

**Restricted Processing Approach:**

*Therapist: "We'll process the fear from last night's incident, but not challenge your overall vigilance—that's keeping you safe right now. We can fully process once you're in a safe environment."*

**First Responder Protocols**

Special considerations for police, firefighters, EMTs, military:

**Cultural Competence:**

*Therapist: "I know in your profession, showing vulnerability isn't easy. This isn't about weakness—it's about maintaining your operational readiness."*

*First Responder: "I can't afford to break down."*

*Therapist: "EMDR actually prevents breakdown by processing the trauma before it gets stuck. Think of it as mental equipment maintenance."*

**Dosing Approach:**

Process one incident per session to maintain functioning:

*Therapist: "You've responded to multiple traumatic calls. We'll take them one at a time, starting with the one that bothers you most when off-duty."*

**Acute Stress Disorder Interventions**

**Early Intervention Principles:**

1. **Normalize responses:** *Therapist: "Your symptoms—hypervigilance, intrusive memories, avoidance—are normal responses to abnormal situations."*
2. **Install adaptive information:** *Therapist: "Your survival system worked perfectly—you're alive. Now we help it recognize the danger has passed."*
3. **Prevent consolidation:** *Therapist: "Processing now, while memories are still forming, can prevent PTSD development."*

**Complex Emergency Situations**

**Multiple Incident Exposure**

*Client: "Three separate attacks in one week. I don't know which to process."*

*Therapist: "Let's create a timeline. We'll process them chronologically, as each may have made you more vulnerable to the next."*

**Witness Trauma**

*Client: "I couldn't help them. I just watched them die."*

*Therapist: "Witness trauma carries unique pain—the helplessness of observing. What did you do after witnessing?"*

*Client: "Called 911, stayed with them."*

*Therapist: "You didn't do nothing. You did what was possible. Let's process the helplessness and find the helper." [BLS]*

**Vicarious Traumatization**

For therapists, journalists, aid workers:

*Client/Therapist: "I can't stop seeing my client's trauma images."*

*Supervisor: "Vicarious trauma is occupational hazard for us. Let's process these intrusive images while strengthening your professional boundaries."*

**Post-Disaster EMDR Applications**

**Natural Disaster Protocol:**

*Day 1-3: Safety and stabilization only* *Week 1: Begin R-TEP if stable* *Week 2-4: Process worst moments* *Month 2-3: Address ongoing triggers* *Month 3+: Future templating for recovery*

**Clinical Example - Earthquake Survivor:**

*Therapist: "The earthquake was two weeks ago. What disturbs you most now?"*

*Client: "The sound. Any rumble terrifies me."*

*Therapist: "Let's process the original sound memory, then install discrimination between earthquake sounds and normal city sounds."*

**Module 6 Quiz**

**Question 1:** The Recent Traumatic Event Protocol (R-TEP) differs from standard EMDR by: a) Avoiding any processing of the trauma b) Including chronological narrative development and extended preparation c) Only using cognitive techniques d) Requiring hospitalization

**Answer: b) Including chronological narrative development and extended preparation** *Explanation: R-TEP modifications include extended preparation for safety, chronological processing through narrative development, and emphasis on present triggers and future templating, adapting to the ongoing consolidation of recent memories.*

**Question 2:** When working with ongoing trauma (such as domestic violence), the therapist should: a) Refuse to provide any treatment b) Process all trauma immediately c) Focus on resource building and process only what's safe while developing a safety plan d) Tell the client to leave immediately

**Answer: c) Focus on resource building and process only what's safe while developing a safety plan** *Explanation: With ongoing trauma, safety is paramount. Treatment focuses on building internal resources, processing what can be safely addressed without eliminating necessary protective responses, and developing concrete safety plans.*

**Question 3:** The Group Traumatic Episode Protocol (G-TEP) incorporates: a) Only individual therapy b) Competitive processing c) Drawing and butterfly hug self-administration within a group setting d) Avoiding any bilateral stimulation

**Answer: c) Drawing and butterfly hug self-administration within a group setting** *Explanation: G-TEP allows for efficient treatment of multiple trauma survivors by combining group psychoeducation with individual processing using drawing for expression and self-administered butterfly hugs for bilateral stimulation.*

**Module 7: Special Populations and Protocol Modifications**

**Duration: 120 minutes**

**EMDR with Children and Adolescents**

Developmental considerations fundamentally alter EMDR application across pediatric populations.

