EMDR Skills Start to Finish:

Rapid, Safe, and Proven Skills and Techniques for Your Trauma Treatment Toolbox

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Part I: The Neuroscience of Trauma

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Triune Brain

Survival Brain Reptilian
(Lower brain)

Emotional Brain Limbic
(Interior area)

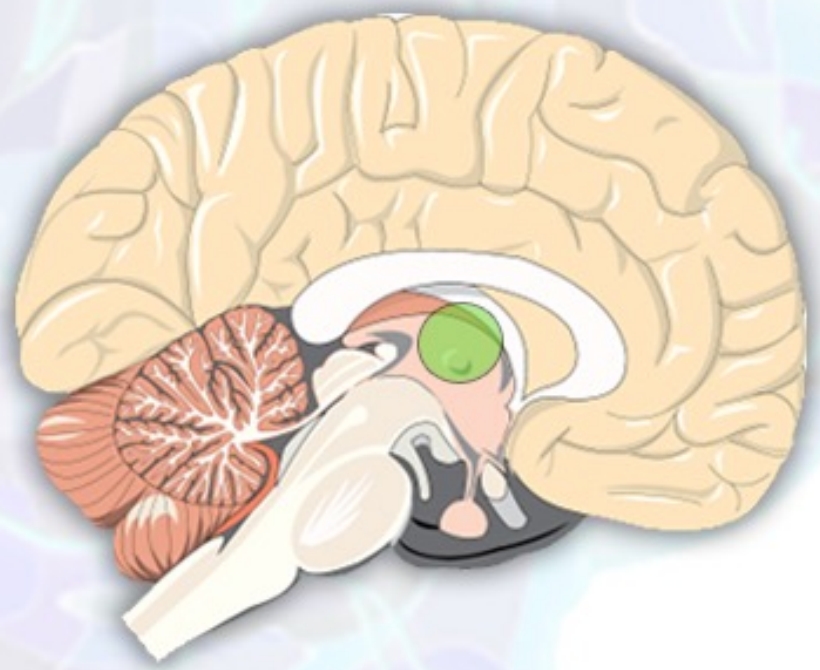
Thinking Brain
(Cerebral cortex)

Limbic System

Thalamus

Gateway for sensory information (except smell)

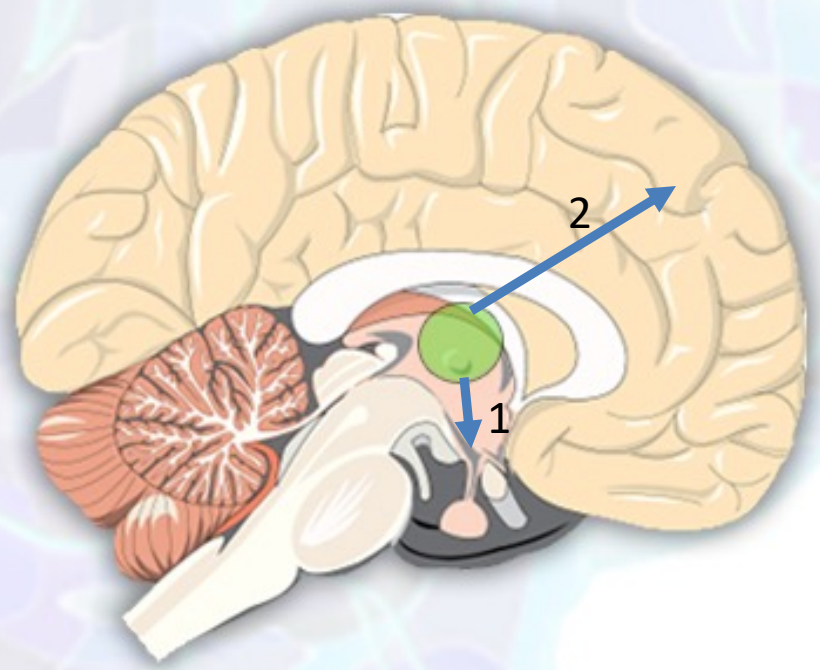
Main objective is to share sensory information with as much of the brain as possible, as fast as possible!



