

EMDR]]

/EYE Movement
Desensitization &
Reprocessing

EMDR / Kendal Hart Training /

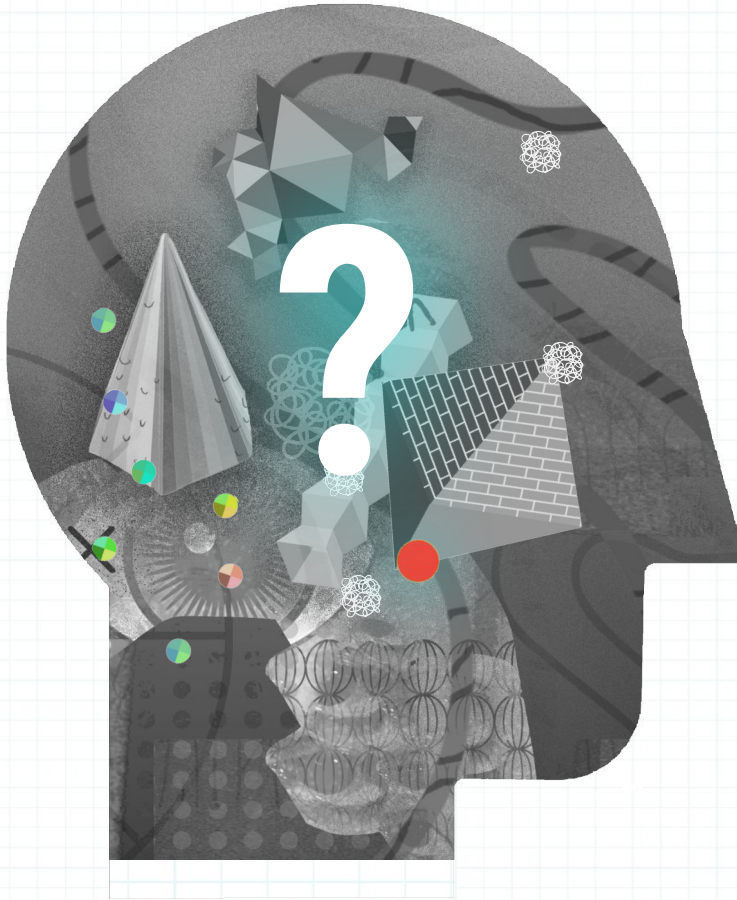
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August, 2025

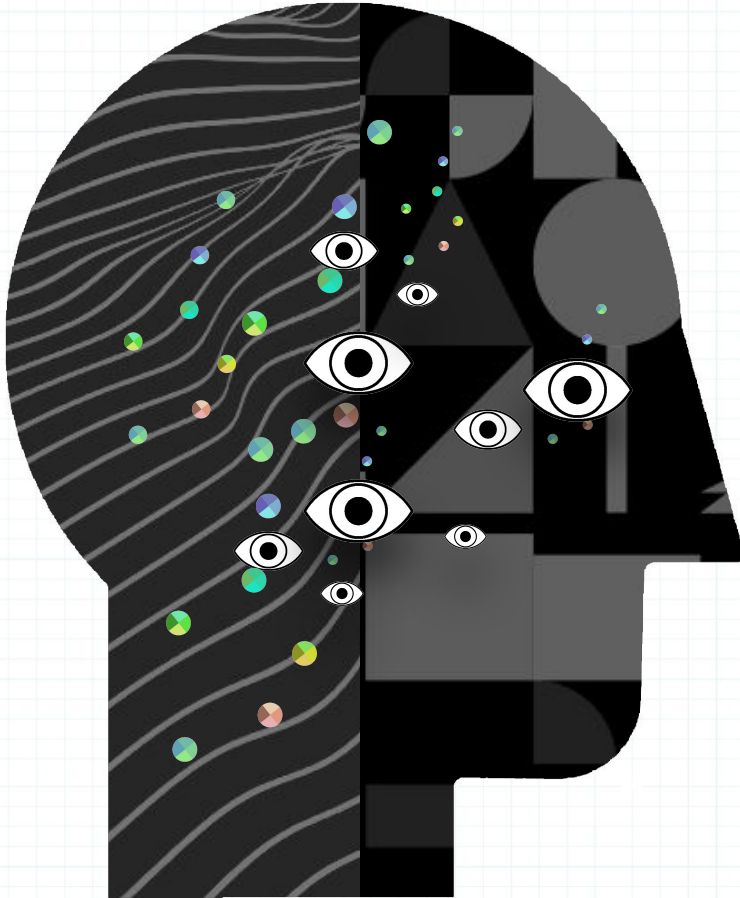


/ What is EMDR?

> EMDR stands for *Eye Movement Desensitization & Reprocessing*.

> EMDR is a psychotherapy approach originally developed by **Francine Shapiro** in the late 1980s, designed to help people process **distressing or traumatic memories**. (Shapiro, 2018)

> At its core, EMDR is based on the **Adaptive Information Processing (AIP) model**, which suggests that traumatic or highly stressful experiences can become **“stuck” in the nervous system in unprocessed form**. These memories may continue to trigger distress, through **flashbacks, body sensations, or emotional responses**, even long after the event. (Shapiro, 2018)



/ EMDR is Experiential & integrative:

- > EMDR is often described as an **integrative therapy** rather than a single “pure” approach, because it draws from and combines multiple traditions.
- > **Core Foundations EMDR Combines:**

- ___ **Psychodynamic therapy**

→ Focus on early experiences, unconscious processes, and unresolved memories. EMDR helps bring those “stuck” memories to conscious processing.

- ___ **Cognitive Behavioral**

Therapy (CBT) → Examines how thoughts, feelings, and behaviors are interconnected. EMDR uses **cognitive interweaves** and belief reprocessing (e.g., shifting “I am powerless” to “I can handle this”).

- ___ **Exposure therapy**

→ Like prolonged exposure, EMDR asks clients to recall traumatic events while reducing avoidance, but it integrates bilateral stimulation to reduce distress and reframe the memory.

- ___ **Somatic/body-based**

therapies → EMDR attends to sensations in the body as memories are processed, aligning with somatic experiencing and polyvagal-informed practices.

- ___ **Mindfulness**

→ Clients learn to notice thoughts, emotions, and body states in the moment without judgment, especially when “dual attention” keeps them partly in the present while recalling the past.

- ___ **Person-centered/humanistic**

→ The therapeutic relationship and client’s self-healing capacity are central, echoing Rogers’ emphasis on empathy, unconditional positive regard, and authenticity.

- ___ **Systems theory**

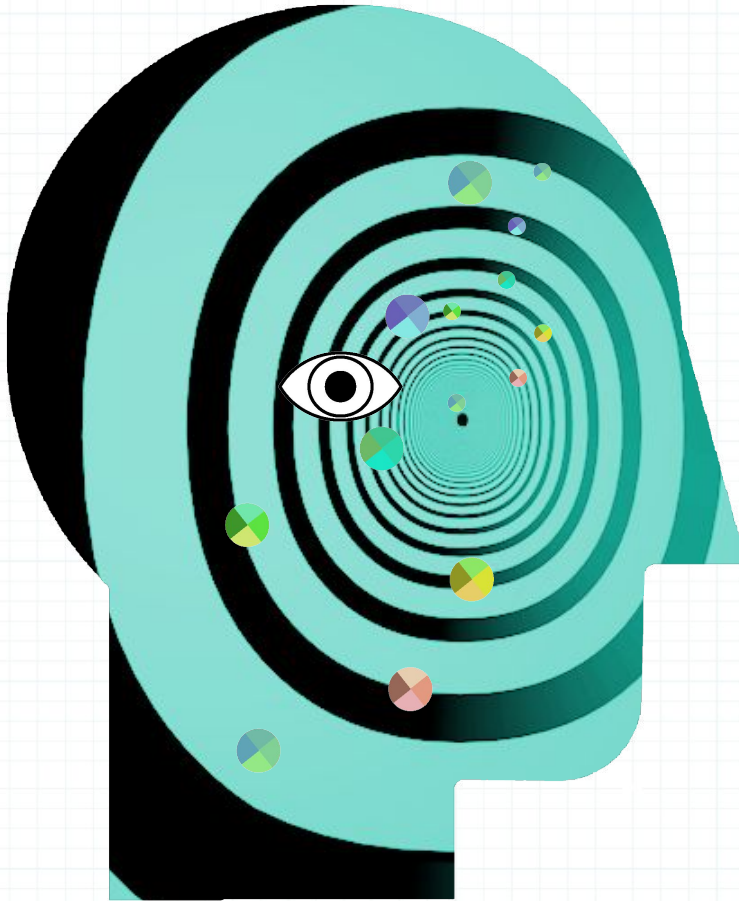
→ EMDR acknowledges that trauma impacts not just the individual but also relational and systemic contexts; some EMDR protocols consider attachment and family systems.



/ EMDR & The Adaptive Information Processing (AIP) Model

> AIP is the theoretical framework underlying EMDR therapy. It proposes that the human brain has an innate ability to process experiences and integrate them into a healthy memory network

> When events are distressing or traumatic, this natural processing system can become "stuck," leaving the memory stored in a maladaptive form, complete with the original *images, thoughts, emotions, and body sensations*, rather than being integrated as part of a resolved narrative..



/ In the AIP model:

— **Unprocessed memories** are thought to be the **root** of current psychological symptoms, influencing how individuals feel, think, and respond to present-day situations.

— **Therapeutic processing** (such as EMDR) helps connect these **maladaptively stored memories** to more adaptive memory networks, allowing new associations, insights, and emotional relief to emerge.

— **Once fully processed**, the memory remains accessible but **no longer triggers** the same intense emotional or physiological responses.



/ 3 pronged approach:

In EMDR, the **three-pronged approach** is one of the core pillars of how treatment is structured. It ensures that therapy isn't just about clearing a single memory, but about healing across **past, present, and future**.

The three-pronged approach prevents EMDR from being "symptom-patching." Instead, it:

- > **Resolves the root** (past).
- > **Interrupts the cycle** (present).
- > **Builds new pathways** (future).

8 Phases of EMDR:

Past → Phases 1, 3, 4

Present → Phases 2, 6, 7, 8

Future → Phase 5 (+ future template work)

1. Past Memories

/ Focus: Identifying and reprocessing the *earliest or most disturbing traumatic experiences* that laid the foundation for current symptoms.