**Developmental Modifications by Age**

**Early Childhood (Ages 3-6):**

*Preparation Adaptations:*

*Therapist: "We're going to play a special game that helps scary feelings get smaller. First, let's make a magical safe place. Where would you like to be?"*

*Child: "With my puppy in my room!"*

*Therapist: "Perfect! Can you draw that for me?"*

[Child draws]

*Therapist: "Now let's make it stronger with butterfly hugs. Can you show me how a butterfly moves its wings?"*

**Middle Childhood (Ages 7-11):**

*Cognitive Adaptations:*

*Therapist: "When the bad thing happened, your brain got confused and stored it wrong—like putting a library book on the wrong shelf. EMDR helps your brain put the memory where it belongs."*

*Child: "So it won't bother me anymore?"*

*Therapist: "Right. It becomes just a story about something that happened, not something happening now."*

**Adolescence (Ages 12-17):**

*Engagement Strategies:*

*Therapist: "I know this might seem weird—waving fingers and stuff. But the research is solid. Think of it like defragging a computer hard drive."*

*Teen: "Whatever. Let's just get this over with."*

*Therapist: "I get the skepticism. How about we try one small thing first, see if you notice any difference?"*

**Play Therapy Integration**

**EMDR Through Play:**

*Therapist: "Let's have your teddy bear tell the story about what happened."*

*Child: [Through bear] "The bad man scared me."*

*Therapist: "Teddy was so brave. Let's help Teddy feel better. Can you and Teddy do butterfly wings together?"*

[Child hugs self while holding bear]

*Therapist: "What does Teddy notice now?"*

*Child: "Teddy feels stronger!"*

**Parental Involvement Protocols**

**Parent as Resource:**

*Therapist to Parent: "You'll be your child's co-regulator. When we practice the butterfly hug at home, you do it with them."*

*Parent: "What if they get upset during the week?"*

*Therapist: "Use the 'magic rainbow' we installed. Remind them: 'Remember your rainbow? Let's paint it in the air together.' Then call me if needed."*

**EMDR with Complex PTSD and Dissociative Disorders**

**Phase-Oriented Treatment**

**Stabilization Phase (Months 1-6+):**

*Therapist: "With your level of dissociation, we'll spend significant time building internal cooperation before processing."*

*Client: "But I want the memories gone now."*

*Therapist: "Think of it like surgery—we need to ensure you're stable enough for the procedure. Rushing could cause more fragmentation."*

**Working with Dissociative Parts**

**Parts Mapping:**

*Therapist: "Let's map your internal system. Who inside needs to be consulted before we process?"*

*Client: "The protector won't let us. The little one is terrified."*

*Therapist: "Can we negotiate with the protector? What would help them feel safe enough to allow healing?"*

**Modified Processing:**

*Therapist: "We'll process with all parts observing from a safe distance first. Everyone watch from the conference room while the memory plays on a screen outside."*

**Fractionated EMDR**

For severe dissociation—processing in small pieces:

*Therapist: "We'll process just the first minute of the memory today. Everyone inside agree?"*

*Client: "The protector says okay, but only one minute."*

*Therapist: "One minute it is. Protector, you're in charge of the stop signal."*

**EMDR with Addiction and Substance Use Disorders**

**The Addiction Memory Network**

**Targeting Sequence:**

1. Trauma underlying addiction
2. First use memories
3. Progression milestones
4. Relapse triggers
5. Future recovery scenarios

**Clinical Application:**

*Therapist: "Tell me about your first drink."*

*Client: "Fourteen. My father had just hit me. I found his whiskey."*

*Therapist: "So alcohol became connected to escaping pain. Let's process that original pain first, then the association with alcohol."*

**Urge Reduction Protocol**

**Processing Triggers and Cravings:**

*Therapist: "Rate your craving 0-10 when you imagine your trigger situation."*

*Client: "Seeing the bar? It's a 9."*

*Therapist: "Hold that image and notice where you feel the craving in your body." [BLS]*

*Client: "The craving is dropping... it's like a 5 now."*

*Therapist: "Continue." [BLS]*

**EMDR with Medical Trauma and Chronic Pain**

**Pain Protocol**

**Targeting Pain Memories:**

*Therapist: "When did the pain first begin?"*

*Client: "The surgery. I woke up during it."*

*Therapist: "That traumatic awakening may be maintaining your pain response. Let's process that memory."*

**Phantom Limb Pain**

*Therapist: "Even though your leg is gone, your brain still has the leg's memory. We'll process the trauma of loss and update your brain's body map."*

*Client: "You mean the pain might stop?"*

*Therapist: "Many clients find significant relief once we process the amputation trauma and grief."*

**EMDR with Military and Combat Trauma**

**Moral Injury Protocol**

*Veteran: "It wasn't fear. I did things that go against everything I believed."*

*Therapist: "Moral injury is different from PTSD. The wound is to your conscience. Let's process not just what happened, but what it meant to you."*