Thalamus: The Two Pathways

1. Fast, short path to the amygdala…

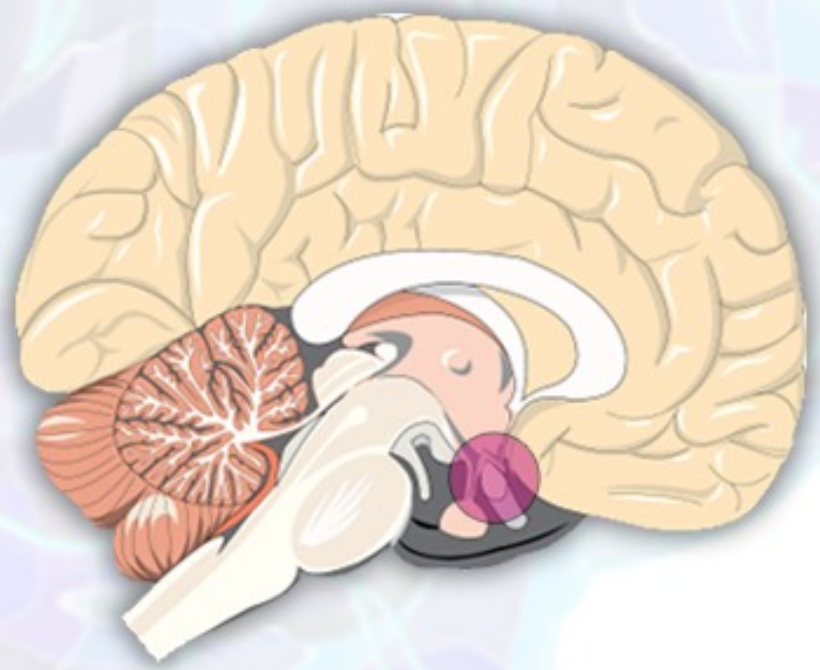
2. Slow, long path to the cortex…



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

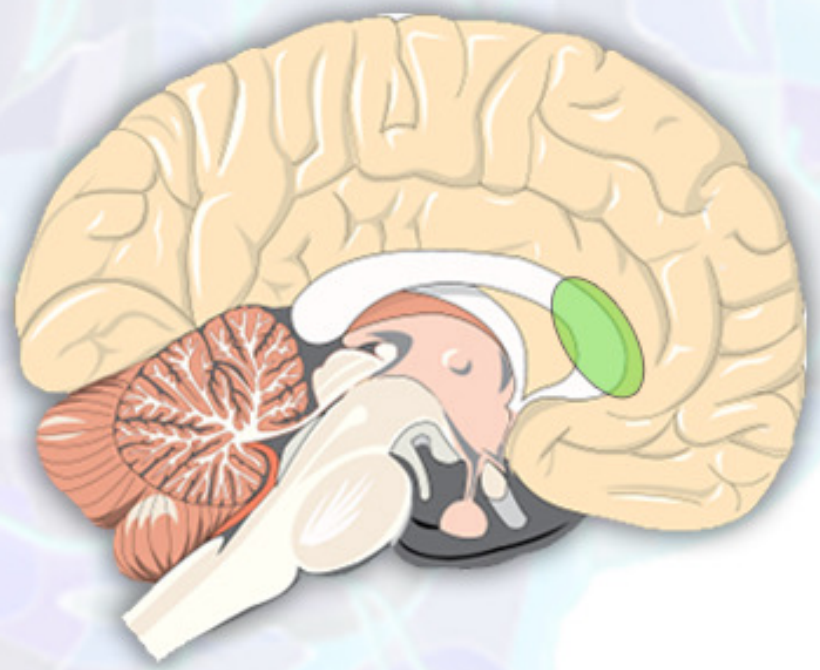
Hippocampus

- 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”

Cortex: Frontal Lobe

Prefrontal Cortex:

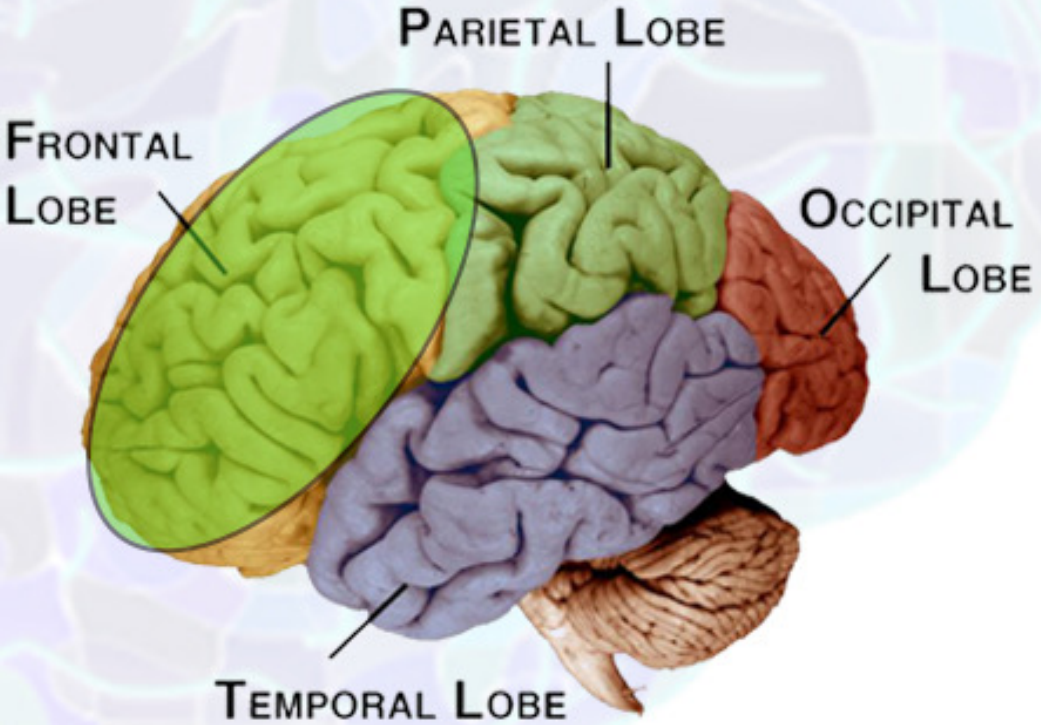
- Rational thought
- Goal-making
- Decision-making
- Sense of others
- Personality
- OFC

Primary Motor Cortex

- Movement

Cingulate Cortex

- Emotion regulation
- Expectation of pain
- Conflict monitoring



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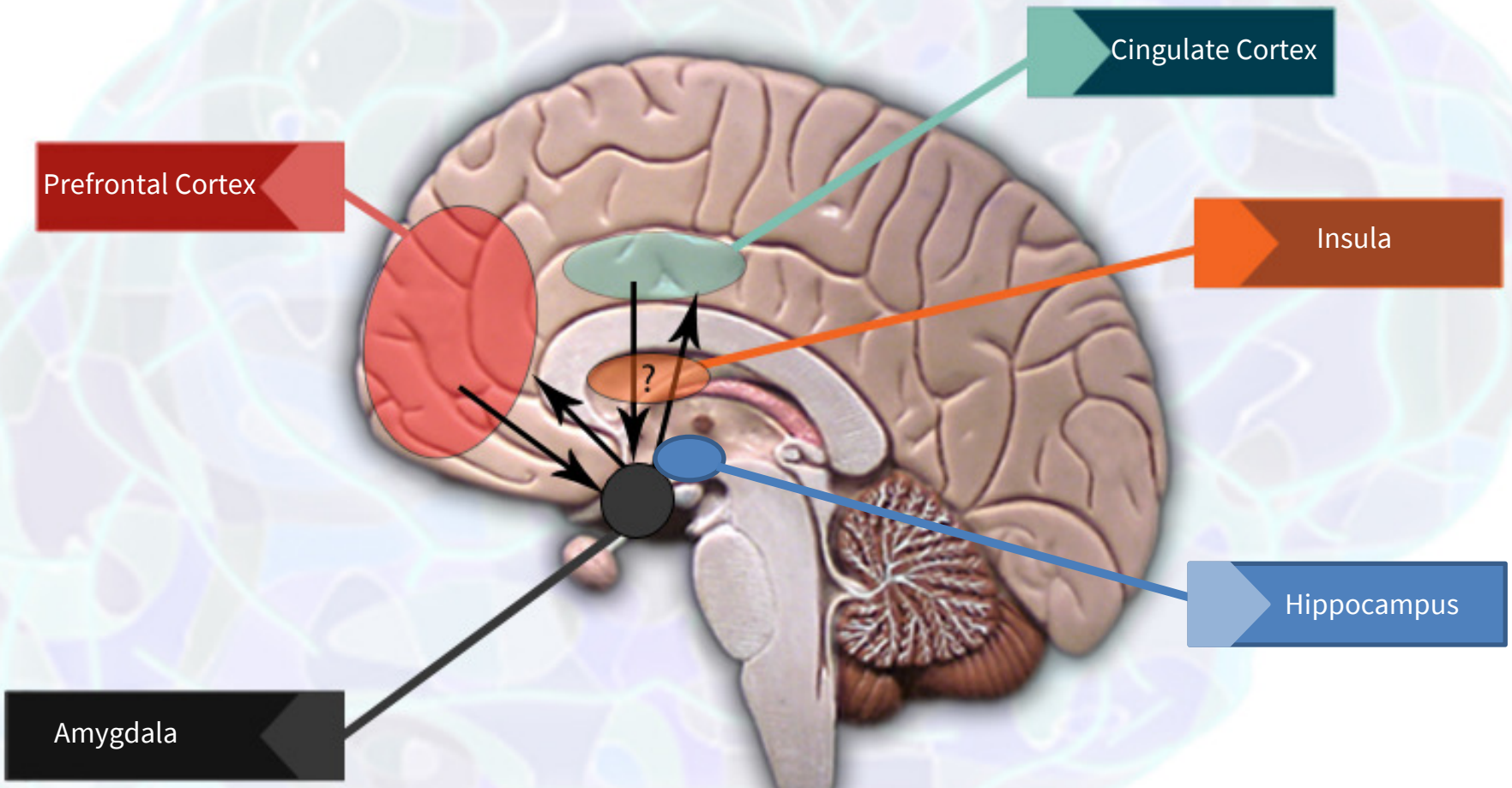
The Neuroscience of Trauma