/ Why it matters: Unprocessed memories often carry the "stuck" negative beliefs (e.g., "I'm powerless," "I'm not safe") and raw body sensations that shape how the person responds today.

/ Example: A client with social anxiety may process early school experiences of humiliation that created the core belief, "I don't belong."

2. Present Triggers

/ Focus: Targeting *current situations or stimuli* that activate those old wounds.

/ Why it matters: Even if past trauma is processed, present-day cues (a boss's tone, a certain smell, a partner's expression) can keep reactivating the nervous system.

/ Example: A combat veteran may no longer feel trapped in their war memory, but hearing fireworks in the neighborhood still brings panic.

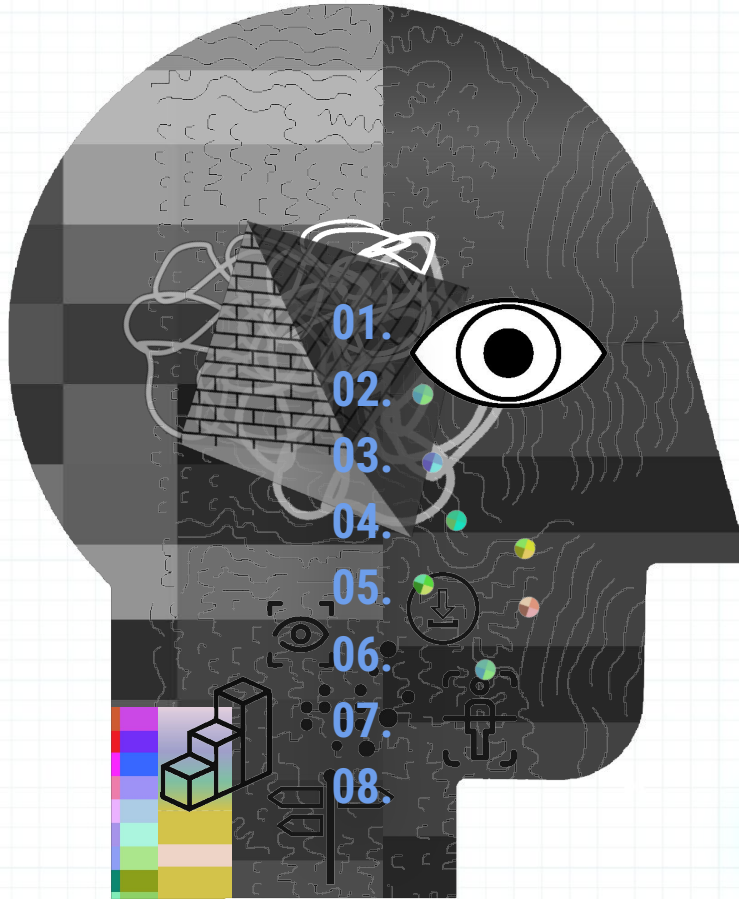
3. Future Templates

/ Focus: Installing new, adaptive ways of responding to future challenges.

/ Why it matters: Healing isn't just about reducing distress, it's about **living forward with resilience and agency**.

/ How it's done: The therapist guides the client to imagine a future scenario (e.g., speaking in public, setting a boundary, going to a doctor's appointment) while embodying the new adaptive belief (e.g., "I can handle it," "I am safe now"). Bilateral stimulation reinforces this "rehearsal."

/ Example: A client who once avoided driving after a car accident imagines driving calmly to work, anchored in the belief, "I am in control."



/ The 8 Phases of EMDR (Shapiro, 2018)

1. History Taking: [6-12 sessions / Basically Talk Therapy / Searching for Core Negative Cognitions (NC)] Gather client background and trauma history. • Identify potential target memories (past traumas, current triggers, feared future scenarios). • Assess readiness and suitability for EMDR (screen for dissociation, stability, etc.).

2. Preparation: [Resourcing] Build therapeutic alliance and provide psychoeducation on EMDR. • Develop stabilization and grounding skills (e.g., safe/calm place, resource installation). • Ensure client understands dual attention (past memory + present safety).

3. Assessment: • Select a **target memory**. • Identify the **image** that represents the worst part. • Identify **negative cognition (NC)** about self (e.g., "I'm powerless"). • Identify **positive cognition (PC)** desired (e.g., "I am in control"). • Rate **VOC (Validity of Cognition)** for the PC (1-7 scale). • Identify **emotions** and **SUD (Subjective Units of Disturbance)** (0-10 scale). • Notice **body sensations** linked to the memory.

4. Desensitization: Client holds the image + NC + body sensations while engaging in **bilateral stimulation (BLS)** (eye movements, taps, tones). • Therapist uses prompts: "Notice that... What do you get now?" • Continue sets until distress decreases and associations shift.

5. Installation: Strengthen the chosen **positive cognition** with bilateral stimulation. • Increase VOC rating until it feels true (goal = 6-7).

6. Body Scan: Ask client to think of the target memory + positive cognition. • Notice any **residual tension or disturbance** in the body. • Use BLS to process any remaining sensations until clear.

7. Closure: Ensure client leaves the session stable and grounded, even if processing wasn't complete. Use containment exercises, safe place, or relaxation if needed. Normalize continued processing between sessions.

8. Reevaluation: At the start of the next session, check if: The distress is still low (SUD). • The positive belief still feels valid (VOC). • Any new material has surfaced that needs processing.

Timing estimates for each phase

01.

HISTORY



6-12 sessions

02.

PREPARATION



1 session

03.

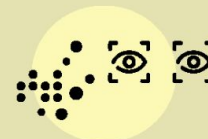
ASSESSMENT



.5 session

04.

DESENSITIZATION



1 session per target
(sometimes many more for complex trauma)

05.

INSTALLATION



[Part of Desensitization]

06.

BODY SCAN



[Part of Desensitization]

07.

CLOSURE



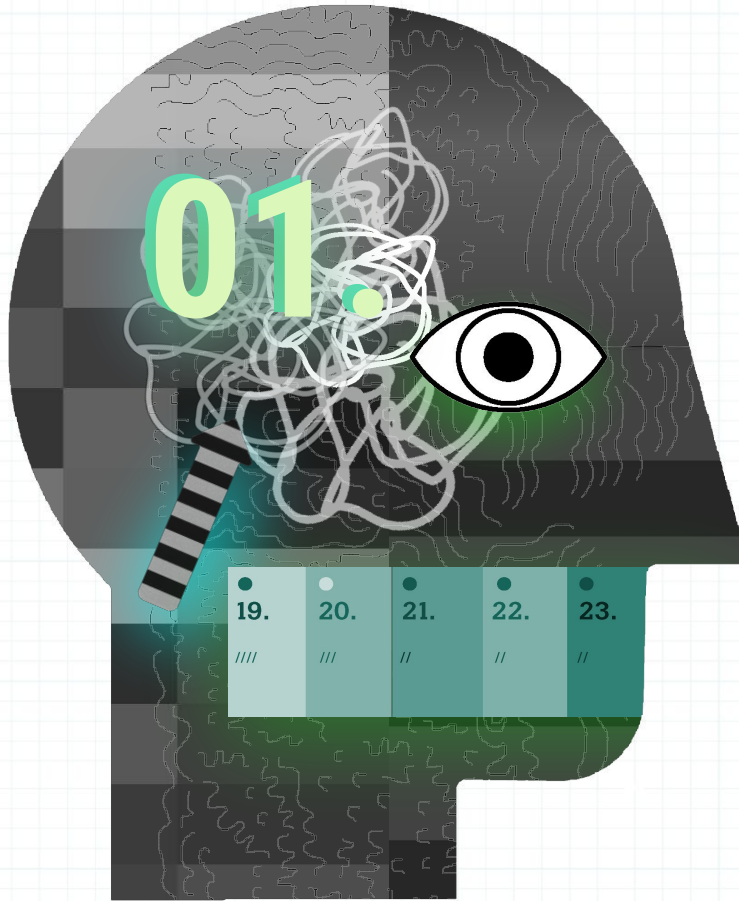
[5-10 at end of session]

08.

REEVALUATION



10-20 Minutes
At beginning of each session



/ How **Phase 01.** *History Taking* works:

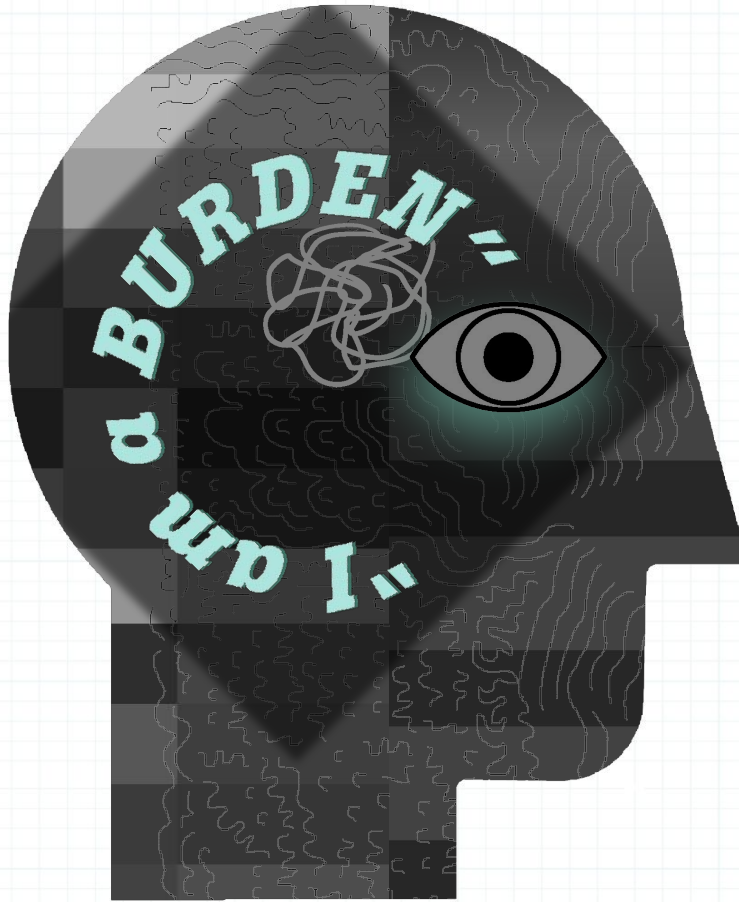
___ **Minimum of 06-12 Sessions:** Searching for core Negative Cognition (NC), or Touchstone Memory (Shapiro, 2018). With Complex trauma there can be many NC's.

