
EMDR:
A Rapid and Proven Treatment for Trauma
Jennifer Sweeton PsyD, MS, MA
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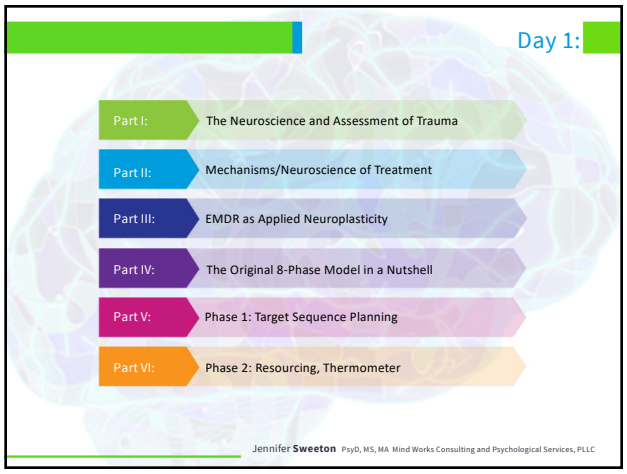
Day 1:
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Part II: Mechanisms/Neuroscience of Treatment
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Part IV: The Original 8-Phase Model in a Nutshell
Part V: Phase 1: Target Sequence Planning
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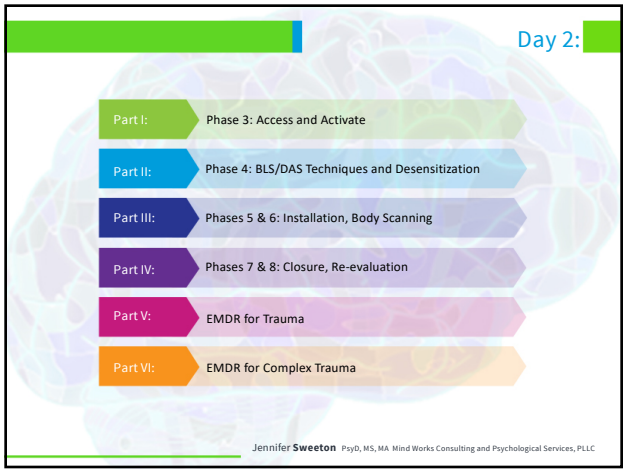
Day 2:
Part I: Phase 3: Access and Activate
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Part IV: Phases 7 & 8: Closure, Re-evaluation
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Welcome to Day 1
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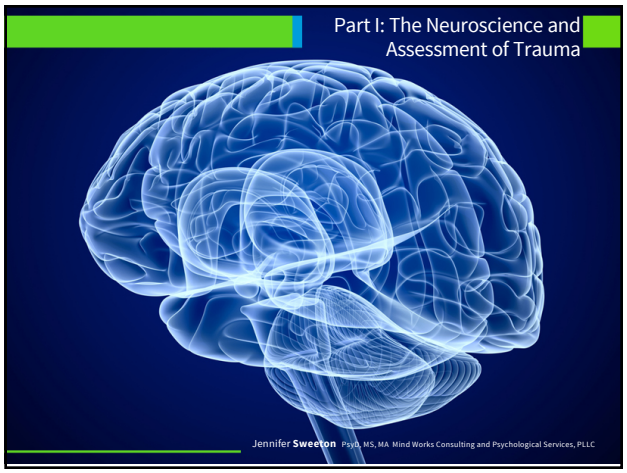
Part I: The Neuroscience and Assessment of Trauma
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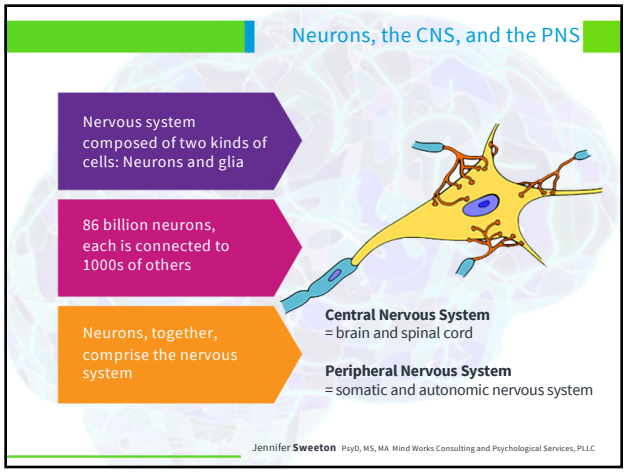
Neurons, the CNS, and the PNS
Nervous system composed of two kinds of cells: Neurons and glia
86 billion neurons, each is connected to 1000s of others
Neurons, together, comprise the nervous system
Central Nervous System
= brain and spinal cord
Peripheral Nervous System
= somatic and autonomic nervous system
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Autonomic nervous system

Sympathetic Nervous System: "Stress Response" or "Fight or Flight"

Characterized by 1,400 biochemical and psychophysiological changes in the body

Dulls/deactivates functioning in cortical areas of the brain

Leads to long-term health consequences when dysregulated

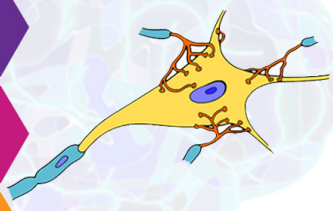
Parasympathetic Nervous System: "Relaxation Response"

The opposite of "stress response," characterized by lowered blood pressure and heart rate, slowed breathing, other indices of relaxation

Meant to be our homeostasis, the state we are in most of the time

Survival Responses

- Fight/Flight
- Freeze
- Fawn



Clinical Implications Of Freeze

Who freezes?
- Children
- Survivors of sexual violence

Outcomes?
- Dissociation
- More severe posttrauma symptoms
- Relaxation is triggering
- Developmental trauma/Personality disorders

****Remember, you don't get to "choose" your survival response, and freeze can be very adaptive.****

Limbic System

Triune Brain

- Survival Brain Reptilian (Lower brain)
- Emotional Brain Limbic (Interior area)
- Thinking Brain (Cerebral cortex)

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Limbic System

Thalamus

- Gateway for sensory information (except smell)
- Main objective is to share sensory information with as much of the brain as possible, as fast as possible!

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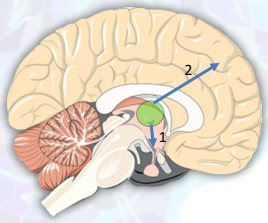
Limbic System

Thalamus: The Two Pathways

1. Fast, short path to the amygdala…
2. Slow, long path to the cortex…



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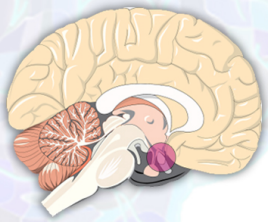
Limbic System

Amygdala

- "Fear brain" or "smoke alarm"
- Asks "Is this dangerous?"
- Involved in fear/threat detection
- Involved in implicit memory
- Begins stress response through activation of the HPA axis

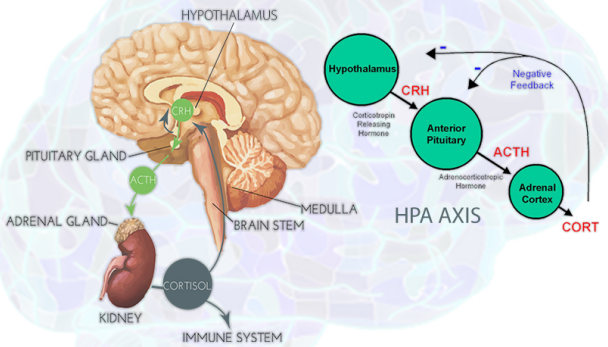


Limbic System

Hypothalamus

- Regulates autonomic functions
- Enacts the will of the amygdala
- Starting point for the stress pathway in the brain (HPA Axis)

Stress Response System



Limbic System

Hippocampus

- Involved in learning and memory
- Explicit, declarative, autobiographical memory
- Impaired functioning when under stress

Limbic System

Insula

- Site of proprioception and interoception
- Allows us to be aware of internal experiences and states
- Critical for emotional awareness

Limbic System

Cingulate Cortex

- Considered a limbic AND cortical structure
- Involved in monitoring conflict, emotion regulation, pain expectancy
- Contains the Anterior Cingulate Cortex, the "Emotion Regulation Center"

Cortical Areas

Triune Brain

- Survival Brain Reptilian (Lower brain)
- Emotional Brain Limbic (Interior area)
- Thinking Brain (Cerebral cortex)

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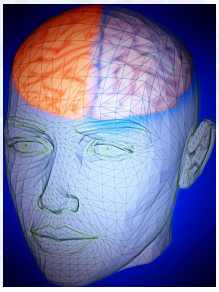
The Two Hemispheres

Left Hemisphere:

- Positive emotions
- Approach behaviors
- Labels thoughts and feelings
- Develops new narratives
- Logical
- More about tasks
- Practical language
- Detail monitoring



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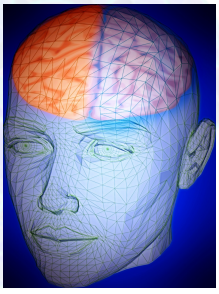
The Two Hemispheres

Right Hemisphere:

- Negative emotions
- Withdrawal behaviors
- Attunement
- Prosody
- Circuits of attachment
- Awareness of body
- Self-regulation
- Empathy
- Intuition



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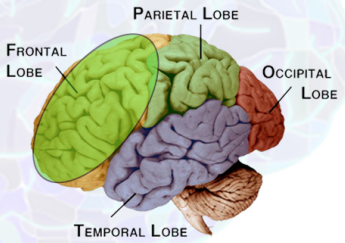
Cortex: Frontal Lobe