*Veteran: "I can't forgive myself."*

*Therapist: "We're not aiming for forgiveness yet—just understanding the impossible situation you were in." [BLS]*

**Military Cultural Competence**

*Therapist: "In combat, your training was to never show weakness. Here, processing trauma is a different kind of strength—the courage to heal."*

**EMDR with Intellectual and Developmental Disabilities**

**Simplified Language Protocols**

*Therapist: "Bad thing happened. Made you sad. We make sad smaller."*

*Client with ID: "Sad here [points to chest]."*

*Therapist: "Good showing me. Watch my hand. Think of sad." [Slower BLS]*

*Client: "Sad getting little!"*

**Caregiver-Assisted EMDR**

*Therapist to Caregiver: "You'll be my co-therapist. When John shows distress at home, you'll guide the butterfly hug we practiced."*

**EMDR with Older Adults**

**Life Review Integration**

*Therapist: "At 80, you have a lifetime of experiences. Some unprocessed traumas may be surfacing now. It's never too late to heal."*

*Older Client: "I never told anyone about the war. Seemed pointless after all these years."*

*Therapist: "Your brain has been carrying this for 60 years. Let's give it the chance to finally put it to rest."*

**Cognitive Decline Considerations**

*Therapist: "With your memory challenges, we'll work with feelings and sensations more than detailed memories. Your body remembers even when your mind doesn't."*

**Cultural and Linguistic Adaptations**

**Using Interpreters**

*Therapist: "We'll have the interpreter present, but during processing, I'll ask them to be silent so your natural language can flow."*

*Client: [Processes in native language]*

\*Therapist: "What are you noticing?"

*Interpreter translates response*

**Cultural Metaphors**

*Therapist: "In your culture, how do people describe emotional healing?"*

*Client: "Like washing the spirit clean."*

*Therapist: "Beautiful. As we process, imagine the bilateral movement as waves washing your spirit clean."*

**Module 7 Quiz**

**Question 1:** When using EMDR with young children (ages 3-6), the most appropriate modification is: a) Using standard adult protocol without changes b) Avoiding EMDR entirely c) Integrating play therapy techniques and simplified language d) Having parents do the therapy

**Answer: c) Integrating play therapy techniques and simplified language** *Explanation: Young children require developmental adaptations including play therapy integration, simplified language, storytelling through toys or drawings, and active parental involvement as co-regulators.*

**Question 2:** In Phase-Oriented Treatment for complex PTSD with dissociation, stabilization typically requires: a) 1-2 sessions b) Several months or longer c) No specific timeframe d) Immediate processing

**Answer: b) Several months or longer** *Explanation: Complex PTSD with dissociation requires extensive stabilization (often 6+ months) to build internal cooperation, develop resources, and ensure sufficient stability before trauma processing begins.*

**Question 3:** When working with moral injury in veterans, EMDR focus shifts to: a) Only the fear-based components b) Processing the meaning and conscience wounds c) Avoiding military experiences d) Immediate forgiveness

**Answer: b) Processing the meaning and conscience wounds** *Explanation: Moral injury involves violations of deeply held moral beliefs, requiring processing of not just what happened but what it meant to the person and the wound to their conscience, different from fear-based PTSD.*

**Module 8: Integration, Ethics, and Professional Development**

**Duration: 90 minutes**

**Integrating EMDR with Other Therapeutic Modalities**

EMDR rarely exists in isolation but rather integrates with comprehensive treatment approaches.

**EMDR and Cognitive-Behavioral Therapy**

**Sequential Integration:**

*Therapist: "We'll use CBT skills for stabilization and EMDR for processing. Your thought logs help identify targets, and EMDR resolves the emotional charge behind negative thoughts."*

**Combined Approach Example:**

*Session Structure:*

* Check-in and homework review (CBT)
* Identify cognitive distortions
* Target underlying memory with EMDR
* Develop balanced thoughts (CBT)
* Assign behavioral experiment

*Clinical Dialogue:*

*Therapist: "Your thought log shows 'I'm a failure' appearing repeatedly. When's the first time you remember thinking this?"*

*Client: "When I failed third grade."*

*Therapist: "Let's process that memory with EMDR, then build new balanced thoughts from a cleared emotional foundation."*

**EMDR and Psychodynamic Therapy**

**Depth-Oriented EMDR:**

*Therapist: "Your transference reaction to me seems connected to early attachment wounds. Let's process those original relational traumas."*

*Client: "You mean my anger at you is really about my mother?"*

*Therapist: "The template was likely formed then. After processing, we can explore how it plays out in our relationship and others."*