___ **Notes are a *MUST*:** Notes are extremely important in this process.

___ **Touchstone Memory/Event-** The earliest memory or experience a client can identify represents the formation of the maladaptive stored memory network. (Shapiro, 2018)

___ **Negative Cognition (NC)-** Negative Belief of self associated with inadequately processed, maladaptive stored negative experience (Shapiro, 2018)

___ **Positive Cognition (PC)-** A positive self-belief is more adaptive than the negative belief being targeted in EMDR. (Shapiro, 2018)



/ Phase 01. Example:

CL: *"I am a burden"* [Core NC?]

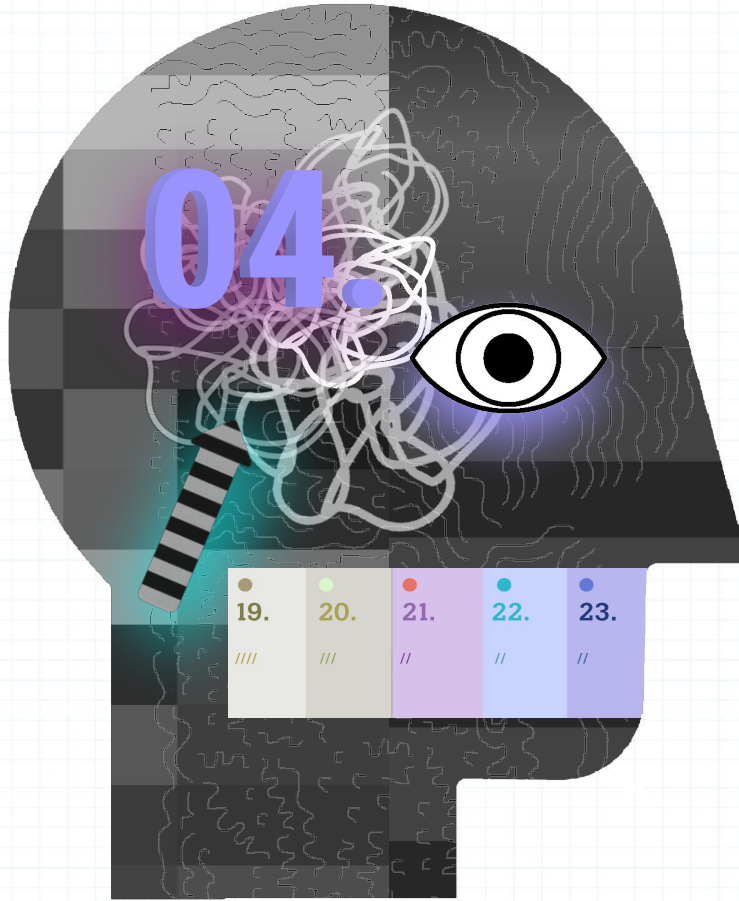
LP: *"Where did you learn that?"* [Core Event]

LP: *"What happens if you were not a burden?"* [PC]

LP: *"You are too smart to feel like that"*

LP: *"When is the first time you remember feeling this way?"* [Core NC?]

LP: *"Do you think your parent sent you a message *don't be a burden*?"* [Image/Event]

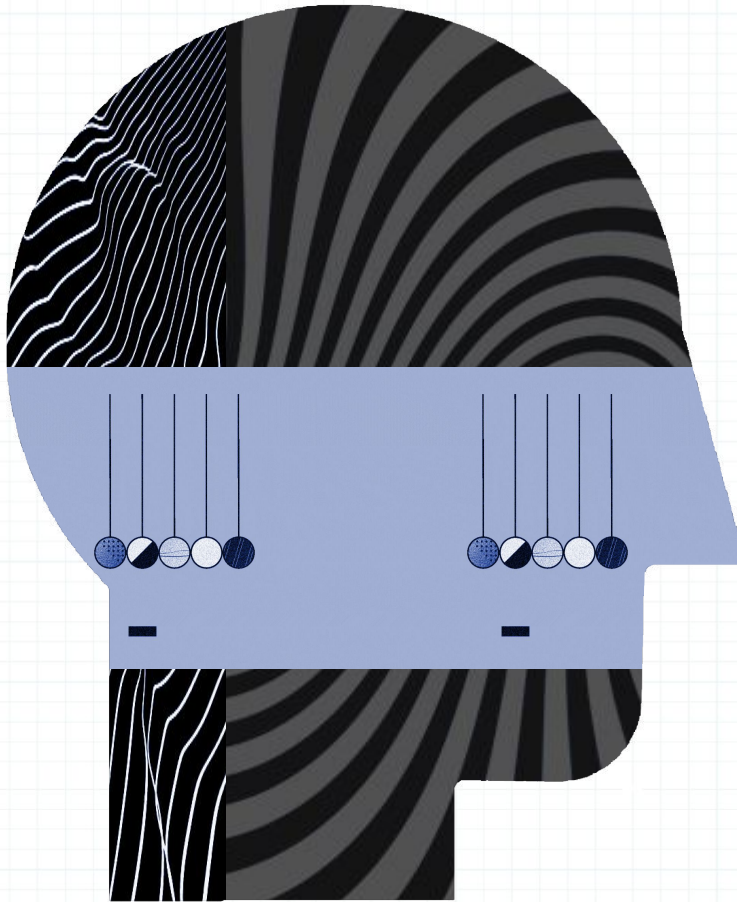


/ How **Phase 04.** *Reprocessing* works:

___ **Bilateral Stimulation:** During Phase 4 of EMDR, a therapist guides the client to recall distressing memories while engaging in bilateral stimulation (such as side-to-side eye movements, alternating sounds, or tapping). (Shapiro, 2018)

___ **Dual Focus:** This dual focus, attending to the memory and the external bilateral stimulation, helps the brain reprocess the memory so it is stored in a more adaptive way. (Shapiro, 2018)

___ **Intensity of Memory:** Over time, the memory itself remains, but its emotional intensity and disruptive impact usually diminish. (Shapiro, 2018)



/ What is Bilateral Stimulation (BLS)?

Bilateral stimulation refers to a rhythmic, alternating pattern of stimulation across the **left and right hemispheres** of the body or sensory system. The focus is **dual-attention**: the client holds the distressing memory in mind while simultaneously tracking external bilateral input.

___. **Eye movements**

(following the therapist's hand or light bar left-right)

___. **Tactile taps**

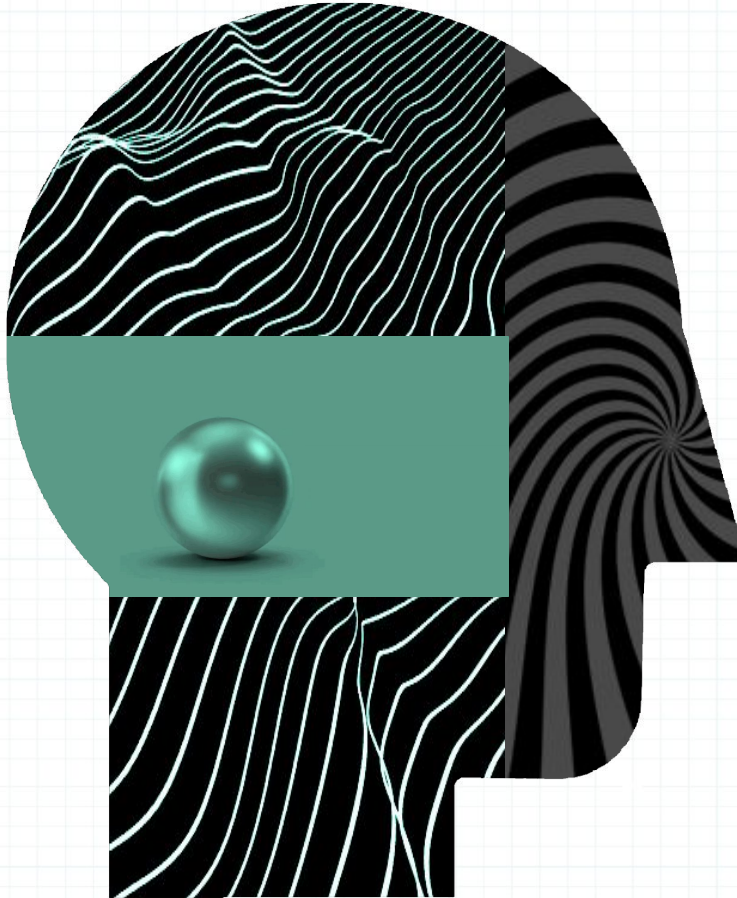
(butterfly hug, buzzers, therapist tapping left/right hands)

___. **Auditory tones**

(alternating left-right beeps through headphones)

___. **Light bar**

(A horizontal bar with moving lights (LEDs) that go back and forth from left to right.)



/ How BLS Works?

Research is still evolving, but several leading theories explain why BLS helps:

1. Accelerated Information Processing

(AIP model – Shapiro, 2018)

- ___ Trauma memories get “stuck” in the nervous system, stored in fragmented form.
- ___ BLS seems to help the brain “reopen” the memory network, linking the old memory with adaptive information.
- ___ The result: memories move from being raw and intrusive → to integrated and “neutral.”

2. Working Memory Taxation Theory

- ___ Holding a vivid traumatic image while performing a demanding task (like tracking eye movements) taxes the **working memory**.
- ___ This makes the memory less vivid and emotionally intense.
- ___ Over time, the memory becomes less disturbing when recalled. *(Think of it like reducing the “volume and resolution” of the memory.)*

3. Orienting Response / Parasympathetic Activation

- ___ The rhythmic, predictable back-and-forth of BLS mimics natural orienting and soothing responses.
- ___ This may activate the **parasympathetic nervous system**, calming the body while distressing material is processed.
- ___ Clients often report feeling more grounded and less “flooded” when BLS is active.

4. REM Sleep Analogy

- ___ Eye movements in EMDR resemble **REM sleep**, when the brain naturally consolidates memories.
- ___ Some researchers propose EMDR mimics this mechanism, allowing traumatic material to be processed during waking therapy.