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)

Part II: Mechanisms and Neuroscience of Treatment

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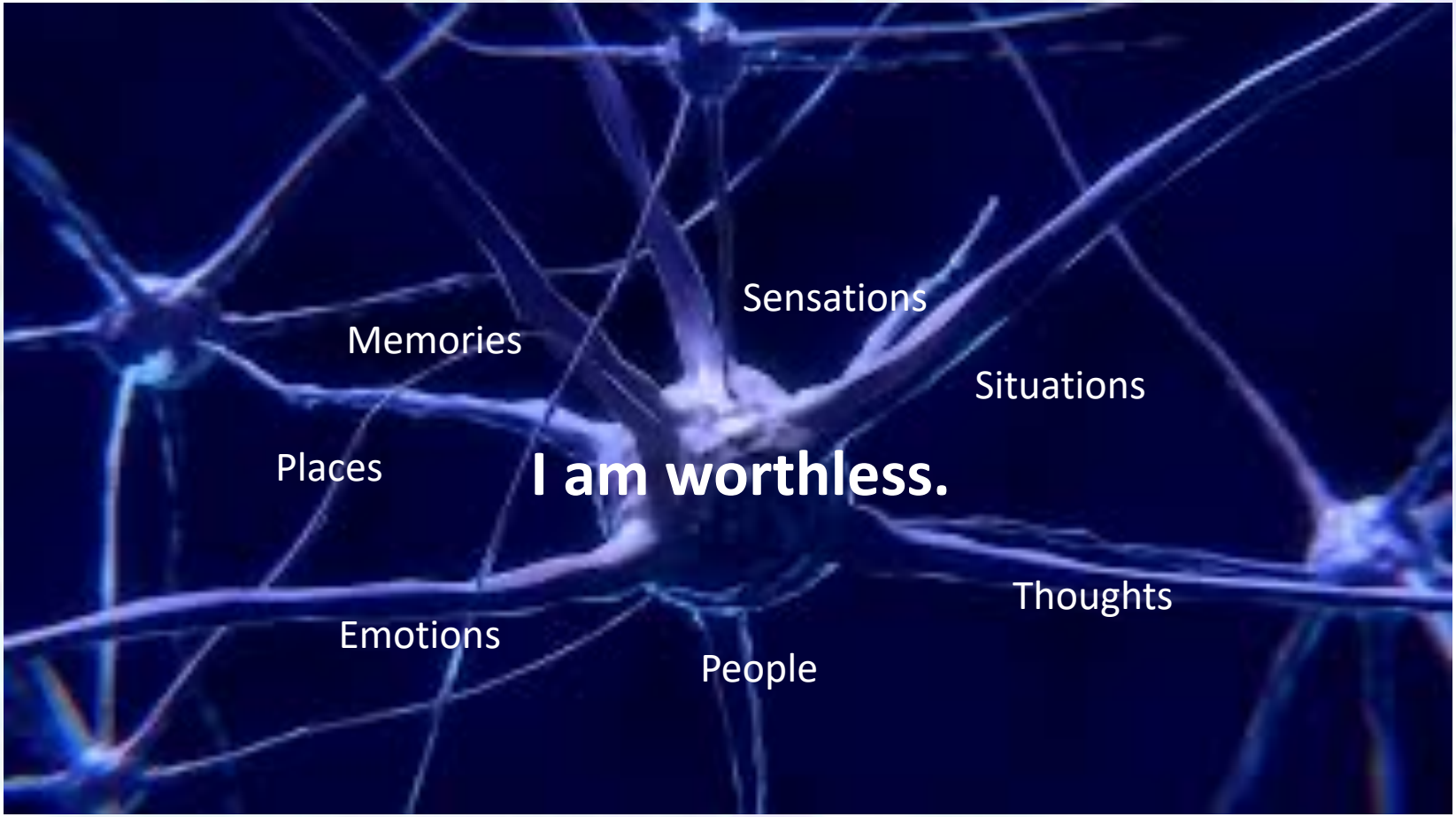
Treating Avoidance