**EMDR and Somatic Approaches**

**Body-Informed Processing:**

*Therapist: "Notice that habitual shoulder tension. Let your body show you when it first learned to hold that pattern."*

*Client: "I'm eight, bracing for my father's rage."*

*Therapist: "Let's process that body memory with bilateral stimulation while staying aware of your shoulders."*

**EMDR and Mindfulness-Based Therapies**

**Mindful Processing:**

*Therapist: "Bring mindful awareness to the trauma memory—observing without judgment, like clouds passing."*

*Client: "I can watch it without being in it."*

*Therapist: "Maintain that observer stance while we add bilateral stimulation."*

**Ethical Considerations in EMDR Practice**

**Competence and Training Requirements**

**Ethical Standard:** Only practice within competence boundaries.

**Clinical Scenario:**

*Client: "I have DID. Can you help me?"*

*Therapist: "I have basic EMDR training but haven't specialized in dissociative disorders. I can refer you to a colleague with that expertise, or I could pursue additional training if you're willing to wait."*

**Informed Consent for EMDR**

**Comprehensive Consent Elements:**

\*Therapist: "Before we begin EMDR, I need to explain the process, risks, and benefits:

* EMDR can temporarily increase distress before improvement
* Processing continues between sessions
* Some memories might surface unexpectedly
* Physical sensations may occur
* You maintain complete control and can stop anytime
* Success rates are high but not guaranteed
* Alternative treatments are available

Do you have questions about any of this?"\*

**Managing False Memory Concerns**

**Ethical Approach:**

*Client: "What if I remember something that didn't happen?"*

*Therapist: "EMDR doesn't create memories but processes existing ones. We focus on your current symptoms rather than determining historical accuracy. If legal proceedings are involved, we need to discuss implications."*

**Boundary Considerations**

**Touch and EMDR:**

*Therapist: "Some forms of bilateral stimulation involve touch—like tapping your hands. Are you comfortable with that, or would you prefer visual or audio methods?"*

*Client: "No touch please."*

*Therapist: "Absolutely. We'll use eye movements or sounds instead."*

**Professional Development and Consultation**

**Continuing Education Requirements**

**EMDRIA Certification Path:**

1. Basic training (Level 1 & 2)
2. 10 hours consultation
3. 25 sessions with 50 clients
4. Passing certification exam
5. Ongoing CE requirements

**Case Consultation Example**

*Presenting to Consultant:*

*Therapist: "My client loops on self-blame despite multiple interweaves. She insists she caused her abuse."*

*Consultant: "What's her developmental age at trauma onset?"*

*Therapist: "Four years old."*

*Consultant: "Try a developmental interweave: 'What is a four-year-old's only job?' Often it's just 'to be a kid' that unlocks processing."*

**Developing EMDR Expertise**

**Specialization Areas:**

* Attachment trauma
* Dissociative disorders
* Addiction protocols
* Pain protocols
* Performance enhancement
* Recent trauma protocols

**Vicarious Trauma and Therapist Self-Care**

**Recognizing Vicarious Trauma:**

*Supervisor: "I notice you're seeming burned out. How many trauma sessions weekly?"*

*Therapist: "About 20 EMDR sessions."*

*Supervisor: "That's intensive exposure. What's your self-care protocol?"*

*Therapist: "I haven't really had one."*

*Supervisor: "Let's develop one. Some therapists even self-administer bilateral stimulation after difficult sessions."*

**Therapist Self-Care Protocol:**

1. Regular personal therapy
2. Peer consultation
3. Varied caseload
4. Bilateral stimulation for self
5. Mindfulness practice
6. Physical exercise
7. Creative outlets

**Documentation and Risk Management**

**EMDR-Specific Documentation:**

*Progress Note Example:*

"EMDR session #3 targeting childhood abuse (age 7). Began Phase 4 (Desensitization) with SUD 9. Processed through multiple channels including somatic (tension), emotional (fear to anger to sadness), and cognitive (self-blame to appropriate responsibility). Used developmental interweave when client looped. Some abreaction appropriately managed. Ended at SUD 0, installed PC 'I was an innocent child' to VoC 7. Clear body scan. Client stable using safe place for closure. Between-session processing expected. Plan: Check for aspects next session, then target school bullying memory."

**Building an EMDR Practice**

**Marketing Considerations:**

*Elevator Pitch Example:* "I specialize in EMDR, a research-proven therapy that helps your brain naturally heal from trauma. Unlike traditional talk therapy, EMDR processes disturbing memories so they stop triggering current distress. Most clients see significant improvement in 6-12 sessions."