/ Client Experience

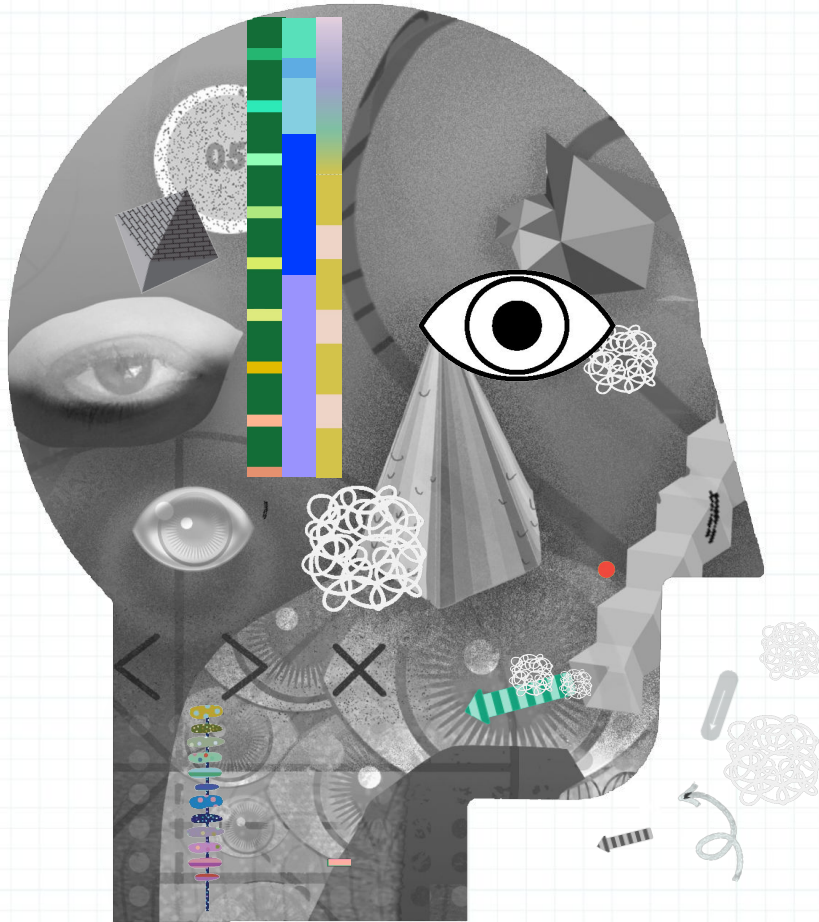
During BLS, clients may notice:

- ___ Memories shifting or new associations emerging.
- ___ Emotions “moving through” more quickly.
- ___ Disturbance decreasing (lower SUD rating).
- ___ Increased ability to access adaptive beliefs.

/ Summary

Bilateral Stimulation is the *engine* of EMDR, it helps the brain reprocess stuck trauma by:

- ___ Linking traumatic memories to adaptive networks (AIP).
- ___ Reducing vividness and distress (working memory).
- ___ Soothing the nervous system (orienting/parasympathetic).
- ___ Mimicking natural processing states (REM sleep).



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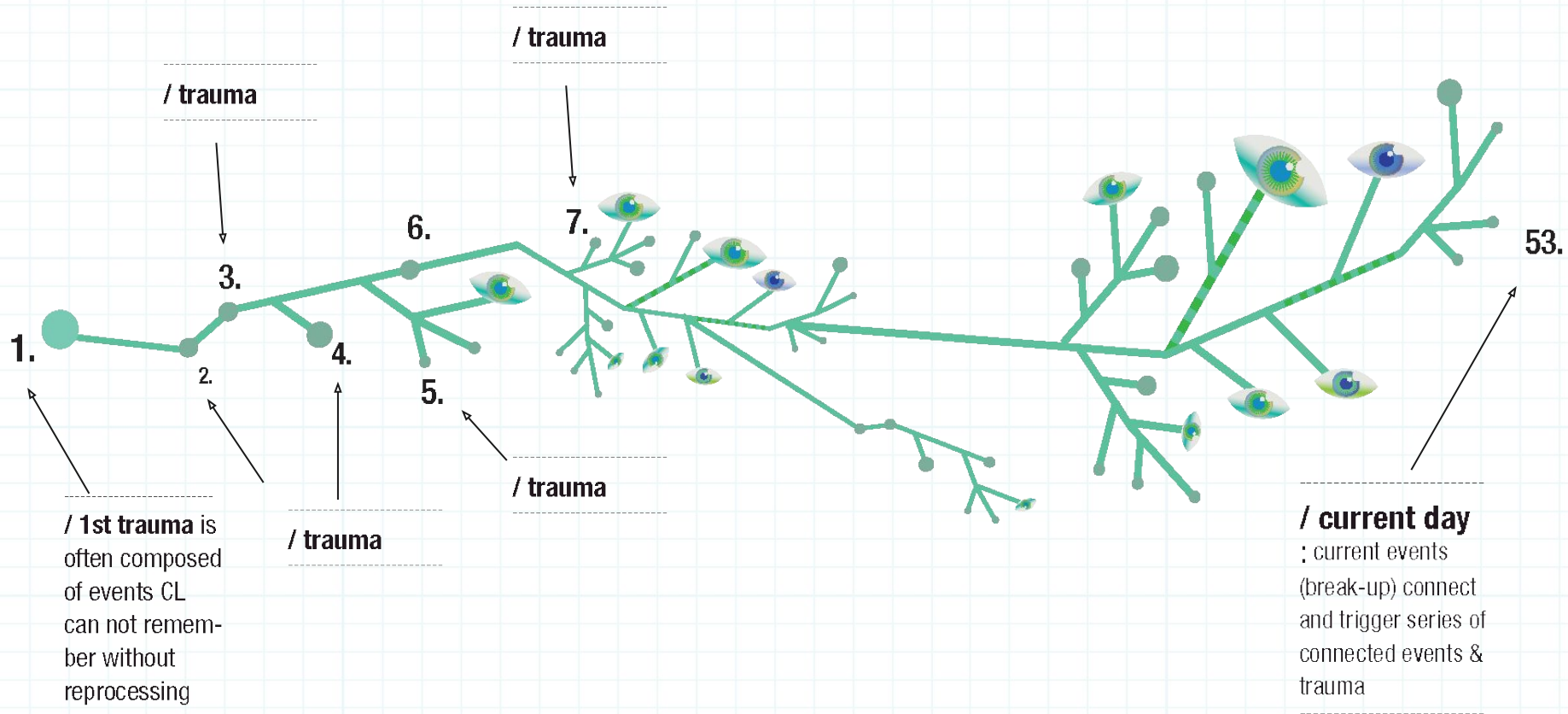
/ Understanding Trauma:

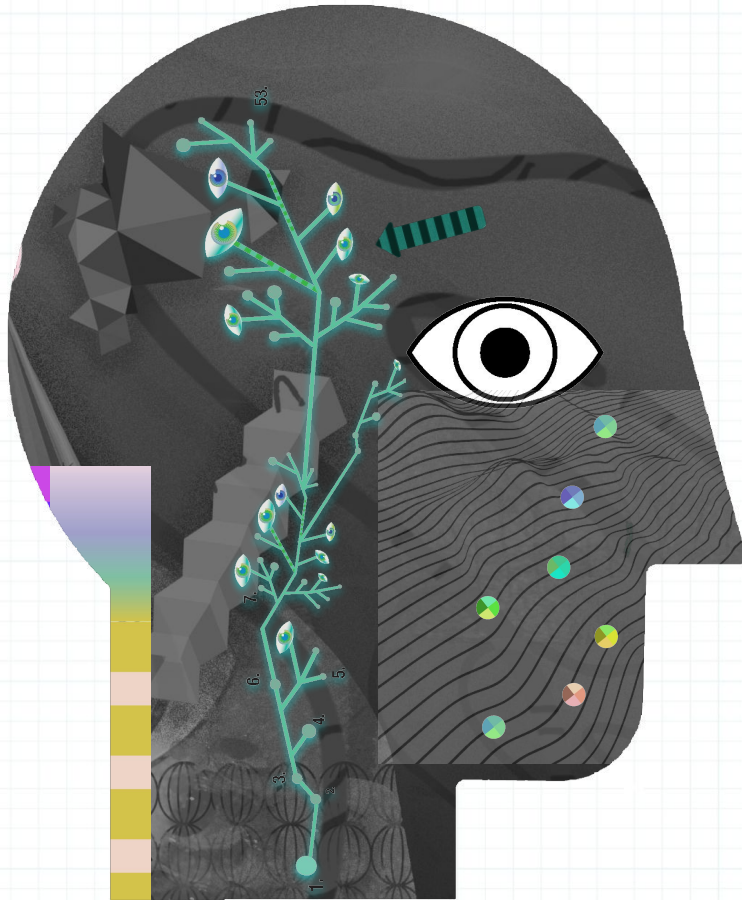
Individuals experience trauma from a variety of sources. The individual's perception of the event impacts the level of trauma.

(Shapiro, 2018)

/ Trauma can be:

- ___ Single incident
- ___ Complex trauma- multiple incidents throughout a lifetime, often involving relational traumas
- ___ Neglect- the absence of emotional, physical, psychological needs met in childhood.
- ___ Physical abuse
- ___ Sexual abuse
- ___ Emotional abuse
- ___ Verbal abuse



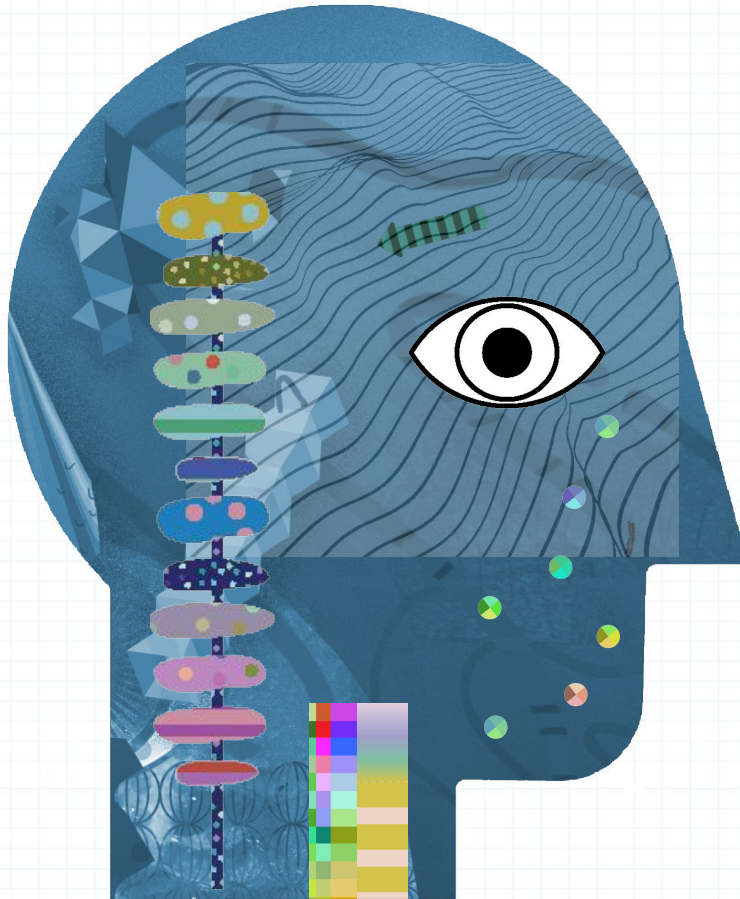


/ Neurobiology of Trauma (Shapiro, 2018)

Trauma alters the way the brain functions. Traumatic stress is associated with increased cortisol & fight-flight-freeze-fawn (norepinephrine) responses to subsequent stressors.