- **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.

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

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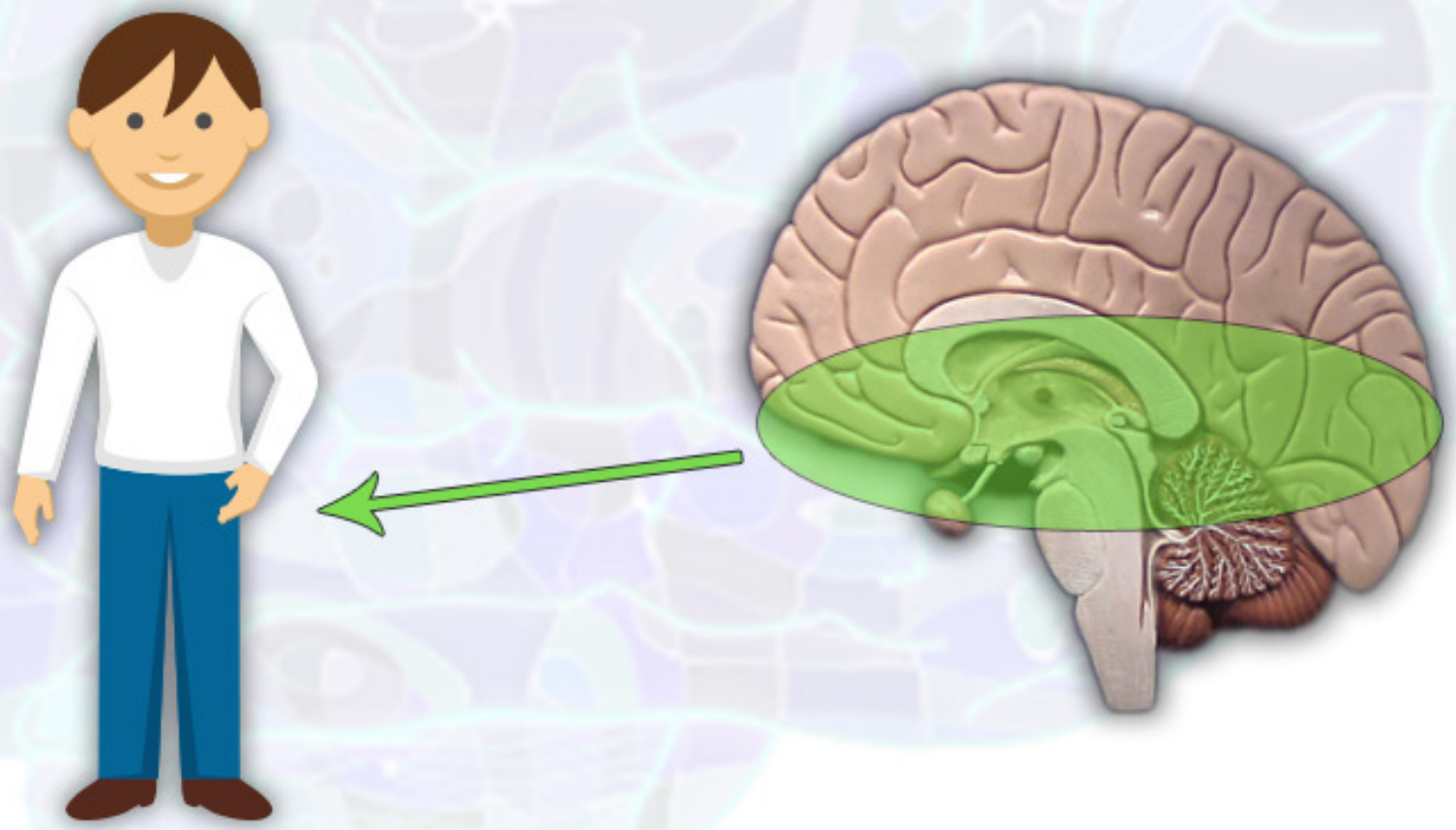
Bottom-up Interventions