**Research and Evidence-Based Practice**

**Staying Current:**

Essential journals:

* Journal of EMDR Practice and Research
* European Journal of Psychotraumatology
* Journal of Traumatic Stress

**Contributing to Research:**

*Therapist: "I'm collecting outcome data for all my EMDR cases. Would you consent to your anonymized data contributing to research?"*

*Client: "If it helps others, absolutely."*

**Quality Assurance**

**Fidelity Monitoring:**

Regular checks:

* Following all 8 phases
* Appropriate target selection
* Adequate BLS sets
* Proper interweave use
* Complete installation
* Thorough body scan

**Module 8 Quiz**

**Question 1:** When integrating EMDR with other therapeutic approaches, the best practice is: a) Never combine EMDR with other methods b) Use EMDR for processing and other approaches for stabilization and integration c) Only use one approach per client d) Always use EMDR alone

**Answer: b) Use EMDR for processing and other approaches for stabilization and integration** *Explanation: EMDR integrates well with other modalities. CBT skills aid stabilization, psychodynamic work explores patterns, and somatic approaches inform body awareness. Integration creates comprehensive treatment.*

**Question 2:** Informed consent for EMDR should include information about: a) Only the benefits b) Temporary distress increase, between-session processing, and maintaining client control c) Guaranteed success d) Nothing specific to EMDR

**Answer: b) Temporary distress increase, between-session processing, and maintaining client control** *Explanation: Ethical informed consent includes potential temporary distress increase, processing between sessions, possible memory surfacing, physical sensations, client control, success rates, and alternatives.*

**Question 3:** For therapist self-care when providing intensive EMDR treatment, recommended strategies include: a) Ignoring vicarious trauma symptoms b) Seeing only trauma clients to specialize c) Regular consultation, varied caseload, and personal self-care protocols d) Working without breaks

**Answer: c) Regular consultation, varied caseload, and personal self-care protocols** *Explanation: Intensive trauma work requires deliberate self-care including regular consultation, varied caseload to prevent oversaturation, personal therapy, and active self-care protocols including possibly self-administered bilateral stimulation.*

**Module 9: Advanced Clinical Practicum and Case Studies**

**Duration: 120 minutes**

**Complex Case Conceptualization**

**Case Study 1: Multiple Trauma with Dissociation**

**Background:** Sarah, 35, presents with complex PTSD from childhood sexual abuse (ages 5-12), domestic violence in her first marriage (ages 22-27), and a recent car accident. She scores 42 on the DES-II.

**Initial Assessment Dialogue:**

*Therapist: "Sarah, with your history and dissociation level, we'll need a careful approach. Tell me about your internal experience."*

*Sarah: "Sometimes I'm watching myself from outside. Other times, I lose hours. Different parts of me seem to have different opinions."*

*Therapist: "These parts developed to help you survive. We'll work with, not against, them. Can we map who's inside?"*

**Treatment Planning:**

Phase 1: Stabilization (Months 1-4)

* Internal communication establishment
* Resource development for all parts
* Container exercises
* Establishing co-consciousness

*Session 10 Example:*

*Therapist: "Can all parts hear me? I'd like to explain EMDR to everyone."*

*Sarah: "The angry teenager says she's listening but doesn't trust you."*

*Therapist: "Angry teenager, thank you for protecting Sarah. What would help you trust this process?"*

*Sarah: "She says prove you won't make us weak."*

*Therapist: "What if we could transform reactive anger into intentional boundary-setting—even stronger protection?"*

**Modified Processing Approach:**

*Session 20 - First EMDR Processing:*

*Therapist: "We'll start with a minor memory all parts agree on. Everyone observe from the conference room while 'adult Sarah' watches the memory on a screen."*

*Sarah: "The little one is scared."*

*Therapist: "Little one, you can hide behind the strong protector and just peek out when you feel safe."*

**Case Study 2: Recent Trauma in Emergency Responder**

**Background:** Marcus, 42, paramedic, witnessed pediatric fatality 72 hours ago. Previous trauma exposure without PTSD, but this incident "broke" him.