> chemical messenger in the brain and a hormone (released into the bloodstream by the adrenal glands). It plays a central role in the sympathetic nervous system, the "fight, flight, or freeze" response.

> The amygdala often displays increased activity in response to stimuli that trigger a fear response. The hippocampus is also usually smaller in those who have experienced trauma due to elevated stress hormones making it difficult for the brain to identify danger. Volume loss is also found in the ventromedial prefrontal cortex, making it challenging to control reactions and behavior. (Shapiro, 2018)



/ fight-flight-freeze-fawn *Norepinephrine responses*

> When the body or brain releases norepinephrine, several things happen:

Physiological responses (body-level):

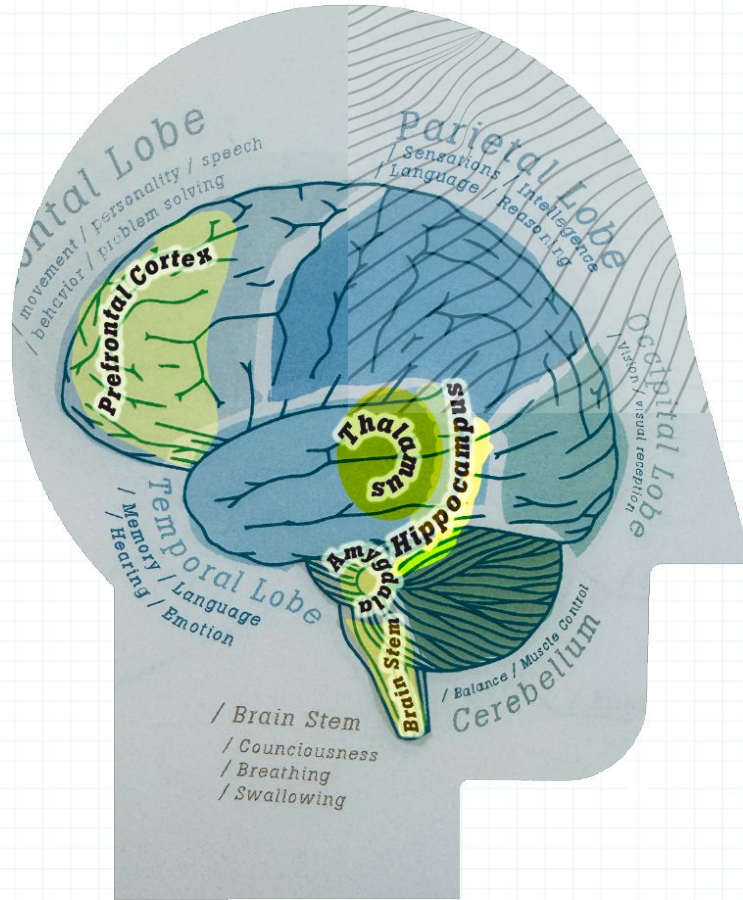
- ___ Increases heart rate and blood pressure
- ___ Expands airways in the lungs
- ___ Increases blood flow to muscles
- ___ Mobilizes glucose (energy) from stores
- ___ Narrows blood vessels in non-essential areas (like skin or digestive tract)

Neurological/psychological responses (brain-level):

- ___ Heightened alertness and vigilance
- ___ Improved attention and focus
- ___ Faster reaction times
- ___ Increased anxiety or stress reactivity in high amounts

Clinical/mental health connections:

- ___ Low norepinephrine activity is linked to **depression, ADHD, brain fog, fatigue.**
- ___ Excess norepinephrine is associated with **anxiety, panic, PTSD hyperarousal, hypertension.**
- ___ Many antidepressants (like SNRIs) and ADHD medications (like stimulants) work in part by **increasing norepinephrine signaling** to improve mood, focus, and energy regulation.



/ Brain Structures Involved in Stress, Memory, and Survival Responses

> How different parts of the brain work together when we perceive, process, and react to danger or emotionally significant events

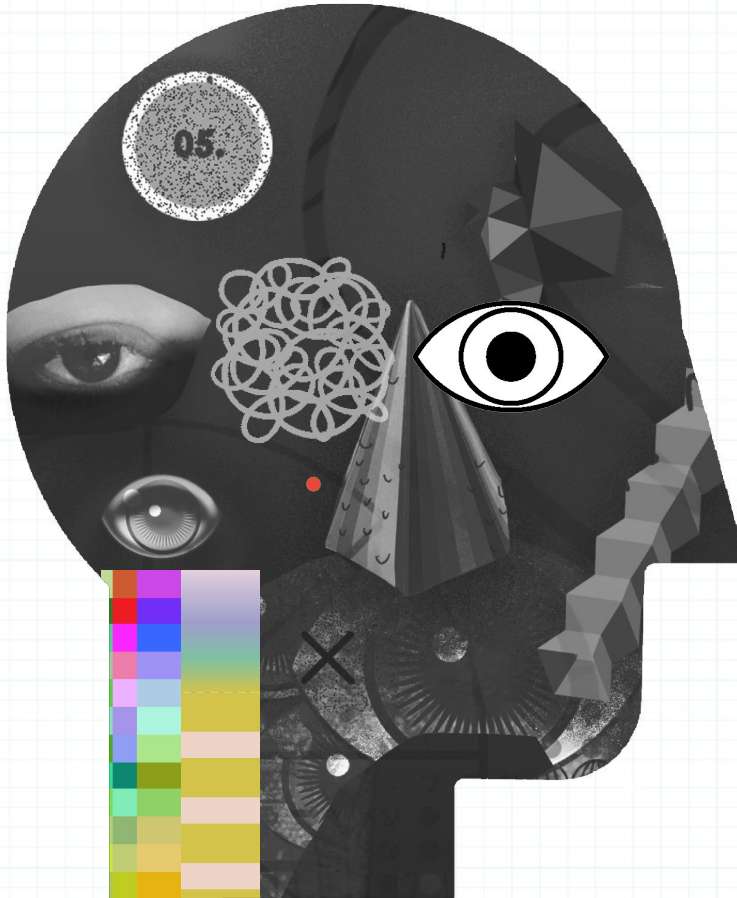
Thalamus → the “relay station” that takes in raw sensory information (sight, sound, touch, smell) and passes it to other brain regions.

Amygdala → the “alarm system,” constantly scanning for danger and attaching emotional meaning (especially fear, threat, or intensity) to sensory input.

Hippocampus → the “memory librarian,” storing facts, consolidating experiences into long-term memory, and linking them to sensory/emotional context.

Prefrontal Cortex → the “executive,” regulating thoughts, decision-making, and self-control — ideally calming or overriding amygdala-driven reactions.

Brain Stem → the “survival switch” or “reptilian brain,” triggering automatic defense mechanisms like fight, flight, freeze, and appease/fawn.

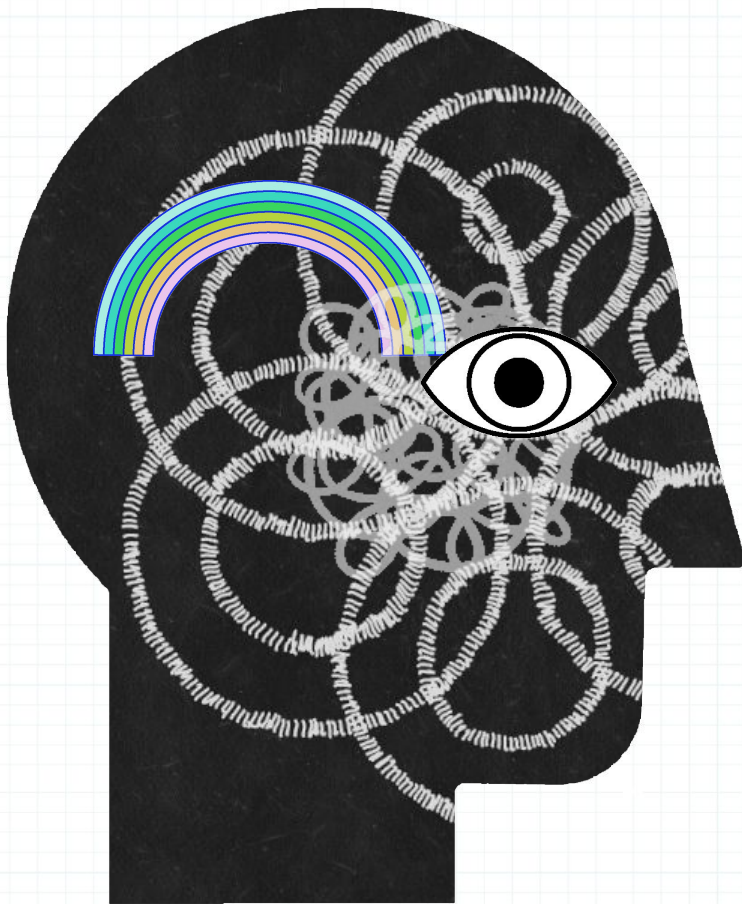


/ What is EMDR used for:

— **PTSD and trauma:** its most well-known application. (Shapiro, 2018; American Psychological Association, 2017)

— **Anxiety, depression, phobias, grief, chronic pain, and medical trauma.** (Hase et al., 2015; Hofmann et al., 2014; Landin-Romero et al., 2018) **Some practitioners are even using it for psychosis.** (Miller, 2015; van den Berg et al., 2015)