Prefrontal Cortex:
- Rational thought
- Goal-making
- Decision-making
- Sense of others
- Personality
- OFC

Primary Motor Cortex
- Movement

Cingulate Cortex
- Emotion regulation
- Expectation of pain
- Conflict monitoring



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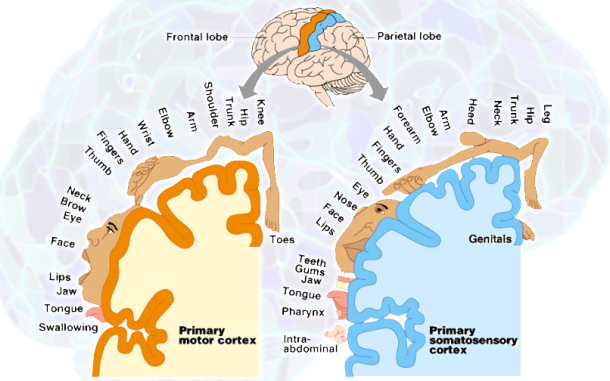
Cortex: Frontal and Parietal Lobes



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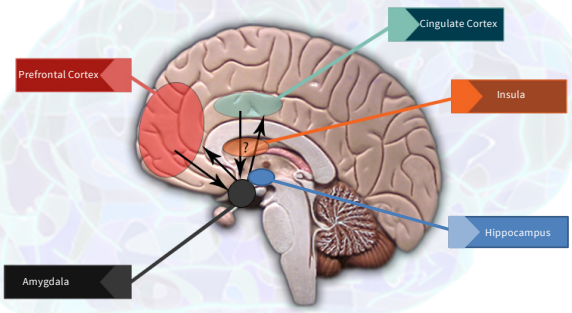
The Neuroscience of Trauma



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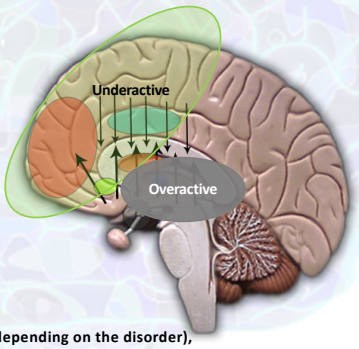
Neuroscience of Mental Illness



In various ways (depending on the disorder), the brain is "bottom heavy"…

"I'm Triggered."

https://www.youtube.com/watch?v=ycu0LSggqvU

Trauma Treatment Roadmap

1. Build the alliance (bottom-up, reduces cortisol)
2. Safely enter the body (increase insula activation)
3. Start bottom-up, working through the body (decrease amygdala activation)
4. Work with both the body *and* mind for memory reconsolidation/retraining (EMDR, Brainspotting), cognitive work (CBT, CPT), and/or other types of exposure (PE, TF-CBT)
5. Integrate behavioral techniques (such as "one feared thing," to teach amygdala to self-regulate; bottom-up and top-down)

Diagnosing PTSD

DSM-5 Symptoms in a Nutshell

- 20 symptoms (17 in DSM-IV), 4 clusters, that result in impairment and/or distress:
  - 1. Re-experiencing: intrusive thoughts, trauma memories, nightmares, feeling distress when thoughts/memories occur.
  - 2. Avoidance: of thoughts, conversations, people, memories, external reminders
  - 3. Thought/mood changes: blame/guilt, "stuck points," amnesia, numbing, loss of interest, disconnection from others
  - 4. Arousal and reactivity: sleep and concentration difficulties, hyperarousal, sensitive startle

Assessing Trauma

- Primary Care PTSD Screen
- PCL-5
- CAPS-5
- Impact of Events Scale-Revised (IES-R)
- Catalogue of resources on the National Center for PTSD Website: http://www.ptsd.va.gov/

Primary Care PTSD Screen

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to? YES / NO
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? YES / NO
3. Were constantly on guard, watchful, or easily startled? YES / NO
4. Felt numb or detached from others, activities, or your surroundings? YES / NO

Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three items.

http://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp

PTSD Checklist

20-item self-report measure that assesses the 20 DSM-5 PTSD symptoms.

Can be used for:

- Monitoring symptom changes
- Screening individuals for PTSD
- Making a provisional PTSD diagnosis

The scale is 0-4 for each symptom. Rating scale descriptors are the same: "Not at all," "A little bit," Moderately," "Quite a bit," and "Extremely."

A provisional PTSD diagnosis can be made by treating each item rated as 2 = "Moderately" or higher as a symptom endorsed

http://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp

CAPS-5

- Gold standard in PTSD assessment!
- 30-item structured interview that can be used to:
  1. Make current (past month) diagnosis of PTSD
  2. Make lifetime diagnosis of PTSD
  3. Assess PTSD symptoms over the past week
- Questions also target the onset and duration of symptoms, subjective distress, impact of symptoms on social and occupational functioning, improvement in symptoms, PTSD severity, and specifications for the dissociative subtype (depersonalization and derealization).

http://www.ptsd.va.gov/professional/assessment/adult-int/caps.asp

What the Diagnoses Miss

- The presence of trauma
  - Neglect doesn't count
  - Many ACEs don't count
  - Some forms of traumatic loss don't count
- Physical symptoms/manifestations
  - Headaches
  - Stomach/gastrointestinal problems
  - Common colds
  - Heart-related issues
- Simple vs complex trauma
  - van der Kolk's proposed diagnosis: Developmental Trauma Disorder

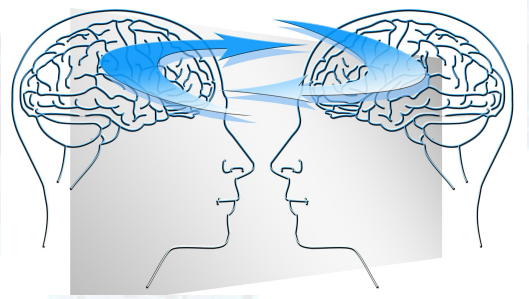
Part II: Mechanisms and Neuroscience of Treatment

Neuroscience of the Alliance

- Therapeutic alliance = Bottom-up approach to therapy
- The therapeutic alliance accounts for between 15-50% of the outcome variance (depending on which studies you believe).
- Various bodies of research indicate that *brains can interact with and influence other brains*…
  - Brain waves align when people make eye contact and "attune"
  - Mothers can soothe infants and reduce their cortisol by focusing on them using their PFC (through eye contact and touch)

Neuroscience of the Therapeutic Alliance

What is the mechanism?



Discovery of Mirror Neurons

- Mirror Neuron Hypothesis: There is a link between particular neurons in our own brain and other people's actions.
- Dual action: Brain contains a system of neurons that fire in response to the intentional actions of others, and also when we perform those same actions (Gallese, Fadiga, Fogassi, & Rizzolatti, 1996).
- Emotional centers also have mirror-like qualities (Singer et al., 2004)
- **Best way to activate mirror neurons is via right hemisphere!**

Implications of Mirror Neurons

- Mirror neurons are the neural mechanism of the therapeutic alliance.
- They allow clients to have a different, (hopefully) reparative *experience* in therapy.
- Clients can, through this alliance, re-learn and heal attachment.
- **The therapeutic alliance remains the MOST important "approach" or "technique" you will use with a client.**

Mirroring Exercise

Social Medicine is Real!

- The therapeutic alliance IS an evidence-based intervention – 15-50% of outcome variance!
- Connection with others – "social medicine":
  - Reduces cardiovascular reactivity (Lepore, et al, 1993)
  - Reduces blood pressure (Spitzer, et al, 1992)
  - Reduces vulnerability to catching a cold (Cohen, et al, 2003)
  - Reduces anxiety (Cohen, 2004)
  - Slows cognitive decline (Bassuk, et al 1999)
  - Improves sleep (Cohen, 2004)
  - Improves depression (Russell & Cutrona, 1991)
  - Reduces cortisol levels (Kiecolt-Glaser, et al, 1984)

Implications of Mirror Neurons

Oxytocin vs. Cortisol

https://www.ted.com/talks/kelly_mcgonigal_how_to_make_stress_your_friend/transcript?language=en

"Your biological stress response is nudging you to tell someone how you feel, instead of bottling it up."

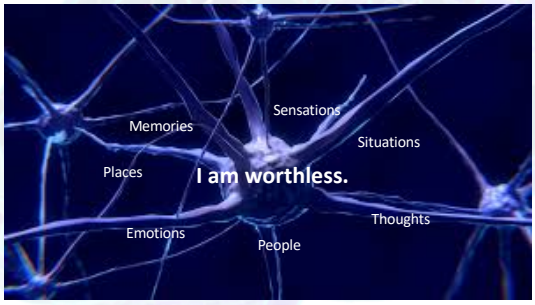
Treating Avoidance

- **Importance of treating avoidance in trauma and anxiety.**
- **Cognitive theory of PTSD**
- **Hallmark of anxiety disorders and trauma: AVOIDANCE!!**
- **Avoidance is the driver of these conditions.**
- **Why people avoid – it's intelligent, but doesn't work. What it lures you to do is a trap.**

What are people avoiding??? NEURAL NETWORKS!

Neural Networks

Neural Networks



Rules of Neuroplasticity

1. Neurons that fire together wire together (Hebb's Rule, 1949)
2. Use it or lose it.
3. You have to activate a network to change it.
4. Your attention is the network you're in.
5. State to Trait: Repetition and effort promotes brain change.
6. Brain change is active, not passive.