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

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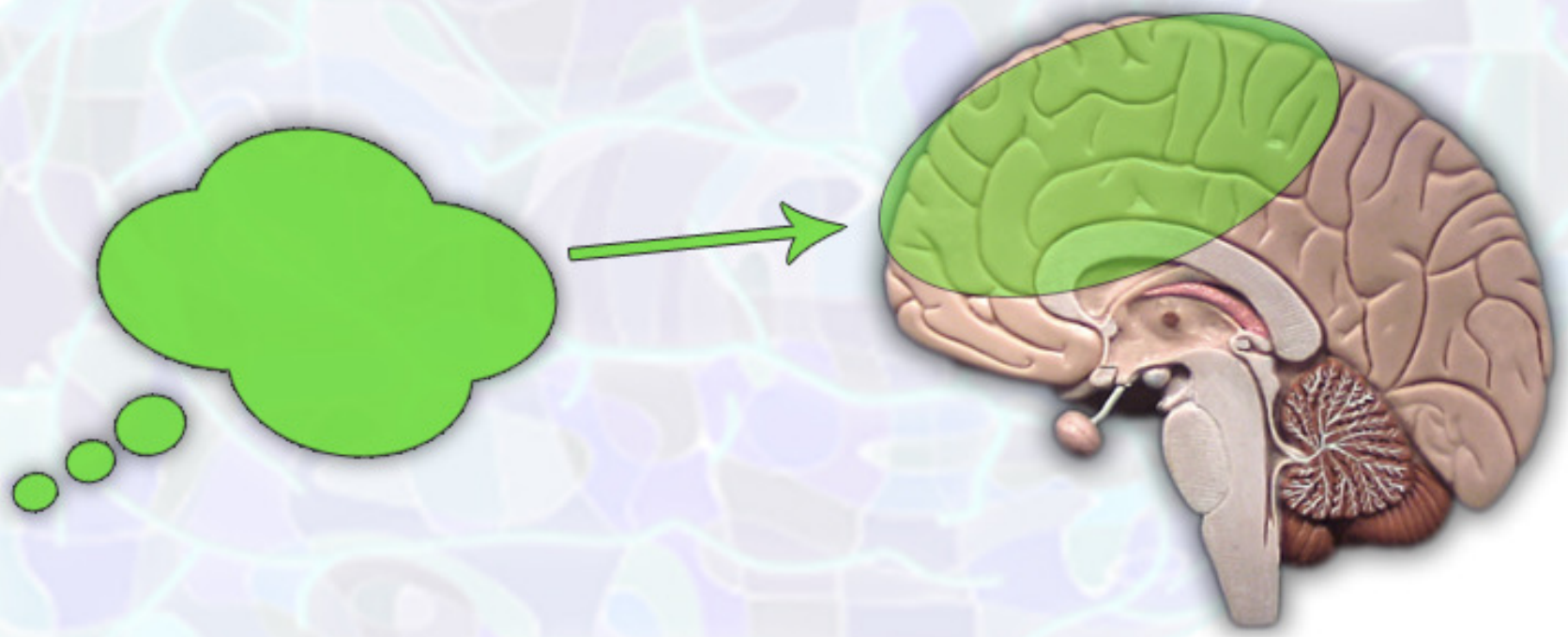
Top-down Interventions

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

Horizontal Interventions

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

Part III: EMDR as Applied Neuroplasticity

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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

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).