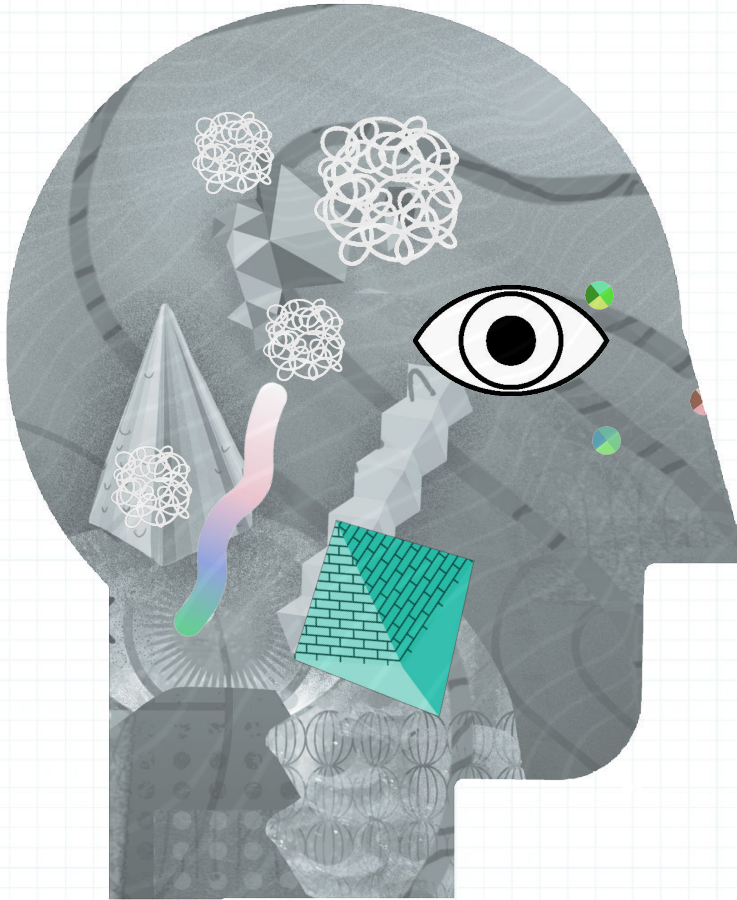
— Emerging adaptations are also being used in **palliative care** (Hase et al., 2008; Bae et al., 2016), **addiction** (Hase et al., 2008; Perez-Dandieu & Tapia, 2014), and with **neurodivergent populations, ADHD, Autism.** (Adler-Tapia & Settle, 2014; Lobregt-van Buuren et al., 2019)



/ Experience for clients

> Many clients report that after successful EMDR processing, the memory feels like it's **"in the past"** rather than something they're **reliving**.

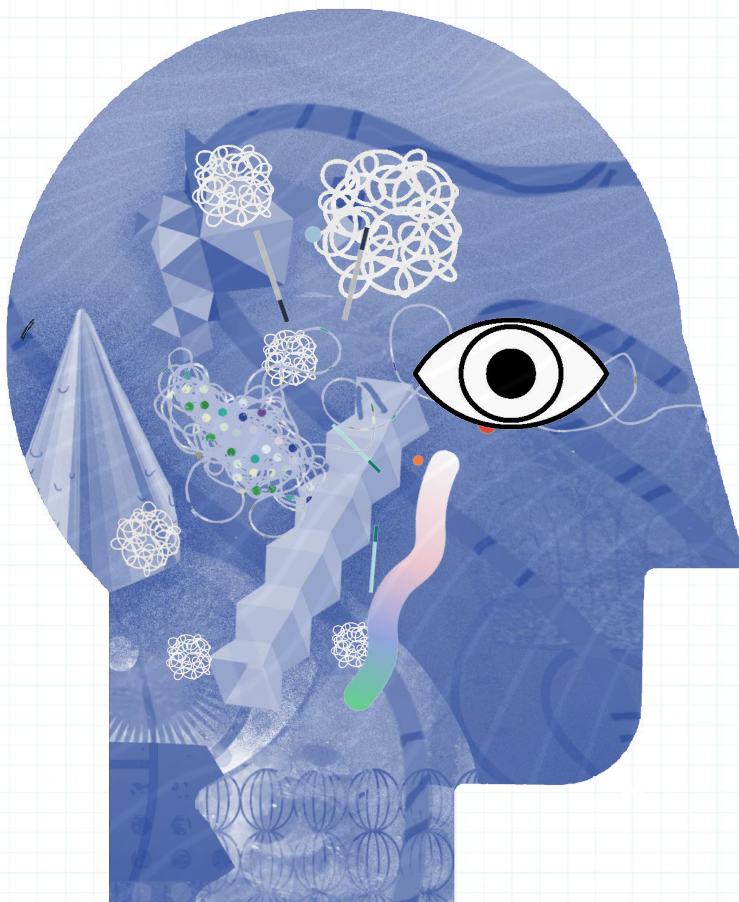
> The body often feels **calmer, and beliefs shift from negative** (e.g., "I'm powerless") **to more adaptive** (e.g., "I survived").



/ Standard EMDR Protocol (Shapiro, 2001)

> The classic structure used for
PTSD and trauma processing.

1. History-taking
2. Preparation (stabilization, resourcing)
3. Assessment (identify target memory, negative/positive cognitions, SUD, VOC)
4. Desensitization (bilateral stimulation + memory processing)
5. Installation (strengthen adaptive belief)
6. Body scan
7. Closure
8. Re-evaluation



/ Other EMDR Protocols

> Commonly Used Adaptations

___ **Recent Traumatic Event**

Protocol (R-TEP) For early interventions, often soon after accidents, natural disasters, or acute trauma.

___ **Group Traumatic Episode**

Protocol (G-TEP) Adaptation of R-TEP for groups, often used in communities after disasters or war.

___ **Phobia Protocol**

For specific phobias (e.g., flying, animals, injections). Incorporates imaginal exposure with EMDR.

___ **Addiction/Craving Protocol**

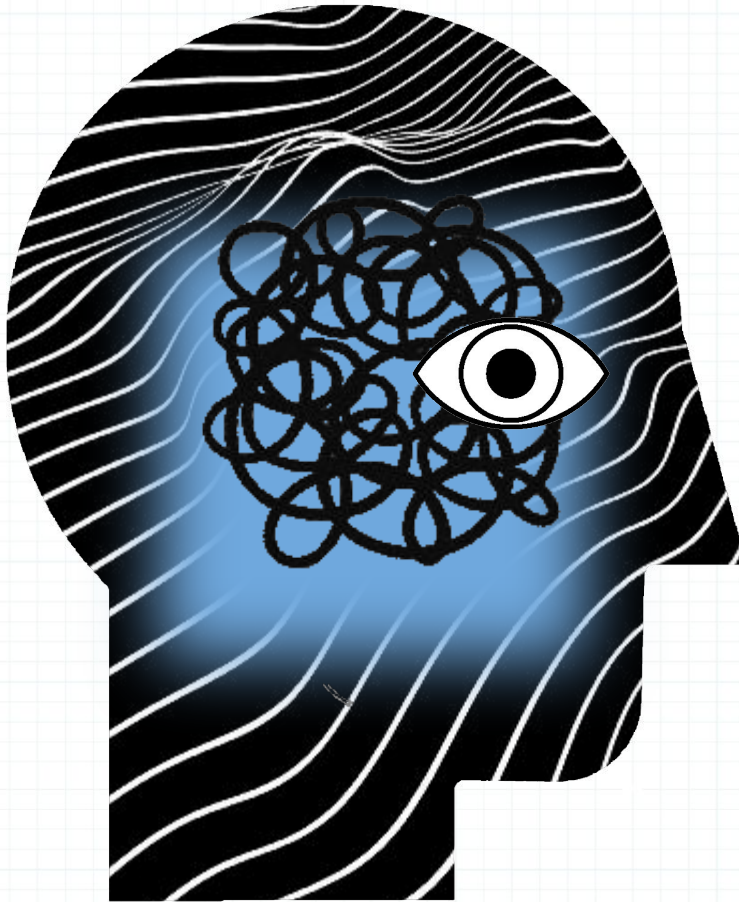
(DeTUR, Popky) Targets the triggers and urges underlying addictive behavior, integrating resource installation.

___ **Pain Protocol**

Used for chronic pain or medically-related trauma; focuses on body memories and pain perception.

___ **Flash Technique** (Manfield, 2017)

Client focuses on a positive engaging image while the traumatic memory is processed indirectly with bilateral stimulation, designed for highly overwhelming trauma.



/ Special Population Protocols

___ **Child EMDR Protocols**

Adapted with more imagery, play, drawing, or storytelling.

___ **Blind-to-Therapist**

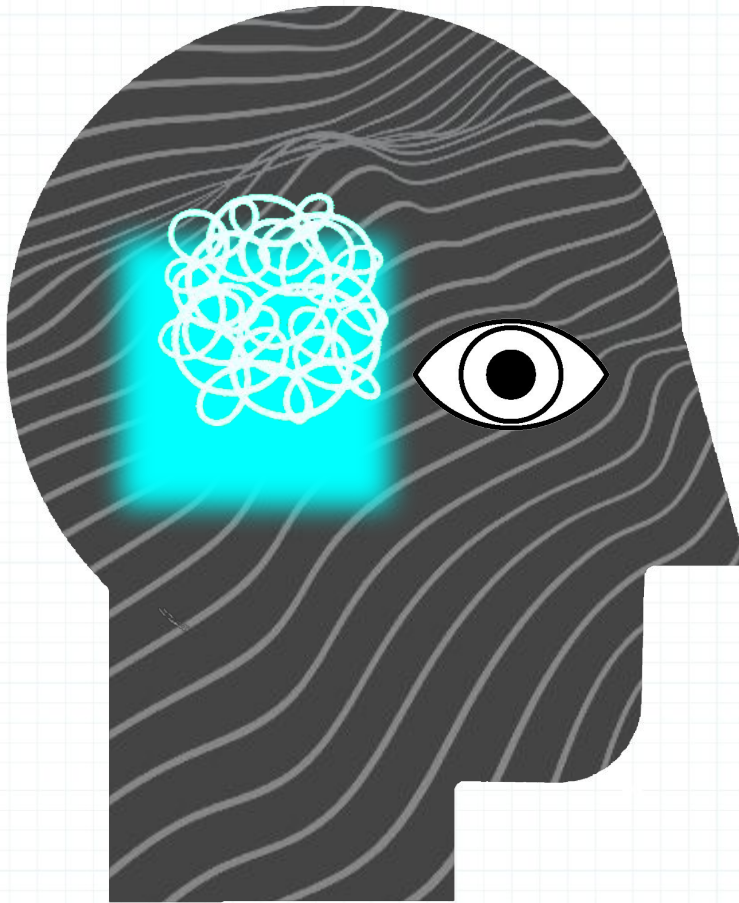
Protocol (Blanchard, 2006)
Client doesn't have to disclose the trauma details; useful with shame, secrecy, or cultural barriers.