Networks and Therapy

The rules of neuroplasticity applied to therapy (more on EMDR soon…)

- We want to strengthen some pathways/networks, and weaken others.
- Through reframing we help direct clients' attention to more helpful ways of interpreting situations, building more positive networks and neglecting the unhelpful ones.
- We can exit networks, and/or shift them.
- Remember, brain change takes effort and repetition!

Promote Neurogenesis

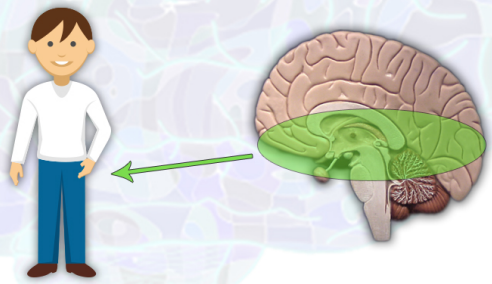
- BDNF = brain derived neurotropic factor
  - Consolidates connections between neurons
  - Promotes growth of myelin to make neurons fire more efficiently
  - Acts on stem cells in the hippocampus and PFC to grow into BRAND NEW NEURONS!
- Increase your neurogenesis by…
  - Exercise
  - Not consuming too many calories
  - Incorporating Omega-3s into your diet
- Decrease your neurogenesis by…
  - Aging (sorry!)
  - Experiencing chronic stress
  - Marijuana use

Ways to Change the Brain: Three Options

1. **Bottom-up interventions:** Working with the body/going through the body to change the brain
2. **Top-down processing:** Working with the mind/going through the mind to change the brain
3. **Horizontal processing:** Working across hemispheres or across sensory modalities

Bottom-up Interventions

Going through the body/senses to change the brain (especially the lower parts of the brain)



Bottom-up Interventions

01 Sensory awareness or exposure techniques

02 Interoceptive awareness or exposure techniques

03 Proprioceptive awareness or exposure techniques

04 Yoga

05 Qigong

06 Diaphragmatic breathing

07 Body scan

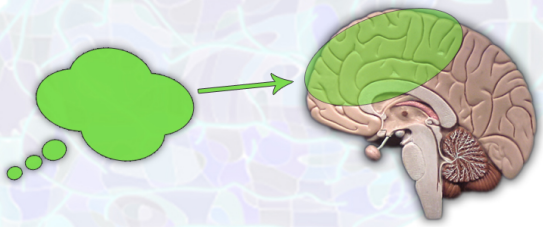
08 Progressive muscle relaxation

09 Autogenic training (both bottom-up and top-down)

10 Exercise

Top-down Interventions

Using the mind (thoughts) to change the brain (usually the upper parts of the brain)



Top-down Interventions

- Cognitive restructuring/ reappraisal
- Autogenic training (both bottom-up and top-down)
- Acceptance and Commitment Therapy cognitive exercises
- Empty chair technique
- Transcendental meditation
- Assertiveness training, communication techniques
- Focus meditations
- Talk therapy

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Horizontal Interventions

1. Processing across modalities or hemispheres
2. Art therapy
3. Cross-hemispheric processing
4. EMDR!!!

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Part III: EMDR as Applied Neuroplasticity

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Working with Memory in Therapy

"Although PTSD is triggered by trauma, it is really a disease of memory. The problem isn't the trauma; it's that ...the emotional charge of the memories remains hair-trigger and consequently intrudes into numerous activities of daily living." – George Lindenfeld

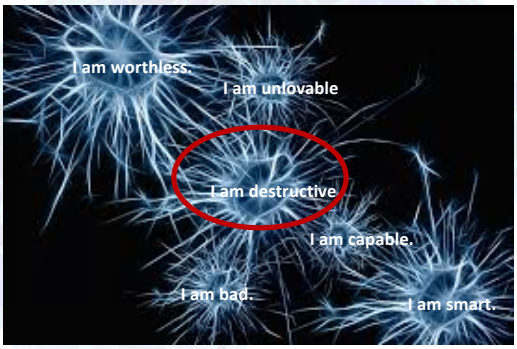
- Working with memories is one way to change neural networks in the direction of health.
- Every time you recall a memory you change it by the context, mood, vantage point of present moment.
- Memories change in response to new experiences, thoughts, and emotions.
- In EMDR we retrieve memories from hippocampus, bringing them to the PFC. Then, the two structures interact (working memory), update the memory, and then re-encode it into the hippocampus.

EMDR: A 3-in-One!!!

EMDR promotes brain change from three directions: bottom-up, top-down, and horizontal.

EMDR is a 3-in-1 intervention, making it very powerful. The more ways you can change the brain at once, the more powerful the technique/intervention!

Trauma Networks



Trauma Networks

Why is it so hard to change trauma networks?

The memories consolidate incorrectly, creating networks that are…

- Rigid (concrete wall)
- Fragmented (difficult to integrate components)
- Easy to trigger (due to survival instinct)
- Very difficult to get out of once in
- Impervious to new information or influence from more adaptive networks

Neuroscience of EMDR

Decreased activation in limbic areas and increased activation in prefrontal brain regions (Pagani et al., 2007).

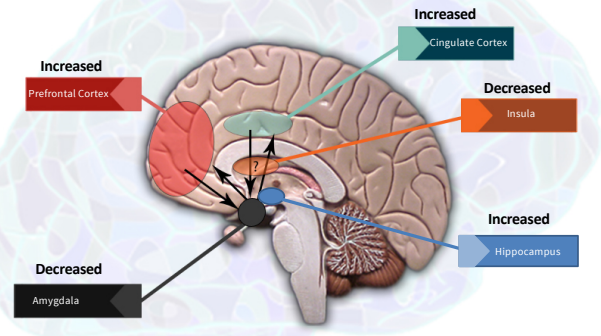
Reduced:

- Amygdala activation, leading to fear extinction (Voogd et al., 2018)
- Thalamus activation, leading to less reactivity (Rousseau et al., 2019)
- Insula activation (Malejko et al., 2017)

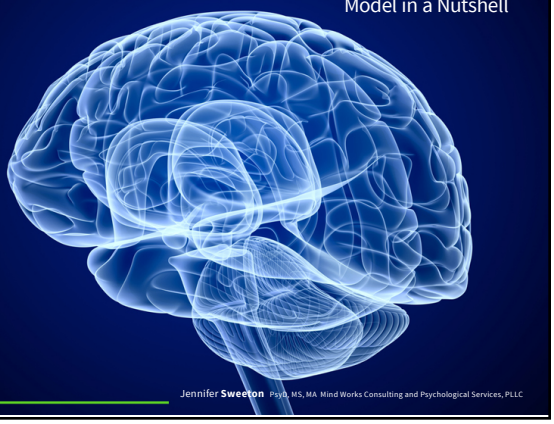
Increased:

- ACC activation (Boccia et al., 2015)
- PFC activation, including dlPFC and vmPFC (Rousseau et al., 2018)
- Hippocampal activation (Malejko et al., 2017)
- Enhanced amygdala and hippocampus resting state functional connectivity with prefrontal cortical regions (Zhu et al., 2018)

The Neuroscience of EMDR



Part IV: Original 8-Phase Model in a Nutshell



EMDR in the Big Picture

1. Build the alliance (bottom-up, reduces cortisol)
2. Safely enter the body (increase insula activation)
3. Start bottom-up, working through the body (decrease amygdala activation)
4. Work with both the body *and* mind for memory reconsolidation/retraining (EMDR, Brainspotting), cognitive work (CBT, CPT), and/or other types of exposure (PE, TF-CBT)
5. Integrate behavioral techniques (such as "one feared thing," to teach amygdala to self-regulate; bottom-up and top-down)

EMDR Abbreviations

- EMDR = Eye movement desensitization and reprocessing
- NC = Negative cognition
- SUDs = Subjective units of distress (linked to NC)
- PC = Positive cognition
- VoC = Validity of positive cognition
- DoF = Degrees of freedom ("window of tolerance")
- TSP = Target sequence planning

EMDR Overview/ Order of Operations

- Stage 1: Case Conceptualization/Planning
  - Phase 1: Target Sequence Planning (or Target Mapping)
  - Phase 2: Preparation: Grounding, resourcing, stabilization, explain logistics
- Stage 2: Processing: Neural Network Consolidation
  - Phase 3: Access and Activate
  - Phase 4: Desensitization
  - Phase 5: Installation of PC
  - Phase 6: Body Scan
- Stage 3: Summary and Revisiting Treatment Goals
  - Phase 7: Closure
  - Phase 8: Reevaluation
  - Three-Pronged Approach, consolidate entire network
    - Work on more past incidents
    - Work on present triggers
    - Imagine future triggers (emphasize in anxiety!!!)