**R-TEP Application:**

*Session 1 (Day 3 Post-Incident):*

*Therapist: "Marcus, your nervous system is still actively processing. We'll work with, not against, this natural process."*

*Marcus: "I can't get her face out of my mind. She looked like my daughter."*

*Therapist: "That connection makes this especially painful. Let's process chronologically. Start from the call coming in."*

*Marcus: "Dispatch said pediatric emergency..."*

[Processing each segment as it arises]

*Therapist: "Notice that part. Just notice." [BLS]*

*Marcus: "I'm remembering my training kicked in. I did everything right."*

*Therapist: "Your professional self functioned perfectly even while your parent self was terrified. Hold both truths." [BLS]*

**Case Study 3: Addiction with Underlying Trauma**

**Background:** Jennifer, 28, alcohol use disorder, sober 30 days. Drinks to "numb out" from sexual assault at 19.

**Integrated Treatment Approach:**

*Session 8 - Targeting Trauma-Addiction Link:*

*Therapist: "Now that you're stabilized in recovery, let's explore the connection between the assault and your drinking."*

*Jennifer: "I had my first blackout drink the night after it happened."*

*Therapist: "So alcohol became your anesthesia. Let's process the assault, then the association with alcohol."*

**Processing Sequence:**

1. Original assault (Sessions 8-10)
2. First drink memory (Session 11)
3. Progression memories (Sessions 12-13)
4. Relapse triggers (Sessions 14-15)
5. Future templates for sobriety (Session 16)

*Session 11 - First Drink Memory:*

*Therapist: "Hold the memory of that first drink after the assault."*

*Jennifer: "I remember thinking 'finally, numbness.'"*

*Therapist: "What do you know now that you didn't then?"*

*Jennifer: "That numbness became a prison."*

*Therapist: "Hold both—the desperate need for relief and the knowledge of where it led." [BLS]*

**Advanced Technical Challenges**

**The Looping Client**

**Clinical Scenario:**

*Client: [After 5 sets] "I keep seeing his face, over and over."*

**Intervention Sequence:**

1. **Change BLS parameters:** *Therapist: "Let's try faster movements with sound added."*
2. **Check for blocking belief:** *Therapist: "What would happen if this image changed?"* *Client: "I might forget to be careful."*
3. **Interweave:** *Therapist: "Can you be careful without carrying his face?"*
4. **Resource interweave:** *Therapist: "Bring in your protective figure to stand between you and the face."*

**The Intellectualizing Client**

*Client: "I understand cognitively that it wasn't my fault, but—"*

*Therapist: "Let's drop below the thoughts. Where in your body does the 'but' live?"*

*Client: "I don't feel anything in my body."*

*Therapist: "Then let's exaggerate. If your body could feel, where would it be?"*

*Client: "I guess... my throat?"*

*Therapist: "Imagine breathing into your throat. What happens?" [BLS]*

*Client: [Suddenly tearful] "Oh god, all the words I never said."*

**The Abreacting Client**

**Managing Intense Abreaction:**

*Client: [Sobbing uncontrollably during BLS]*

*Therapist: [Calm, steady voice, continuing BLS] "That's it. Let it move through. You're safe here. I'm with you. The feelings are leaving through your tears. Keep going."*

[Continue until peak passes]

*Therapist: "Beautiful work. Your system is releasing what it's held for so long. What are you noticing now?"*

*Client: "Exhausted but... lighter somehow."*

**Advanced Interweave Applications**

**The Development Interweave Sequence**

For stuck childhood trauma:

1. **Age check:** *"How old were you?"*
2. **Capability check:** *"What can a [age]-year-old do against an adult?"*
3. **Responsibility check:** *"Whose job was it to protect you?"*
4. **Survival check:** *"What did you do to survive?"*
5. **Success check:** *"And did you survive?"*
6. **Reframe:** *"So you did exactly what you needed to do."*

**The Parts Interweave**

For internal conflict:

*Client: "Part of me wants to let go, part won't."*

*Therapist: "Can the part that won't let go speak?"*

*Client: "It says if I let go, I'll be vulnerable."*

*Therapist: "Thank that part for protecting you. Ask what it needs to know to allow healing."*

*Client: "It needs to know I can protect myself now."*

*Therapist: "Can you show that part your adult resources?"*

**Group EMDR Applications**

**Structure for Group Processing**

**Group of 8 Assault Survivors:**

*Facilitator: "We'll process individually within our group container. Everyone identify your target. When ready, begin your butterfly hug. I'll time us for 2-minute sets."*

[Group processes simultaneously]

*Facilitator: "And pause. Without sharing details, thumbs up if you noticed shift, sideways if same, down if worse."*

[Adjust accordingly]

**Intensive EMDR Protocols**

**Weekend Intensive Structure**

**Friday Evening (3 hours):**

* Assessment and preparation
* Resource installation
* Begin first target

**Saturday (8 hours):**

* Complete first target
* Process 2-3 additional targets
* Install future templates

**Sunday (4 hours):**

* Process remaining aspects
* Integration work
* Closure and planning

**Clinical Management:**

*Therapist: "Intensive EMDR is like surgery versus weekly physical therapy. We'll do in one weekend what might take months weekly. Are you prepared for intense but efficient work?"*