___ **Early Trauma**

Protocol (Leeds & Shapiro)
For preverbal trauma or attachment-related wounds.

___ **Recent Event Protocols in Crisis/Palliative Care**

Gentle versions focused on reducing acute distress, enhancing peace, or addressing medical trauma.



/ Specialized Clinical Needs

> These are **specialized clinical strategies in EMDR therapy** that therapists use when the standard process needs extra support, particularly with clients who have more complex presentations (e.g., dissociation, fragility, blocked processing).

___ **Cognitive Interweave**

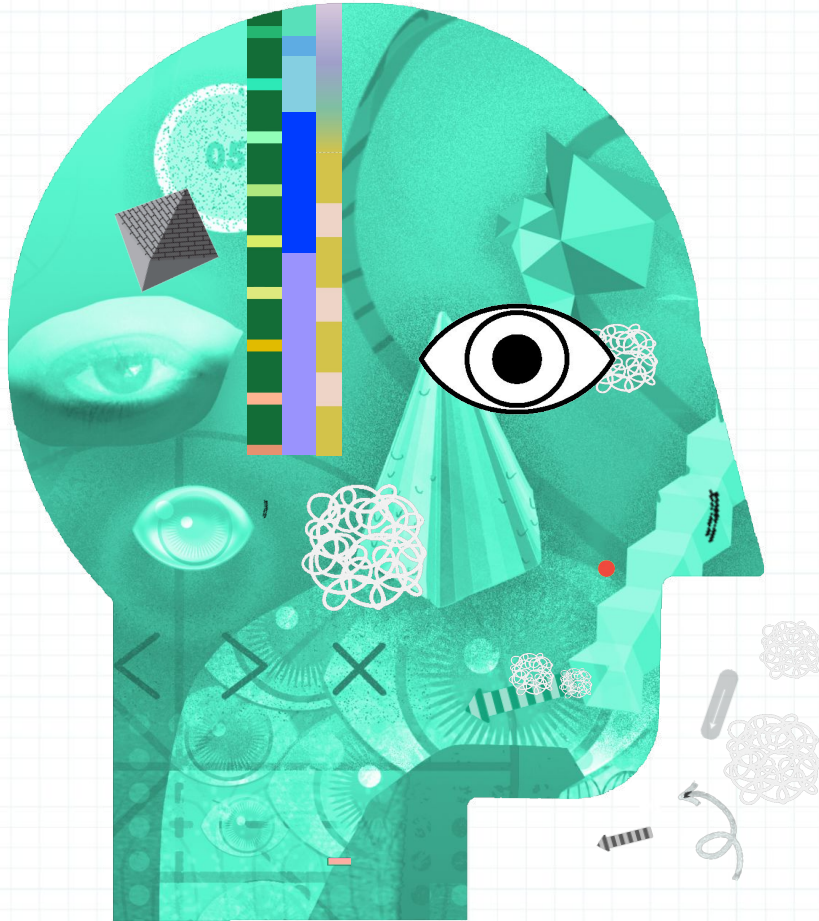
A set of interventions therapists can integrate when processing gets blocked, using gentle prompts, metaphors, or psychoeducation.

___ **Resource Development and Installation (RDI)**

Strengthening inner resources (e.g., safety, nurturing figures) before trauma work.

___ **Constant Installation of Present Orientation and Safety (CIPOS)**

For clients with dissociation or fragility, frequently grounding them in present safety during processing.

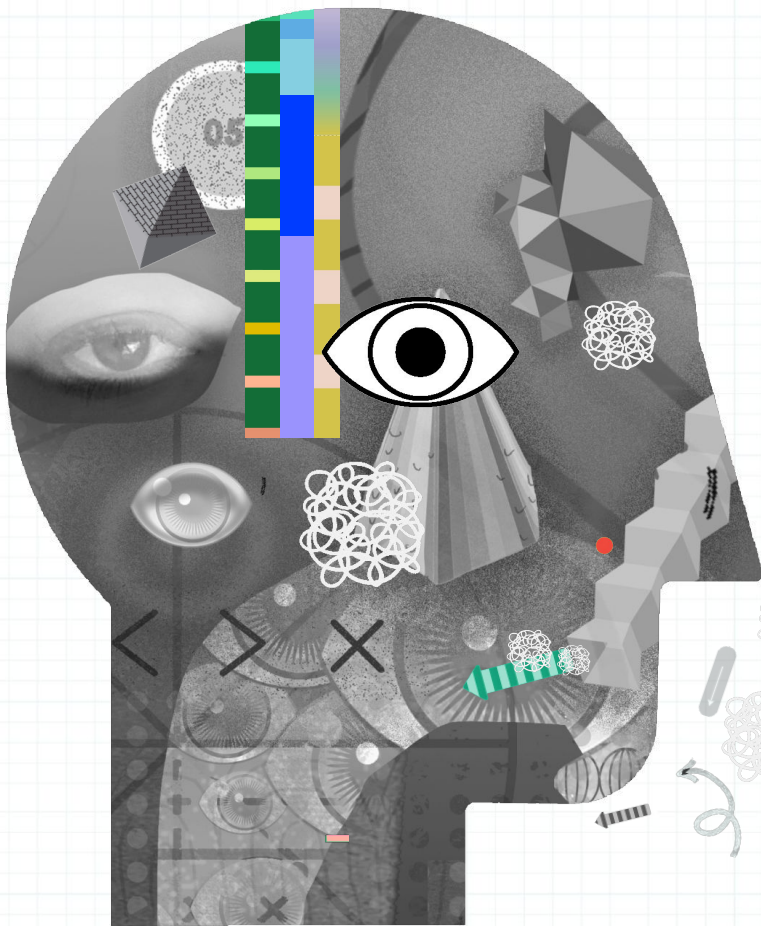


/ What are signs a client could benefit from EMDR

Clients who feel **“stuck in the past,”** experience **trauma symptoms,** or hold **persistent negative beliefs about themselves** often benefit from EMDR, *once safety and resources are in place.*

/ Client Needs to engage in EMDR:

- ___ Clients need to have Nervous System Activation
- ___ Clients need to be able to have one foot in the past and the other foot in the present
- ___ Clients who dissociate are not ready for Phase 04



/ Trauma & Memory-Related Signs

Intrusive symptoms: recurrent flashbacks, nightmares, or distressing images tied to past events.

Avoidance: client avoids reminders of trauma but still feels "haunted" by it.

Frozen memories: they describe a memory as *stuck*, "like it just happened yesterday," with no sense of time passing.

Physiological distress when recalling events: rapid heart rate, sweating, stomach pain, or panic-like symptoms when exposed to triggers.

/ Emotional & Cognitive Signs

Overwhelming affect: emotions flood in ways that feel unmanageable or "too big for the present moment."

Negative self-beliefs: "I'm not safe," "I'm unworthy," "I'm broken." These often stem from traumatic experiences.

Recurrent guilt/shame: especially when disproportionate to current situations.

Emotional numbing or detachment: difficulty accessing feelings or being fully present.

/ Somatic & Medical Signs

Body-based trauma: chronic pain, somatic complaints, or unexplained physical symptoms linked to stress or trauma.

Triggers without words: the client experiences strong body reactions but struggles to verbalize why.

Medical trauma history: distress tied to hospitalizations, procedures, or illness that still lingers.

/ Relational & Developmental Signs

Attachment wounds: strong reactions to abandonment, betrayal, rejection, or unmet childhood needs.

Repeating relational patterns: "I always end up with people who hurt me," often tied to unprocessed early experiences

Motivated for change: they want relief from past burdens and are open to processing.

Can maintain dual awareness: able to notice they are in the present even while touching into past memory (with preparation).

Has some grounding/coping skills: can tolerate distress in session with support (if not yet, Phase 2 of EMDR focuses on building this).

Expresses curiosity about EMDR or alternative approaches when talk therapy feels repetitive or "stuck."

/ When to pause or prepare before EMDR

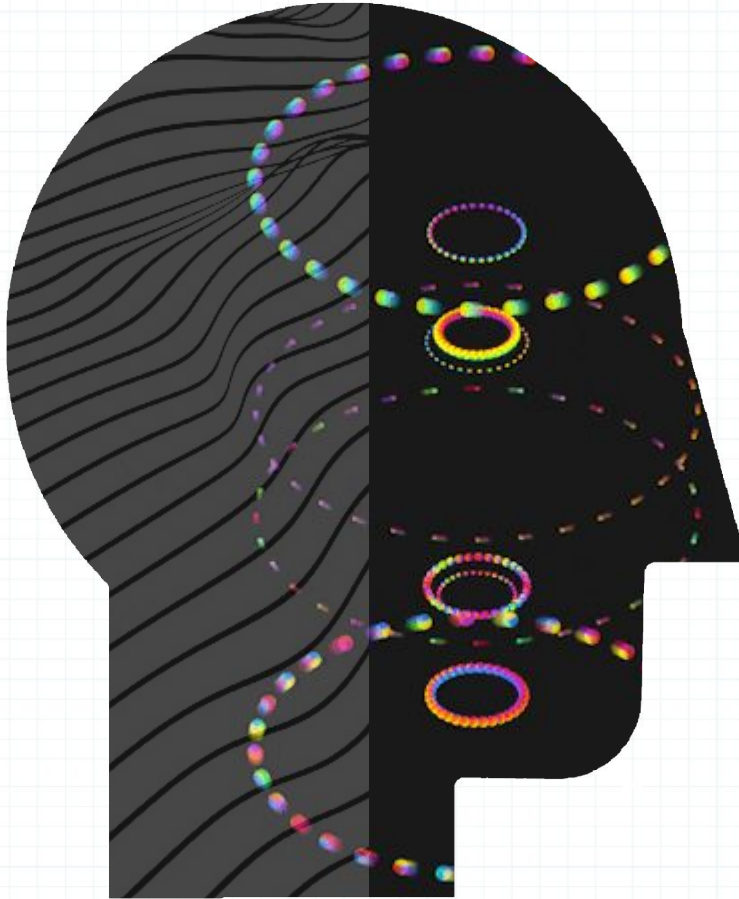
Not every client is ready right away. Red flags for delaying reprocessing (but not necessarily EMDR as a whole) include:

___ Unmanaged dissociation without stabilization strategies.

___ Active substance dependence.

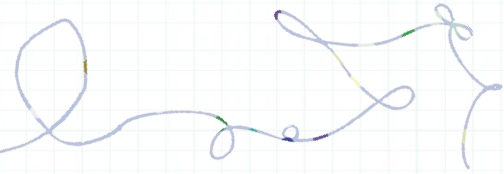
___ Current crisis or unsafe environment.