Part V: Phase 1: Target Sequence Planning

Overview: Phase 1: Target Sequence Planning

1. Biopsychosocial intake (“big” and “little” ‘T’ traumas)
2. Evaluation/Assessment (PCL, CAPS-5, etc)
3. **Psychoeducation about EMDR**
4. Treatment plan (broadly speaking)
5. **Select “target” for initial EMDR focus:**
   1. **Target Sequence Planning, or**
   2. **Target Mapping**
6. **Select type of processing:**
   1. **EMD (Restricted Processing)**
   2. **EMDr (Contained Processing)**
   3. **EMDR (Unrestricted Processing)**

Phase 1: Psychoeducation About EMDR

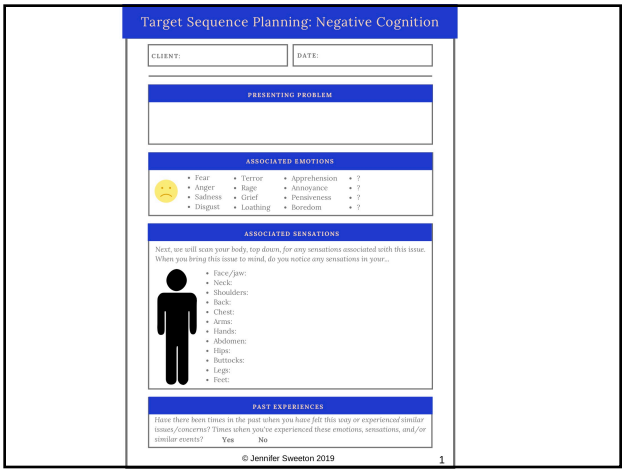
"A lot of clients find that they become 'stuck' with regard to past memories and distressing events, where they experience unwanted thoughts, sensations, and emotions about the events. It's also common to feel on guard, vigilant, and jumpy, and to try to avoid people and situations that remind the person of the traumatic event. Finally, some people notice that after distressing events, their thoughts change, and they may blame themselves, or think differently about themselves and others, than they used to, and this can feel really upsetting.

It's believed by trauma experts that one reason for these symptoms can be that traumatic memories are processed (or 'consolidated') differently than non-traumatic memories, in a way that leads to the symptoms I just described. However, it is possible to reconsolidate and reprocess these memories, which helps reduce distressing posttrauma symptoms. That is what EMDR aims to do! One of the perks of EMDR techniques, also, is that you don't have to relive every little piece of a traumatic event, nor do you have to tell me about the details. This makes EMDR more doable for a lot of clients, and research has shown it to be very effective for many clients, helping them feel better, sleep better, feel calmer, and experience fewer posttrauma symptoms!"

Phase 1: Belief-Focused Target Sequence Planning

Beliefs are the verbalization of the triggered past emotions and sensations (Shapiro)

1. Ask about what is bringing them to therapy.
2. Identify emotions, physical sensations, and other symptoms linked to the presenting problem.
3. Inquire about whether *any of these* has occurred in the past.
4. Glean from this discussion the NC
5. "Take temperature" (SUDS) of NC to ensure some activation.
6. Identify other memories that are part of the NC network
7. Locate the "touchstone memory"
8. Imagine future instances where the NC may arise
9. Repeat the above, but with an identified PC
10. Map the above on the TSP Worksheets (in your materials)



Target Sequence Planning: Negative Cognition

CLIENT: DATE:

PRESENTING PROBLEM

ASSOCIATED EMOTIONS

- Fear
- Anger
- Sadness
- Disgust
- Terror
- Rage
- Grief
- Loathing
- Apprehension
- Annoyance
- Pensiveness
- Boredom
- ?
- ?
- ?
- ?

ASSOCIATED SENSATIONS

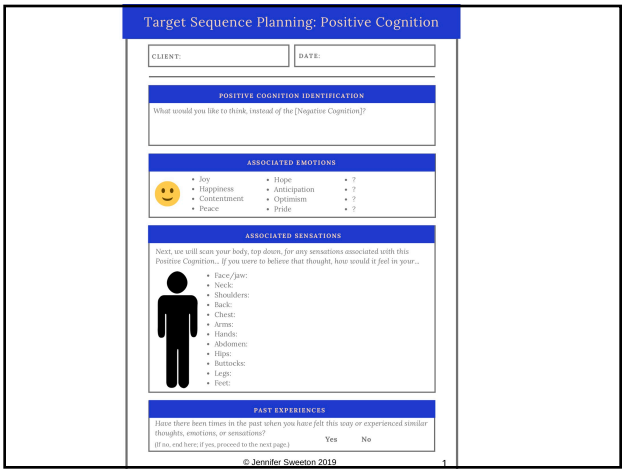
Next, we will scan your body, top down, for any sensations associated with this issue. When you bring this issue to mind, do you notice any sensations in your...

- Face/jaw:
- Neck:
- Shoulders:
- Back:
- Chest:
- Arms:
- Hands:
- Abdomen:
- Hips:
- Buttocks:
- Legs:
- Feet:

PAST EXPERIENCES

Have there been times in the past when you have felt this way or experienced similar issues/concerns? Times when you've experienced these emotions, sensations, and/or similar events? Yes No

1



Target Sequence Planning: Positive Cognition

CLIENT: DATE:

POSITIVE COGNITION IDENTIFICATION

What would you like to think, instead of the [Negative Cognition]?

ASSOCIATED EMOTIONS

- Joy
- Happiness
- Contentment
- Peace
- Hope
- Anticipation
- Optimism
- Pride
- ?
- ?
- ?
- ?

ASSOCIATED SENSATIONS

Next, we will scan your body, top down, for any sensations associated with this Positive Cognition... If you were to believe that thought, how would it feel in your...

- Face/jaw:
- Neck:
- Shoulders:
- Back:
- Chest:
- Arms:
- Hands:
- Abdomen:
- Hips:
- Buttocks:
- Legs:
- Feet:

PAST EXPERIENCES

Have there been times in the past when you have felt this way or experienced similar thoughts, emotions, or sensations? Yes No

(If no, end here; if yes, proceed to the next page.)

 1

Demonstration: Target Sequence Planning

Phase 1: Tips

- Ensure the target is sufficiently activated (SUDS around 30 or higher), but also within client's DoF.
- If presenting problem is activating but the NC is not, you may have selected a NC that does not fully resonate.
- Target NC/PC should be an "I statement."
- Notice integration or lack of integration of networks (make mental note; other networks can be revisited later).
- Start with most activating/intense/distressing network, OR touchstone memory, if multiple targets are identified.

Part VI: Phase 2: Preparation/Resourcing, Distress Thermometer

Overview: Phase 2: Preparation & Resourcing, Distress Thermometer

1. Bottom-Up Resourcing/Stabilization
   - Sensory Awareness Techniques
     - Grounding
   - Breathing Exercises
     - Vagus nerve activation
     - Four count breath
     - Butterfly breathing
   - Body-Based Techniques
     - Body scan
     - Autogenic training

Overview: Phase 2: Preparation & Resourcing, Distress Thermometer

2. Top-Down Resourcing/Stabilization
   - Places
     - Container
     - Secure/comfortable place
   - People
     - Circle of support
     - Nurturing/protective figure
     - Incorporate *slow* BLS and attunement for enhancement
3. External Resourcing/Stabilization
   - People as resources
   - Places as resources
4. Distress Thermometer
   - Boiling/Freezing points
   - Degrees of Freedom

Phase 2: Bottom-Up Resourcing/Stabilization: Breathing Techniques

"Mindful breathing is a technique whereby individuals direct their awareness and attention to their breath, and to any sensations that arise (Kabat-Zinn, 1990)."

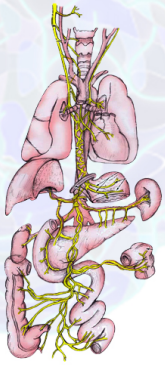
Breathing techniques are recommended for anxiety management (Davis et al., 2008) due to their ability to reduce autonomic arousal and amygdalar activity.

Techniques can be open or closed, and are largely bottom-up.

BUT, for breathing exercises to work we need to breathe through our diaphragm!

Diaphragmatic Breathing: Vagus Nerve

1. 10th cranial nerve
2. Activates the PNS
3. Depends on acetylcholine to function
4. Relaxes you and reduces inflammation
5. Stimulated through diaphragmatic breathing!



Diaphragmatic Breathing: Vagus Nerve

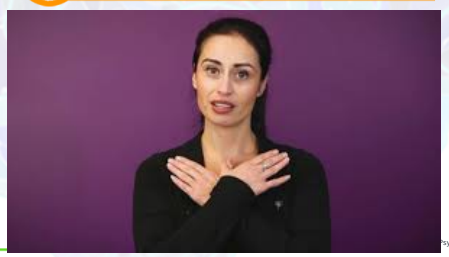
1. Wonder woman pose
2. La-Z-Boy pose
3. Sit on your hands
4. Halasana (and other yoga poses)

Diaphragmatic Breathing: Four Count Breath

Jennifer **Sweeton** PsyD, MS, MA Mind Works Consulting and Psychological Services, PLLC

Diaphragmatic Breathing: Butterfly Breathing

1. Cross your hands and place them on your chest.
2. As you breathe, gently alternate tapping on your chest, just below your collar bone.



Psychological Services, PLLC

Phase 2: Bottom-Up Resourcing/Stabilization: Body-Based Techniques: Autogenic Training

Mindfulness technique where person focuses on selected sensations (Gonzalez de Riviera, 1997) in order to achieve psychophysiological relaxation (Stetter & Kupper, 2002).

Autogenic training improves self-regulatory capacities and trains individuals to modify the functioning of their autonomic nervous system by repeating a sequence of statements about warm and heavy sensations felt throughout the body.

A bottom-up AND top-down technique!

Jennifer **Sweeton** PsyD, MS, MA Mind Works Consulting and Psychological Services, PLLC

Phase 2: Bottom-Up Stabilization Techniques: Grounding and Attunement

Phase 2: Top-Down Resourcing/Stabilization: Places

1. Container
   - Follow instructions in Container Worksheet
   - Container must be large enough to hold your "stuff"
   - Container must have a way you can put your stuff in and take your stuff out
   - Container must be comfy enough inside that your stuff will want to stay put
2. Secure/comfortable place
   - Follow instructions in Secure Place Worksheet
   - Better if this place exists
   - Even better if you can visit it sometimes/often
   - Connect with sensory details of this place
   - Can be "safe" but does not have to be

CLIENT: DATE:

Container Worksheet

Rule 1: The container must have a way for you to put your emotional "stuff" in, and a way for you to take it out.
Rule 2: The container be welcoming on the inside, so that your "stuff" will want to stay there.
Rule 3: The container must be large enough to hold all of the "stuff" youhave.
Rule 4: The container must not be attached to you in any way (such as tied to you).