**Module 9 Quiz**

**Question 1:** When working with high dissociation (DES score >40), the first phase of EMDR should focus on: a) Immediate trauma processing b) Months of stabilization and internal communication c) Medication only d) Avoiding EMDR entirely

**Answer: b) Months of stabilization and internal communication** *Explanation: High dissociation requires extended stabilization (typically 3-6+ months) to establish internal communication, develop co-consciousness, and ensure all parts agree to processing before beginning trauma work.*

**Question 2:** In the R-TEP protocol for recent trauma, processing is done: a) Randomly b) Chronologically through the event c) Backwards from the end d) Only cognitively

**Answer: b) Chronologically through the event** *Explanation: R-TEP processes recent trauma chronologically from before the event through to current safety, helping the brain organize and consolidate the memory adaptively while it's still in the active consolidation phase.*

**Question 3:** When a client continually loops on the same material, the intervention sequence should be: a) Stop EMDR permanently b) Change BLS parameters, check for blocking beliefs, then use interweaves c) Process harder d) Refer to another therapist

**Answer: b) Change BLS parameters, check for blocking beliefs, then use interweaves** *Explanation: Looping indicates blocked processing. The systematic approach involves first changing BLS parameters, then checking for blocking beliefs, and finally using targeted interweaves to introduce adaptive information and restart processing.*

**Part Two Comprehensive Examination**

**10-Question Assessment for Part Two**

**Question 1:** The Flash Technique is particularly useful for: a) Simple phobias only b) Extremely disturbing memories that overwhelm the client c) Future templating only d) Resource installation

**Answer: b) Extremely disturbing memories that overwhelm the client** *Explanation: The Flash Technique allows processing of highly disturbing memories by having clients briefly "blink" at the trauma while focusing primarily on positive/neutral content, reducing overwhelming distress during processing.*

**Question 2:** When using EMDR with active addiction, treatment should: a) Never be attempted b) Process trauma underlying addiction after initial stabilization c) Focus only on the addiction d) Require 1 year sobriety first

**Answer: b) Process trauma underlying addiction after initial stabilization** *Explanation: After initial stabilization (usually 30+ days sobriety), EMDR can effectively process trauma underlying addiction, then target addiction-specific memories and install recovery templates.*

**Question 3:** G-TEP (Group Traumatic Episode Protocol) is designed for: a) Individual therapy only b) Mass trauma incidents affecting multiple people c) Children exclusively d) Chronic pain groups

**Answer: b) Mass trauma incidents affecting multiple people** *Explanation: G-TEP efficiently treats multiple trauma survivors simultaneously through group psychoeducation combined with individual processing using self-administered butterfly hugs and artistic expression.*

**Question 4:** Moral injury in military populations requires focusing on: a) Fear and safety only b) Wounds to conscience and meaning c) Physical injuries only d) Avoiding military content

**Answer: b) Wounds to conscience and meaning** *Explanation: Moral injury involves violations of deeply held moral beliefs, requiring processing not just what happened but what it meant to the person's sense of self and values, distinct from fear-based PTSD.*

**Question 5:** With ongoing trauma (domestic violence, war zones), EMDR should: a) Not be provided b) Process everything immediately c) Focus on resource building and process only what's safe d) Wait until all danger passes

**Answer: c) Focus on resource building and process only what's safe** *Explanation: With ongoing trauma, treatment prioritizes resource building and processes only what won't compromise necessary protective responses, while developing concrete safety plans.*

**Question 6:** The Urge Reduction Protocol for addiction addresses: a) Only psychological cravings b) Triggers and cravings through bilateral stimulation c) Medication management d) Group therapy dynamics

**Answer: b) Triggers and cravings through bilateral stimulation** *Explanation: The Urge Reduction Protocol uses EMDR to process addiction triggers and cravings directly, applying bilateral stimulation while focusing on trigger situations to reduce their power.*

**Question 7:** When integrating EMDR with young children (ages 3-6), appropriate modifications include: a) Standard adult protocol b) Storytelling through toys, drawing, and butterfly hugs with caregiver involvement c) No bilateral stimulation d) Cognitive restructuring only

**Answer: b) Storytelling through toys, drawing, and butterfly hugs with caregiver involvement** *Explanation: Young children require developmental adaptations including play therapy integration, storytelling through toys/drawings, simplified language, and active caregiver involvement as co-regulators.*

**Question 8:** Intensive EMDR protocols (weekend intensives) are beneficial because: a) They're cheaper b) They process in days what might take months weekly c) They avoid all side effects d) They require less skill