___ Severe instability in daily functioning.



/ Evidence Based Recognition for EMDR:

EMDR is endorsed by the World Health Organization (WHO), Department of Veterans Affairs, & APA (American Psychological Association) as an evidence-based PTSD treatment.



/ Thank you ! :-)

/ Questions?

/ FAQ's are on the following page :-)

FAQ:

EMDR FAQ for Curious Practitioners

Big-Picture Questions

Q: What exactly is EMDR? Is it hypnosis? Meditation? CBT with eye movements?

A: EMDR (Eye Movement Desensitization and Reprocessing) is a comprehensive psychotherapy approach, not hypnosis or meditation. It has an eight-phase protocol that addresses past trauma, present triggers, and future resiliency. Unlike CBT, EMDR doesn't focus on restructuring thoughts through logic; instead, it helps the brain reprocess unprocessed memories using bilateral stimulation (eye movements, taps, tones).

Q: Why do the eye movements matter? Couldn't you just talk it out?

A: The eye movements (or taps, tones) activate both hemispheres of the brain and engage working memory, which reduces the vividness and emotional intensity of traumatic memories. Talking alone doesn't fully access the stuck neural networks; EMDR helps the brain file memories into adaptive storage.

Q: Does EMDR erase memories?

A: No—memories remain, but their emotional charge decreases. Clients remember what happened but no longer feel flooded, frozen, or overwhelmed by it.

Q: Is it evidence-based or more of an alternative therapy?

A: EMDR is evidence-based. It's recommended by the World Health Organization (WHO), the American Psychological Association (APA), and the U.S. Department of Veterans Affairs (VA) as an effective treatment for PTSD.

Q: Can EMDR really work so quickly, or is that exaggerated?

A: Some clients notice rapid relief after just a few sessions, especially with single-incident trauma. But for complex trauma, attachment wounds, or dissociation, EMDR typically requires a longer process with careful preparation.

Mechanism & Science Questions

Q: How does bilateral stimulation actually help the brain process trauma?

A: It helps the brain access and reprocess stuck traumatic memories by linking them to adaptive networks. Research suggests it mimics processes similar to REM sleep, where the brain naturally integrates memory.

Q: Is it like REM sleep?

A: Yes, the eye movements are thought to resemble REM's bilateral activation. Both involve memory reconsolidation and emotional processing.

Q: Does EMDR change the brain permanently, or just temporarily?

A: Neuroimaging studies suggest lasting changes—clients show reduced amygdala hyperactivation and stronger prefrontal regulation after successful EMDR.

Q: Why do some people cry or feel sensations in their body during EMDR?

A: Trauma is stored in the body as well as the mind. During reprocessing, old somatic memories (tight chest, nausea, trembling) can surface and then release as the nervous system integrates the experience.

Clinical Use Questions

Q: Who is EMDR for? Only veterans or people with PTSD?

A: While EMDR is best known for PTSD, it also helps with anxiety, depression, grief, phobias, chronic pain, and even performance issues. It's widely adaptable.

Q: Can you use EMDR with kids?

A: Yes. EMDR is effective with children and adolescents. Therapists adapt methods (using drawings, stories, sandtray) to help kids access and process memories safely.

Q: Would EMDR help anxiety, phobias, or depression?

A: Yes. Many anxiety or mood symptoms are linked to unresolved experiences. EMDR can reprocess the root memories fueling those symptoms.

Q: What if the client doesn't remember the trauma—can you still do EMDR?

A: Yes. Therapists can target body sensations, emotions, or "felt experiences" even without a clear memory. EMDR can work with implicit memory.

Q: Is EMDR safe for people with dissociation, psychosis, or active addiction?

A: With careful preparation, EMDR can be used with dissociation, though extra stabilization is essential. For psychosis or active addiction, EMDR may be adapted or deferred until safety and stability are established.

Process & Practical Questions

Q: How many sessions does EMDR take?

A: It varies. A single-incident trauma may resolve in fewer than 10 sessions, while complex trauma often requires months or longer.

Q: Do you have to do the whole eight-phase protocol every time?

A: Yes. While the reprocessing phases are central, the full eight-phase structure (history-taking, preparation, assessment, desensitization, installation, body scan, closure, reevaluation) ensures safety and integration.

FAQ:

Q: What happens if the client gets overwhelmed in the middle of a session?

A: Therapists are trained to use grounding, resource installation, and “stop signals” to ensure safety. The client always remains in control.

Q: Do clients have to talk about their trauma in detail?

A: No. Clients only need to hold the memory in mind; they don't have to describe it out loud for EMDR to work.

Q: What's the difference between EMDR 'tapping' I see on TikTok vs. actual EMDR therapy?

A: TikTok “tapping” is usually just a self-soothing technique using bilateral stimulation. True EMDR involves a structured therapeutic protocol with a trained clinician—it's not just tapping or eye movements alone.

Training & Ethical Questions

Q: Can I use bilateral stimulation with my clients without being EMDR-trained?

A: No. EMDR isn't just bilateral stimulation—it's a complex, evidence-based psychotherapy. Using only one element can be ineffective or even destabilizing without proper training.

Q: Do you need a license to practice EMDR, or just the training certificate?

A: You must be a licensed mental health professional (or on a licensure track) and complete EMDRIA-approved basic training. Certificates alone are not enough.

Q: Why is the training so expensive and lengthy compared to what I see online?

A: Because EMDR is an advanced clinical method requiring supervised practice, feedback, and integration of the eight-phase model—not just learning eye movements.

Q: Are there risks if someone does EMDR without proper training?

A: Yes. Poorly applied EMDR can re-traumatize, destabilize dissociative clients, or leave memories unprocessed. Training ensures ethical, safe, and effective use.

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/ Vocabulary Terms

Abreaction- Dysfunctional information is stimulated and experienced at a high level of disturbance, often displayed with intense emotions.

Adaptive Information Processing Model (AIP)- The distinct information processing model represents the cornerstone of the EMDR approach to psychotherapy and guides clinical practice.

Affect Scan- A procedure using a current situation and body sensations to identify a Touchstone Memory.

Bilateral Stimulation (BLS)- Eye movement, tapping, or alternating auditory stimulus is used as dual attention stimuli (external focus) as the client simultaneously focuses on some aspect of the internal experience.

Blocking Belief- Negative beliefs that are blocking progress in reprocessing.

Channels of Associations- Events, thoughts, emotions, etc., within the targeted memory network that spontaneously arise during reprocessing of the identified target (Touchstone Memory or node)

Cognitive Interweave- A strategy that developed to jump-start blocked processing during challenging sessions with more disturbed clients.

Dissociative Experience Scale (DES)- A self-administered questionnaire measuring dissociative symptoms.

Dual Attention Stimulation (DAS)- The experience of simultaneously attending to both internal (thoughts, emotions, sensations) and external (eye movements, tapping, sounds) stimuli.

Negative Cognition (NC)- Negative Belief of self associated with inadequately processed, maladaptive stored negative experience

Positive Cognition (PC)- A positive self-belief is more adaptive than the negative belief being targeted in EMDR.

Set- 25 or more round trip passes of eye movements or other forms of bilateral stimulation (taps, tones) generally used for most clients during processing. Slower & shorter sets of 6-8 are used only during the Preparation Phase for establishing a Calm or Safe Place.

Subjective Units of Disturbance Scale (SUDS)- A scale measuring the level of distress associated with a memory where 0 is no disturbance or neutral and 10 is the highest disturbance or distress one can imagine.

Target- A term used for the incident focused upon reprocessing within the agreed-upon treatment plan.

TICES- Trigger, Image, Negative Cognition, Emotion, and (body) Sensations

Three-Pronged Protocol- The three-pronged protocol consists of past events, present triggers, and future templates. These are components of the EMDR approach to psychotherapy that ensure comprehensive EMDR treatment effects.

Touchstone Memory/Event- The earliest memory or experience a client can identify represents the formation of the maladaptive stored memory network.

Validity of Cognitions Scale (VOC) - The VOC measures how valid or accurate the positive belief (PC) feels as one focuses on the target memory where 1 feels completely false, and 7 feels completely true.

/ Information about training:

EMDR Kendal Hart Training / / 50 Hour Training /

Reading / Book:

Shapiro, F. (2018). *Eye movement desensitization and reprocessing (EMDR) therapy: Basic principles, protocols, and procedures* (3rd ed.). The Guilford Press.

Learning Objectives /

Part 1:

- Conceptualize clients from an EMDR perspective
- Describe an essential premise of the Adaptive Information Processing (AIP) model
- List the components of memory
- Name the 8 phases of EMDR therapy
- Identify the prongs of the Three-Pronged Protocol of EMDR therapy
- Describe criteria of client readiness for EMDR
- Identify the purpose of the Assessment Phase of EMDR therapy
- Describe strategies for assisting a client in staying within the window of tolerance
- Describe how to close a session with an incomplete target memory
- Describe how to resume reprocessing following an incomplete target memory
- Describe when you would apply the Future Template

Part 2:

- Distinguish between a client's presenting problems and underlying issues
- Describe strategies to treat complex trauma with EMDR
- Describe client factors that indicate the need for additional stabilization and resourcing
- Distinguish between a recent traumatic experience and developmental trauma
- Describe a process to select and prioritize target memories appropriate for EMDR treatment
- Describe how to offer a cognitive interweave when the client's reprocessing is blocked
- Identify various types of cognitive interweaves
- Describe clinical symptoms that may indicate the presence of dissociation during a session
- Describe strategies for working with dissociative responses during reprocessing

/ This is a video
that I found that
can be helpful in
explaining Trauma
and the brain. :-)