MY CONTAINER:

Top-Down Stabilization: Container

CLIENT: DATE:

Secure Place Worksheet

Step 1: Choose the Secure Place: It is recommended the secure place be a real place you've been, if possible.
Step 2: Describe the Secure Place: Connect with what you see, feel, smell, and hear around you when imagining you are there. Jot down this information about your secure place below.
Step 3: Assign a word that describes the secure place – one that will activate thoughts of this place when you say or think it.

MY SECURE PLACE:

SECURE PLACE WORD:

Top-Down Stabilization: Secure Place

Phase 2: Top-Down Resourcing/Stabilization: People

1. Circle of support
   - Follow instructions on Circle of Support Worksheet
   - Visualize "advocacy committee" of supportive others
   - Connect with sensory details of these people
2. Nurturing/protective figure
   - Follow instructions on Nurturing/Protective Figure Worksheet
   - Connect with sensory details of this person
   - Can connect with memory if applicable
3. Incorporate *slow* BLS and attunement for enhancement
   - Follow instructions on BLS and Attunement Handout
   - Attunement important for complex/developmental trauma
   - Can use touch or client can pat themselves: "walking through" or "tapping in"
   - Can use *slow* BLS to enhance intensity of resource (NOT eye movements)

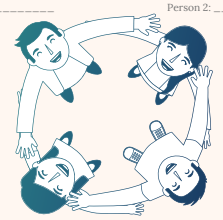
CLIENT: DATE:

CIRCLE OF SUPPORT

FOR RESOURCING

Directions: Identify supportive individuals that you can assign to your "Circle of Support." This circle of support will serve as a mental resource to help you feel strong, grounded, and protected when processing distressing memories and information.

Person 1: _____ Person 2: _____



Person 3: _____ Person 4: _____

CLIENT: DATE:

NURTURING & PROTECTIVE FIGURES

FOR RESOURCING

Directions: Identify individuals that you experience to be nurturing and protective. These can be individuals who you've known, such as family members, or individuals you've never met (Ellen DeGeneres, Jesus, etc.). These individuals will serve as a mental resource to help you feel nurtured and protected when processing distressing memories and information.

Nurturing Figure: _____

Protective Figure: _____

ATTUNEMENT AND BLS

FOR EXTENDED RESOURCING

Build Attunement

For enhanced attunement, sit across from the client, "right brain to right brain" (meaning, your left shoulders are across from/facing one another). You'll each be sitting to the right of one another.

And then lead the client into a resourcing exercise (Container, Secure Place, etc.) while doing one of the below...

BLS: Tapping In...

Place your hands on your knees as you sit with feet on the floor. Have the client mirror you, doing the same. Next, gently begin tapping your legs with each hand, alternating hands. Keep your wrists on your legs as you tap each leg. Be sure to tap very slowly (about 1 tap per 2-3 seconds).

OR...

BLS: Walking Through...

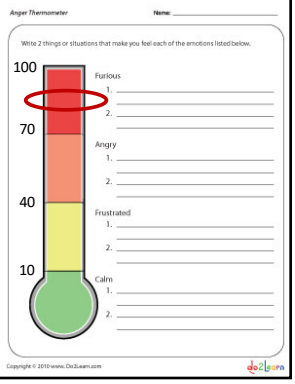
Place your feet flat on the floor. Have client mirror you, placing their feet flat on the floor as well. Next, gently begin alternating tapping your toes, keeping your heels on the floor, and instruct the client to do the same, in tandem with you. Be sure to tap very slowly (about 1 tap per 2-3 seconds).

Phase 2: Distress Thermometer

- Staying stabilized, within "degrees of freedom" (DoF) or "window of tolerance is critical.
- Leaving DoF leads to dissociation or "losing your mind" (amygdalar hijacking)
- Distress thermometer = 1-100, where 1 is no distress and 100 is the worst possible distress
- Want to identify approximate upper and lower limits of distress thermometer ("boiling point" and "freezing point" if applicable)
- Checking in with "temperature" increases "dual awareness," which is when the client can both experience and observe a phenomenon at the same time.
- **Dual awareness can reduce feelings of guilt, blame, and shame.**

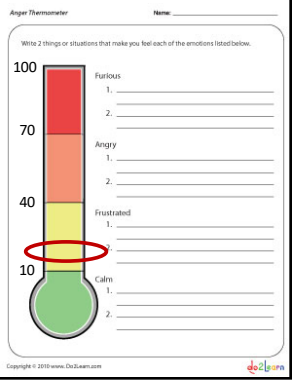
Distress Thermometer

- Ask, *"Do you have a sense of where your own 'boiling point' is, the point at which you feel overwhelmed or out of control?"*
- *Define the upward "anchor" as an example of this.*



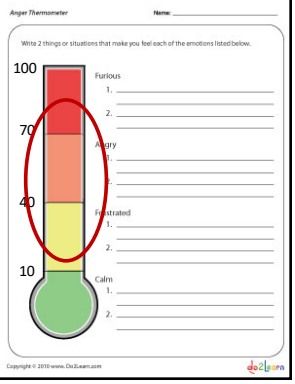
Distress Thermometer

- Ask, *"Do you have a sense of where your own 'freezing point' is, the point at which you feel disconnected, dissociated, or frozen?"*
- *Define the downward "anchor" as an example of this.*



Distress Thermometer

- Between these points is your "Degrees of Freedom"
  - *This is where therapy is done!*
  - ***Resourcing is needed when the boiling or freezing points are approached.***



Phase 3: Access & Activate

Previously "Assessment," referred to as "Access-ment" by Linda Curran

1. Identify a way to stop the process if needed, such as a "time out" hand signal
2. Access PC while keeping image in mind
3. Assess "validity of positive cognition" (VoC, on a scale of 1-7 where 1 is totally untrue-feeling, and 7 is totally true-feeling)
4. Bring to mind an image of the worst part of the memory.
5. Access NC along with image
6. Associated emotions
7. Associated sensations (unless doing EMD, then no sensations)
8. Temperature Check 1-100 (should be at 30+)

(Follow instructions on Access & Activate Worksheet)

Phase 3: Access and Activate

Phase 3: Access & Activate

Tips:

- Describe this phase to the client before conducting it.
- Write down the client's emotions, sensations, and image/target (how they word it) in case they lose the memory and you need to re-activate it. Will save you some time, and re-orient them to the target faster!
- Remind them of the "time out signal" they can use to stop.
- Let them know that you may remind them that the memory is in the past, and they are here now in the present (and remind them of this now).

Part II: Phase 4: BLS/DAS Techniques and Desensitization

Overview: Phase 4: BLS/DAS Techniques and Desensitization

1. BLS/DAS techniques
   - Eye movements
   - Bilateral tactile stimulation
   - Bilateral auditory stimulation
   - "Tapping"
   - Walking
   - Drumming
2. Desensitization
   - EMD
   - EMDr
   - EMDR
   - Tips
   - Demonstration

Phase 4: BLS/DAS Techniques

- BLS = Bilateral Stimulation
- DAS = Dual Awareness Stimulation
- BLS first used in therapy late 1700s (origins in hypnosis), then by Freud
- Two theories: Working Memory, Interhemispheric Communication
- Types of BLS/DAS:
  - ✓ Eye movements: Light bar, hand movement, stick
  - ✓ Bilateral tactile stimulation: Theratapper, Touchpoints
  - ✓ Bilateral auditory stimulation: CDs
  - ✓ "Tapping" (EFT)
  - ✓ Walking
  - ✓ Drumming

Phase 4: Desensitization Preparation

- Sit “right brain to right brain” (helps attunement)
- Test sitting distance
- Test hand distance
- Test movement range
- Test movement speed
- Test movement direction

Demonstration:

Desensitization Preparation, Phase 3, and Phase 4

Desensitization Prep

Phase 4: Desensitization in EMD

1. Do the following 3 times:

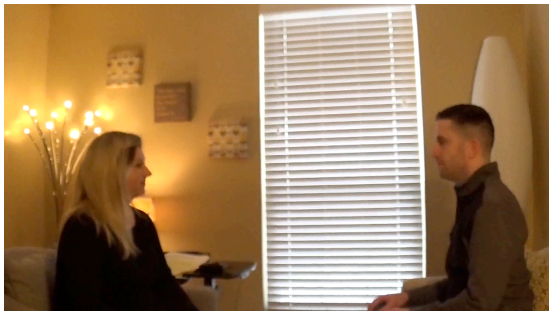
- Conduct approximately 10 seconds of BLS
- As you end the BLS, instruct them: "Breathe in, and let it go…" If possible, take this breath in tandem, increasing attunement
- Ask: "When you think of the worst image of the incident, paired with the NC, what is your temperature/level of distress now (1-100)?" … "Go with that…"

2. Then do the following 1 time:

- Conduct approximately 10 seconds of BLS
- As you end the BLS, instruct them: "Breathe in, and let it go…" If possible, take this breath in tandem, increasing attunement
- Ask: "When you think of the worst image of the incident, paired with the NC, has anything about it changed? What is different, if so?"
- Ask: "What is your temperature/level of distress now (1-100)?" … "Go with that…"

Repeat 1 & 2 several times, follow EMD Worksheet instructions.