**Answer: b) They process in days what might take months weekly** *Explanation: Intensive EMDR protocols allow concentrated processing over consecutive days, achieving in a weekend what might take months of weekly sessions, though they require careful planning and client preparation.*

**Question 9:** Phase-oriented treatment for complex PTSD with dissociation typically requires stabilization lasting: a) 1-2 sessions b) 3-6 months or longer c) 1 week d) No specific timeframe

**Answer: b) 3-6 months or longer** *Explanation: Complex PTSD with significant dissociation requires extended stabilization to establish safety, build resources, develop internal communication, and ensure readiness before trauma processing begins.*

**Question 10:** When EMDR processing continues between sessions, clients should be instructed to: a) Try to force more processing b) Keep a brief log of dreams, memories, and insights without analyzing c) Avoid thinking about the session d) Process with friends and family

**Answer: b) Keep a brief log of dreams, memories, and insights without analyzing** *Explanation: Clients should observe and briefly log what emerges between sessions (dreams, memories, insights, changes) without attempting to analyze or force processing, allowing natural consolidation to occur.*

**Course Conclusion and Certification**

**Integration of Learning**

Congratulations on completing this comprehensive 15-hour EMDR Level 1 Training. You have acquired foundational knowledge and skills in one of the most powerful and extensively researched trauma treatments available.

**Key Competencies Achieved**

Through this training, you have developed competence in:

1. **Theoretical Understanding:** Mastery of the Adaptive Information Processing model
2. **Clinical Assessment:** Comprehensive evaluation for EMDR appropriateness
3. **Eight-Phase Protocol:** Proficiency in all phases from history-taking through reevaluation
4. **Processing Skills:** Managing abreactions, blocks, and complex processing patterns
5. **Clinical Flexibility:** Adapting protocols for diverse populations and presentations
6. **Integration:** Combining EMDR with other therapeutic approaches
7. **Ethical Practice:** Understanding scope, competence, and ethical considerations
8. **Special Applications:** Recent trauma, group protocols, and intensive formats

**Continuing Your EMDR Journey**

**Next Steps:**

1. **Practice:** Begin with simple, single-incident traumas
2. **Consultation:** Seek regular consultation, especially for complex cases
3. **Documentation:** Maintain detailed records of your EMDR sessions
4. **Self-Care:** Implement regular self-care protocols
5. **Continued Learning:** Pursue Level 2 training and specialized protocols

**Resources for Continued Learning**

* EMDR International Association (EMDRIA): www.emdria.org
* EMDR Institute: www.emdr.com
* Journal of EMDR Practice and Research
* Regional EMDR associations and study groups
* Specialized protocol trainings

**Final Reflections**

EMDR represents more than a technique—it's a comprehensive approach to healing that honors the brain's natural capacity for adaptive processing. As you begin integrating EMDR into your practice, remember:

* Every client's processing is unique
* Trust the process while maintaining clinical judgment
* Small changes can cascade into profound transformation
* Your presence and attunement are as important as the protocol
* Healing happens in relationship

**Certification Requirements**

To receive your certificate of completion for 15 CE hours, you must:

* Complete all modules
* Pass both Part One and Part Two examinations with 80% or higher
* Submit course evaluation
* Meet attendance requirements

**Closing Message**

As you embark on your EMDR practice journey, carry with you the knowledge that you are offering clients a path from suffering to healing, from fragmentation to integration, from surviving to thriving. The bilateral stimulation of EMDR mirrors the brain's natural healing rhythms, and as a trained facilitator, you now hold the skills to guide this profound process.

May your practice bring healing to those who suffer, may you find meaning in this sacred work, and may you continue growing in skill and wisdom as an EMDR practitioner.

Thank you for your dedication to learning this transformative approach. The world needs skilled trauma therapists, and through your commitment to excellence in EMDR, you join a global community dedicated to healing trauma and restoring hope.

**Certificate of Completion**

This certifies that you have successfully completed:

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

* Part One: Foundations and Initial Phases (7.5 CE Hours)
* Part Two: Advanced Applications and Special Populations (7.5 CE Hours)

Total Continuing Education Hours: 15

This training meets the education requirements for:

* Licensed Professional Counselors (LPCs)
* Licensed Clinical Social Workers (LCSWs)
* Licensed Marriage and Family Therapists (LMFTs)
* Licensed Psychologists
* Other mental health professionals as approved by licensing boards

*Course Development Team*  
*Last Updated: 2024*  
*Version 1.0*

**Important Note:** This training provides foundational EMDR knowledge. Additional consultation and supervised practice are recommended before working with complex presentations. Always practice within your scope of competence and seek consultation when needed.

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