EMDR Level 1 Training: Complete 15-Hour Continuing Education Course

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

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## Course Overview

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

### CE Credit Information

- \*\*Total CE Hours:\*\* 15.0

- \*\*Approved for:\*\* LPCs, LCSWs, LMFTs, Licensed Psychologists, and other mental health professionals

- \*\*Completion Requirements:\*\* Pass all module quizzes and final examination with 80% or higher

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## MODULE 1: History, Research, and Theoretical Foundations

\*\*Duration: 90 minutes | 1.5 CE Hours\*\*

### 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.\*

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## MODULE 2: Client Assessment and Preparation

\*\*Duration: 90 minutes | 1.5 CE Hours\*\*

### 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."\*

2. \*\*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."\*

3. \*\*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."\*

4. \*\*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.\*

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## MODULE 3: Phases 3-6: Assessment Through Body Scan

\*\*Duration: 120 minutes | 2.0 CE Hours\*\*

### 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?"\*

3. \*\*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."\*

2. \*\*Perspective Shift:\*\*

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

3. \*\*Metaphor/Analogy:\*\*

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

4. \*\*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.\*

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## MODULE 4: Phases 7-8 and Session Management

\*\*Duration: 120 minutes | 2.0 CE Hours\*\*

### 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.\*

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## MODULE 5: Advanced Processing Strategies and Cognitive Interweaves

\*\*Duration: 90 minutes | 1.5 CE Hours\*\*

### Understanding Complex Processing Patterns

As clinicians gain experience with EMDR, they encounter increasingly complex processing patterns requiring sophisticated intervention strategies.

### 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.\*

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## MODULE 6: Recent Traumatic Events and Emergency Response Protocols

\*\*Duration: 90 minutes | 1.5 CE Hours\*\*

### 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.\*

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## MODULE 7: Special Populations and Protocol Modifications

\*\*Duration: 120 minutes | 2.0 CE Hours\*\*

### 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.\*

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## MODULE 8: Integration, Ethics, and Professional Development

\*\*Duration: 90 minutes | 1.5 CE Hours\*\*

### 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.\*

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## MODULE 9: Advanced Clinical Practicum and Case Studies

\*\*Duration: 120 minutes | 2.0 CE Hours\*\*

### 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.\*

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## FINAL COMPREHENSIVE EXAMINATION

\*\*30-Question Assessment Covering All Modules\*\*

### Section 1: Foundations and Theory (Questions 1-6)

\*\*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\*\*

\*\*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\*\*

\*\*Question 3:\*\* Which theoretical mechanism explains EMDR through the dual-task nature of holding traumatic memory while tracking bilateral stimulation?

a) Orienting response theory

b) REM sleep hypothesis

c) Working memory theory

d) Interhemispheric communication

\*\*Answer: c\*\*

### Section 2: Assessment and Preparation (Questions 7-12)

\*\*Question 4:\*\* 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\*\*

\*\*Question 5:\*\* 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\*\*

\*\*Question 6:\*\* 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\*\*

### Section 3: Processing Phases (Questions 13-18)

\*\*Question 7:\*\* 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\*\*

\*\*Question 8:\*\* 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\*\*

\*\*Question 9:\*\* 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\*\*

\*\*Question 10:\*\* 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\*\*

\*\*Question 11:\*\* 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\*\*

### Section 4: Session Management (Questions 19-24)

\*\*Question 12:\*\* 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\*\*

\*\*Question 13:\*\* 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\*\*

\*\*Question 14:\*\* "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\*\*

### Section 5: Advanced Techniques (Questions 25-30)

\*\*Question 15:\*\* 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\*\*

\*\*Question 16:\*\* 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\*\*

\*\*Question 17:\*\* 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\*\*

\*\*Question 18:\*\* 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\*\*

\*\*Question 19:\*\* 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\*\*

\*\*Question 20:\*\* 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\*\*

\*\*Question 21:\*\* 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\*\*

\*\*Question 22:\*\* 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\*\*

\*\*Question 23:\*\* 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\*\*

\*\*Question 24:\*\* 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\*\*

\*\*Question 25:\*\* 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\*\*

\*\*Question 26:\*\* 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\*\*

\*\*Question 27:\*\* 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\*\*

\*\*Question 28:\*\* 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\*\*

\*\*Question 29:\*\* 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\*\*

\*\*Question 30:\*\* 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\*\*

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## 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 the final comprehensive examination 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.

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## Certificate of Completion

This certifies that you have successfully completed:

\*\*EMDR Level 1 Training\*\*

\*A Comprehensive 15-Hour Continuing Education Course\*

\*\*Course Components:\*\*

- Module 1: History, Research, and Theoretical Foundations (1.5 CE Hours)

- Module 2: Client Assessment and Preparation (1.5 CE Hours)

- Module 3: Phases 3-6: Assessment Through Body Scan (2.0 CE Hours)

- Module 4: Phases 7-8 and Session Management (2.0 CE Hours)

- Module 5: Advanced Processing Strategies and Cognitive Interweaves (1.5 CE Hours)

- Module 6: Recent Traumatic Events and Emergency Response Protocols (1.5 CE Hours)

- Module 7: Special Populations and Protocol Modifications (2.0 CE Hours)

- Module 8: Integration, Ethics, and Professional Development (1.5 CE Hours)

- Module 9: Advanced Clinical Practicum and Case Studies (2.0 CE Hours)

\*\*Total Continuing Education Hours: 15.0\*\*

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

\*\*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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