Desensitization: EMD



Phase 4: Desensitization in EMDr

1. Do the following 3 times:

- Conduct approximately 15-20 seconds of BLS
- As you end the BLS, instruct them: "Breathe in, and let it go…" If possible, take this breath in tandem, increasing attunement
- Ask: "When you think of the incident, paired with the NC, what do you notice?" … "Go with that…"

2. Then do the following 1 time:

- Conduct approximately 15-20 seconds of BLS
- As you end the BLS, instruct them: "Breathe in, and let it go…" If possible, take this breath in tandem, increasing attunement
- Ask: "What is your temperature/level of distress now (1-100)?" …
- Ask: "When you think of the incident, paired with the NC, what do you notice?" … "Go with that…"

Repeat 1 & 2 several times, follow EMDr Worksheet instructions.

Phase 4: Desensitization in EMDR

1. Do the following several times:

- Conduct 30-180 seconds of BLS
- As you end the BLS, instruct them: "Breathe in, and let it go…" If possible, take this breath in tandem, increasing attunement
- Ask: "What do you notice?" … "Go with that…"
- When client starts repeating what they notice (or, you know you are getting short on time), ask: "What is your temperature/level of distress now (1-100)?" … "Go with that…"

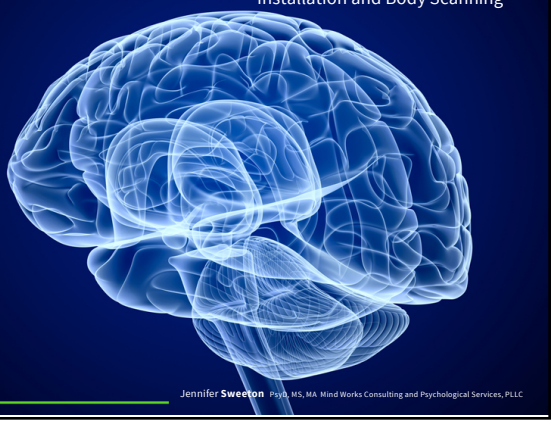
Repeat 1 & 2 several times, follow EMDR Worksheet instructions.

Phase 4: Desensitization

Tips:

- Remember to complete Phase 3: Access & Activate, first
- Remind client about the "time out" signal (or whatever they identified as a hand motion)
- Do not ask for VoC during desensitization.
- Remind client about dual awareness, saying, "Whatever comes up, just notice it…"
- When "temperature" gets to zero, ask client, "What thought comes up now?" Then do a short iteration of BLS with that thought and ensure it stays at zero.
- During EMD and EMDr, stop processing if client opens up different incidents! May restart the process with the new incident if it is more activating.
- When temperature/distress is between 1-10 or so, you may ask, "What keeps it from being a 1?" or "Do you think it is possible for this to go down further?"
- "Brain is an organ of prediction" (Linda Curran); if brain predicts the pattern it will stop paying attention, and it will only be with the memory. You can wiggle fingers, and adjust Theratapper to prevent habituation.

Part III: Phases 5 & 6: Installation and Body Scanning



BUT

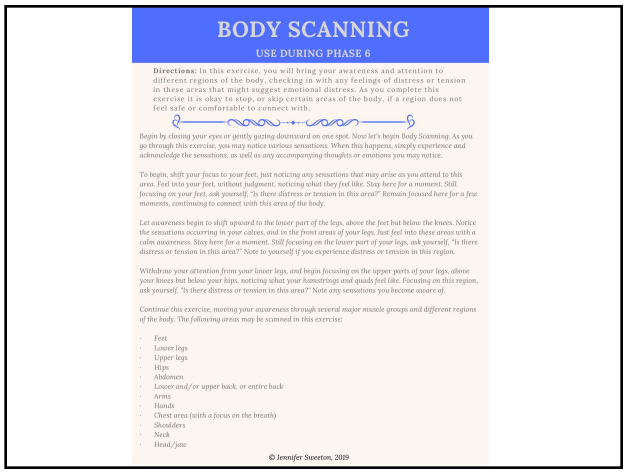
- I'm going to switch this up. We are going to do Phase 6 BEFORE Phase 5. This isn't "real EMDR" but what I prefer, due to how neural networks work.
- It makes sense to neutralize as much as network as possible before integrating positive networks into the trauma/negative neural network.
- Your Step-by-Step handouts for EMD/EMDr/EMDR show Phase 6 as occurring before Phase 5.

Phase 6: Body Scanning

1. Have the client bring to mind an image of the worst part of the incident, and simultaneously bring their awareness to their body.
2. Ask, "Now, with the image of the worst moment in mind, let's start at bottom of the body, moving downward, noticing any sensations that might be associated with this image. I will guide us through this scan; you may stay silent if you do not notice any sensations. If you do notice something other than a neutral or positive sensation, let me know…"
3. Now scan the body with the client, starting at the bottom of the body moving upward (refer to instructions in the Body Scanning Handout).
4. If client does not report any sensations during the scan, pause after the scan and check in, making sure there were only neutral and positive sensations present. If there are no distressing sensations in the body, move to Phase 7.
5. If there are distressing sensations in the body, state, "Keep your mind focused on the worst image of the incident, along with that sensation, and let's go with that…" Then complete 15-30 seconds of BLS/DAS. Repeat until sensations are neutralized.

Follow the Body Scanning Handout instructions…

Practice:
Body Scanning



BODY SCANNING

USE DURING PHASE 6

Directions: In this exercise, you will bring your awareness and attention to different regions of the body, checking in with any feelings of distress or tension in these areas that might suggest emotional distress. As you complete this exercise it is okay to stop, or skip certain areas of the body, if a region does not feel safe or comfortable to connect with.

Begin by closing your eyes or gently gazing downward on one spot. Now let's begin Body Scanning. As you go through this exercise, you may notice various sensations. When this happens, simply experience and acknowledge the sensations, as well as any accompanying thoughts or emotions you may notice.

To begin, shift your focus to your feet, just noticing any sensations that may arise as you attend to this area. Feel into your feet, without judgment, noticing what they feel like. Stay here for a moment. Still focusing on your feet, ask yourself, "Is there distress or tension in this area?" Remain focused here for a few moments, continuing to connect with this area of the body.

Let awareness begin to shift upward to the lower part of the legs, above the feet but below the knees. Notice the sensations occurring in your calves, and in the front areas of your legs. Just feel into these areas with a calm awareness. Stay here for a moment. Still focusing on the lower part of your legs, ask yourself, "Is there distress or tension in this area?" Note to yourself if you experience distress or tension in this region.

Withdraw your attention from your lower legs, and begin focusing on the upper parts of your legs, above your knees but below your hips, noticing what your hamstrings and quads feel like. Focusing on this region, ask yourself, "Is there distress or tension in this area?" Note any sensations you become aware of.

Continue this exercise, moving your awareness through several major muscle groups and different regions of the body. The following areas may be scanned in this exercise:

- *Feet*
- *Lower legs*
- *Upper legs*
- *Hips*
- *Abdomen*
- *Lower and/or upper back, or entire back*
- *Arms*
- *Hands*
- *Chest area (with a focus on the breath)*
- *Shoulders*
- *Neck*
- *Head/jaw*

Phase 6: Body Scanning

Tips:

- Do not take a "temperature" during this phase. We are just checking for presence of distressing sensations (yes/no).
- Doing a formal body scan is an option here (see Body Scanning Handout).
- If repeated focus on/exposure to the sensation does not result in neutralization, pause and inquire about the sensation to learn more. Is this a location where there is chronic pain? Might it be linked to other traumas in some way (through past injury or otherwise)? It is okay if these types of sensations cannot neutralize.
- An alternate way of conducting this phase is to just ask the client about any sensations they experience without guiding them through a body scan.

Phase 5: Installation

1. Have the client bring to mind an image of the worst part of the incident, and simultaneously bring the PC to mind.
2. Ask, "Now, with the image in mind, and the PC in mind, does it feel like the PC is still correct? Meaning, is this still the thought that you'd like to have when you remember this event?"
3. If they say no, reply, "Is there another thought that would fit better right now?" If they answer yes, proceed to reprocessing.
4. Say, "When you think of that image, along with that thought, right now, how true does that thought feel, on a scale of 1-7 where 1 is not at all true, and 7 is totally true?"
5. Make a mental note of whether this score is different than what they had reported in Phase 3.
6. When the client gives the Voc (1-7), repeat BLS/DAS, *slowly*, for about 15 seconds.
7. Ask for VoC after each iteration; when it stops changing, you're done with Phase 5.

Follow the Installation Handout instructions…

Phase 5: Installation

Installation Step-By-Step

Phase 5

STEP 1

Bring to mind an image or other sensory experience of the worst part of the incident, and simultaneously bring the PC to mind.

STEP 2

Now, with the image and PC in mind, does the PC still fit? Is this still the thought you want to have when you remember this event? If not, is there another thought that would fit better?

STEP 3

When you think of that image, along with the PC, how true does that thought feel now, on a scale of 1-7, where 1 is not at all and 7 is completely true?

STEP 4

Now just go with that...
(Conduct 15 seconds of slow BLS.)

STEP 5

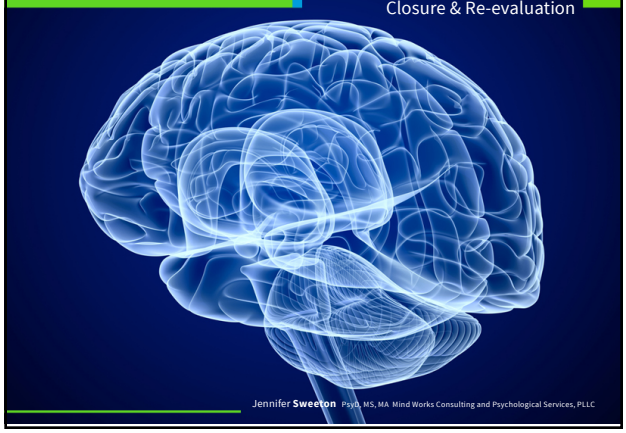
Ask for the VoC after each BLS iteration. When the VoC stops changing, or when it reaches 7, proceed to Phase 6.

Phase 5: Installation

Tips:

- Do not use eye movements for resources except in installation, and do it slowly and only for about 15 seconds.
- Want slow movements to intensify emotions (in general), fast movements to dull emotions.
- Ideally the client moves up to a 7 during this phase, but will not always.
- You can ask, "What keeps this from being a 7?" if the client does not report a VoC of 7. Then, you can do BLS/DAS on the answer they give you, to see if there can be some movement.
- Feel free to install multiple PCs. The more positive networks become integrated into the negative network, the better!

Part IV: Phases 7 & 8: Closure & Re-evaluation



Phase 7: Closure

Tips:

- Process how the session went, how the client is feeling now.
- Use Container or other stabilization/resourcing tool if needed, to stay within DoF.
- Answer questions client may have about what to expect next (i.e., fears about going into crisis, etc.).
- Let client know that this opened network will remain open for several hours (approx. 6), and processing may continue for days afterward. They may experience a change in emotions, sleep, dreams, etc., and this is normal.
- If desired, clinician can check in with client via phone/email the next day, to see how client is doing and help them utilize resourcing/stabilization techniques if needed.

Phase 7: Closure

What is the client's distress/temperature doesn't come all the way down??? This is an "incomplete session"

- This is completely normal; with complex trauma, you will not "cure" someone in one session!
- At about 10 minutes prior to the end of session, consider winding down and stopping Phase 4.
- Emphasize the hard work client has completed that session, and normalize needing to stop before they have fully desensitized.
- Do NOT proceed to Installation or Body Scanning; still end with Desensitization.
- Check client's temperature/distress to ensure they are within their DoF, and practice Container and another bottom-up stabilization/resourcing technique if beneficial.
- Check in with client about their plans for the rest of the day/week, and focus on the here and now, and what they are going to do when they leave session.
- Then complete Phase 7 (Closure) with client and let them know you will continue desensitization next session.

Phase 7: Closure

Phase 8: Re-evaluation

Tips:

- Recap the last session and ask how things have been going for them since then. Note any changes, normalize reactions (when they are to be expected).
- Do a quick repeat of Phases 3-4 to ensure the distress/temperature is still at 1 (or no greater than 10 on a scale of 1-100).
- If distress is still nonexistent, proceed to next piece of treatment plan; if distress has risen, check in about this. Ask if something happened recently that "triggered" the client. Consider additional iterations with question, "What keeps it from being a 1 today?"
- If distress has risen and you redo desensitization, be sure to also conduct Phases 5-7 again, as in the previous session.

Part V: EMDR for Trauma

EMDR for Non-Complex Trauma

Overview and Considerations:

- Always remember you are a clinician, NOT a technician (says Linda Curran)!
- Don't glaze over identifying the NC; this can be more difficult than you think.
- Start with EMDr for titration into EMDR.
- Remember to take notes during Phase 3 for future reference.

Order of Operations: Non-Complex Trauma

Step 1:	Conduct Phases 1-2 in that order.
Step 2:	Phase 3 WILL include asking about sensations.
Step 3:	Still choose target that is most intense/earliest.
Step 4:	Start with EMDr with one target.
Step 5:	Complete Phases 3-7 as described yesterday, containing Phase 4 Desensitization.
Step 6:	Proceed with EMDR (with a different target, or with the initial one), following the same steps.

Part VI: EMDR forComplex Trauma

EMDR in the Big Picture

"Learn the rules like a pro, so you can break them like an artist."
— Pablo Picasso

EMDR for Complex/Devo Trauma

Overview and Considerations:

- Always remember you are a clinician, NOT a technician (says Linda Curran)!
- May not be able to do entire TSP, may be too triggering.
- May choose Target Mapping over Target Sequence Planning if staying focused is difficult or "everything is wrong."
- For pre-verbal trauma, the "target" may NOT be a memory at all, might be a sensation!!! Can do Somatic Targeting instead.
- Be prepared to "inch along" memory by memory.
- Start with EMD for titration into EMDR, consider starting with Phase 2, not 1.
- Attunement is critical.
- Take plenty of notes with these clients; they may jump network to network and it can be good to later remember some of the networks they were referring to while talking.

Order of Operations: Devo/Complex Trauma

Step 1:	Phase 2: Resourcing/Stabilization – most important!!!
Step 2:	Phase 1: TSP/Target Mapping/Somatic Targeting
Step 3:	Still choose target that is most intense/earliest.
Step 4:	Start with EMD with one target.
Step 5:	Complete Phases 3, 4, 5, 7, and 8 (NO Body Scanning!).
Step 6:	Proceed with EMDr, and then EMDR, following the same steps. Repeat with new presenting problems/targets.

Target Sequence Planning

1. Ask about what is bringing them to therapy.
2. Identify emotions, physical sensations, and other symptoms linked to the presenting problem.
3. Inquire about whether *any of these* has occurred in the past.
4. Glean from this discussion the NC
5. "Take temperature" (SUDS) of NC to ensure some activation (only taking SUDS with regard to NC, NOT any associated memory at this point)
6. Identify other memories that are part of the NC network
7. Locate the "touchstone memory"
8. Imagine future instances where the NC may arise
9. Repeat the above, but with an identified PC
10. Map the above on the TSP Worksheets (in your materials)

BUT....

What if a person doesn't fit into a worksheet?

What if the "presenting problem" is difficult to define, or is linked to *several* traumas???

What is "everything is wrong"???

What if the "presenting problem" is linked to a preverbal trauma/implicit memory???

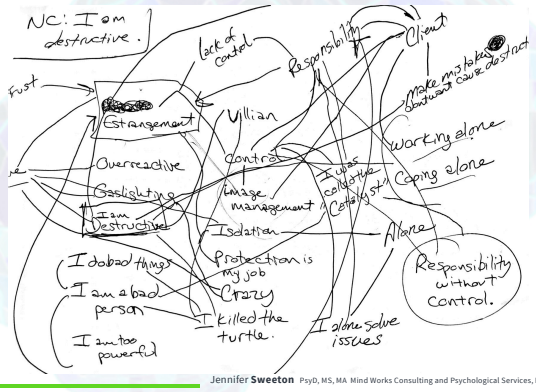
The TSP worksheet may not be possible, and forcing it could be unproductive and overwhelming.

Good news: You can do EMDR with implicit memories/preverbal trauma, and/or when there are many trauma networks!!

Phase 1 Modifications

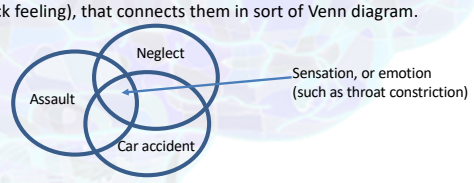
1. **Use Target Mapping in place of Target Sequence Planning**
2. **Use sensations (or emotions) as targets in place of memories as targets**

Network Identification Example (NC)

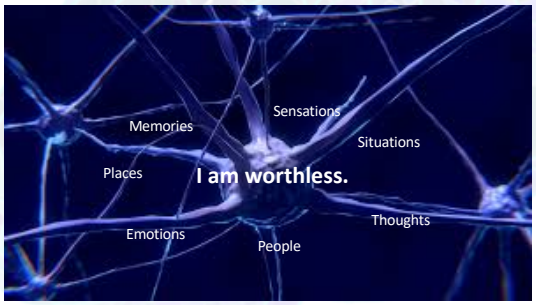


Be Flexible With Targets

- "Classic" EMDR uses explicit memories as targets, but remember that neural networks contain other components that can be activated!
- Clients' traumas may be implicit, preverbal memories…
- Or they may be explicit, but the memories may not be intense for some reason, and other experiences may be dominant (like chest tightening, or a feeling of dread).
- There may be a dominant symptom that is present in MANY traumas (like a sick feeling), that connects them in sort of Venn diagram.



Choose Your Own Adventure

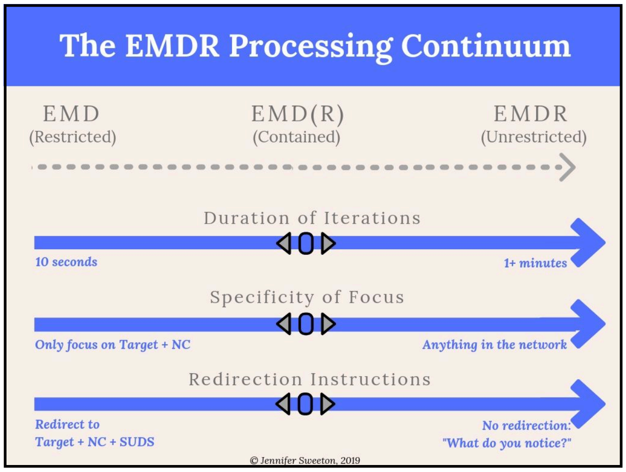


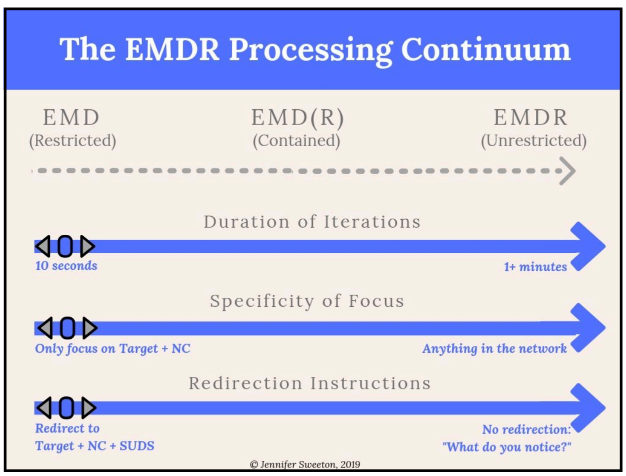
Somatic Targeting (Kiessling, 2012)

- A sensation is the target, instead of an NC or memory.
- Take a dominant symptom and use it as your target. So instead of leading with a belief/thought ("I am helpless"), do TSP with a sensation.
- "When did you feel that sickness?" – and then identify a general timeframe or memory that might go with it (if any).
- Ask about the sensation: "What's that ache? What is the interpretation? What does the sensation mean?" This might help you identify a NC, but perhaps not; don't force this, as you can do EMDR with a sensation as a target.
- So start with the sensation and then identify the memories over time where client experienced that sensation. You can do this with pain too!
- Each memory may have different, same, or similar NC on this sort of timeline. But they all have a sensation in common (overlapping networks – draw this out, like venn diagram, overlapping with stomach pain, though memories may be different circles).
- Good for times when there is implicit memory but no story line. But it will still be in the body, so you can start there when you don't have language. You can process without a NC.

Phase 2 Modifications

1. Do MORE of Phase 2 techniques, and for longer
2. Add "building the therapeutic alliance" as a distinct goal for Phase 2; focus on building "earned secure attachment" with clients and help them build this with others as well
3. Consider psychodynamic psychotherapy as a part of Phase 2
4. Go **slow** with Phase 2 techniques – you may be here for quite a while; titrate into relaxation
5. Ease into body-based exercises, which might be triggering.
6. Cognitive resources may need to be *created*, not just identified.
7. Incorporate resource tapping
8. Consider doing Phase 2 BEFORE Phase 1, as Phase 1 can be overwhelming and destabilizing!


The EMDR Processing Continuum
EMD
(Restricted)
EMD(R)
(Contained)
EMDR
(Unrestricted)
Duration of Iterations
10 seconds
1+ minutes
Specificity of Focus
Only focus on Target + NC
Anything in the network
Redirection Instructions
Redirect to
Target + NC + SUDS
No redirection:
"What do you notice?"
© Jennifer Sweeton, 2019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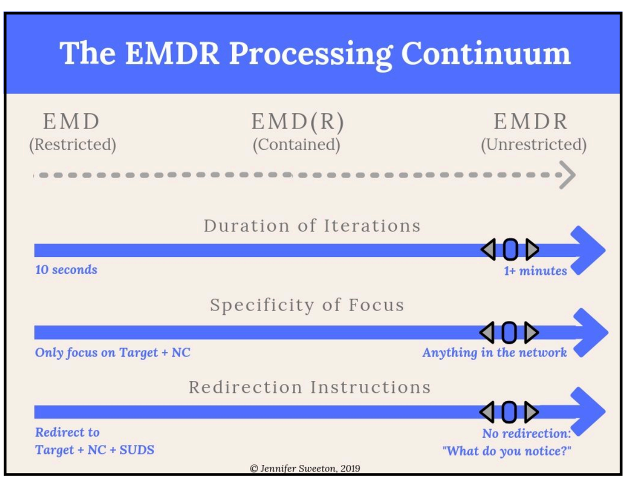
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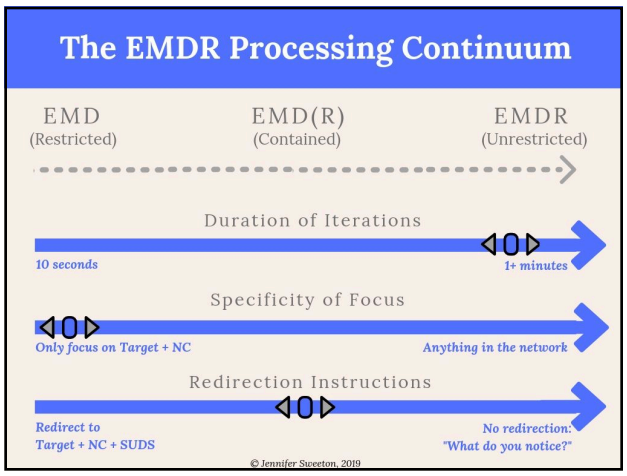
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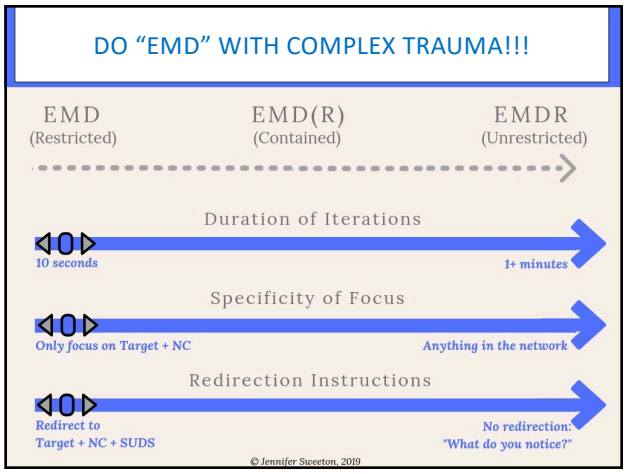
DO "EMD" WITH COMPLEX TRAUMA!!!
EMD
(Restricted)
EMD(R)
(Contained)
EMDR
(Unrestricted)
Duration of Iterations
10 seconds
1+ minutes
Specificity of Focus
Only focus on Target + NC
Anything in the network
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Redirect to
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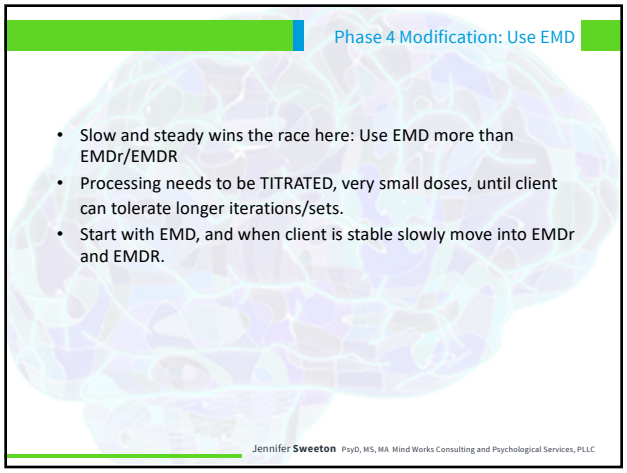
Phase 4 Modification: Use EMD
• Slow and steady wins the race here: Use EMD more than EMDr/EMDR
• Processing needs to be TITRATED, very small doses, until client can tolerate longer iterations/sets.
• Start with EMD, and when client is stable slowly move into EMDr and EMDR.
Jennifer Sweeton PsyD, MS, MA Mind Works Consulting and Psychological Services, PLLC

Phase 4 Modification: Increase Resourcing

- Consider alternating BLS iterations with resourcing techniques:
  - 5 minutes of resourcing
  - 10 seconds of BLS
  - 2 minutes of resourcing
  - 10 seconds of BLS
  - 2 minutes of resourcing
  - 20 seconds of resourcing (if client remains stable)
  - 2 minutes of resourcing
  - 20 seconds of resourcing
  - ….
  - End with 10-15 minutes of resourcing
- **Exposure piece of EMDR is small compared to the resource piece. Instead of spending 20% on resourcing and 80% on exposure, might be 80% on resourcing and 20% on exposure!**

Attachment-Focused EMDR

- Laurel Parnell = AF-EMDR (Attachment-Focused EMDR): http://parnellemdr.com/emdr-and-af-emdr/
- *Attachment-Focused EMDR: Healing Relational Trauma*, 2013
- Video training: *http://drlaurelparnell.com/attachment-focused-emdr-with-a-client-with-severe-early-sexual-abuse/*
- **5 Principles of AF-EMDR:**
  - Foster client safety.
  - Develop and nurture the therapeutic relationship.
  - Use a client-centered approach.
  - Create reparative neuro networks through the use of Resource Tapping.
  - Use modified EMDR whenever client needs to.
  - Read: Attachment-Focused EMDR: Healing Relational Trauma

Limitations of Research

- Not all EMDR studies are randomized clinical trials.
- fMRI imaging measures blood flow, and cannot directly measure neuronal activity. Neuronal signaling occurs approximately 1,000 faster than blood flow, meaning that what we observe in fMRI research is much slower than actual neuronal activity, and may not correspond directly to this activity.
- Due to the high cost of conducting neuroscience research, many studies have a relatively small sample size compared to other types of psychological research. This can compromise validity.
- fMRI research identifies brain activations through the measurement of blood flow. However, some research has shown that it is possible for mental tasks to produce *less* activation in specific brain areas compared to brain activity at rest. Thus, looking solely at brain activations, not deactivations, may produce an incomplete picture of brain functioning.
- Some neuroscience research has been conducted on animals, and may not be directly applicable to humans.