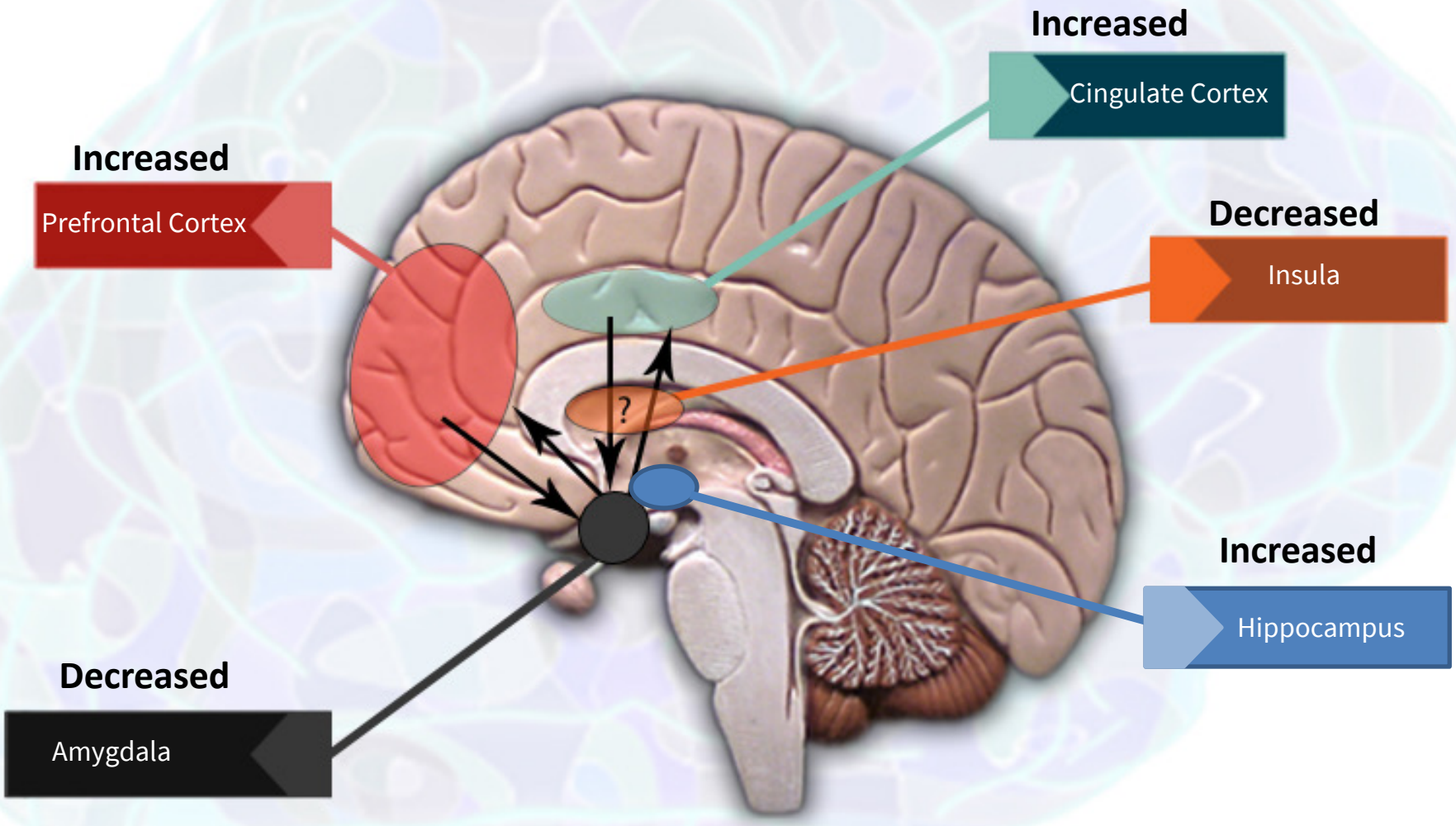
Reduced:

- 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

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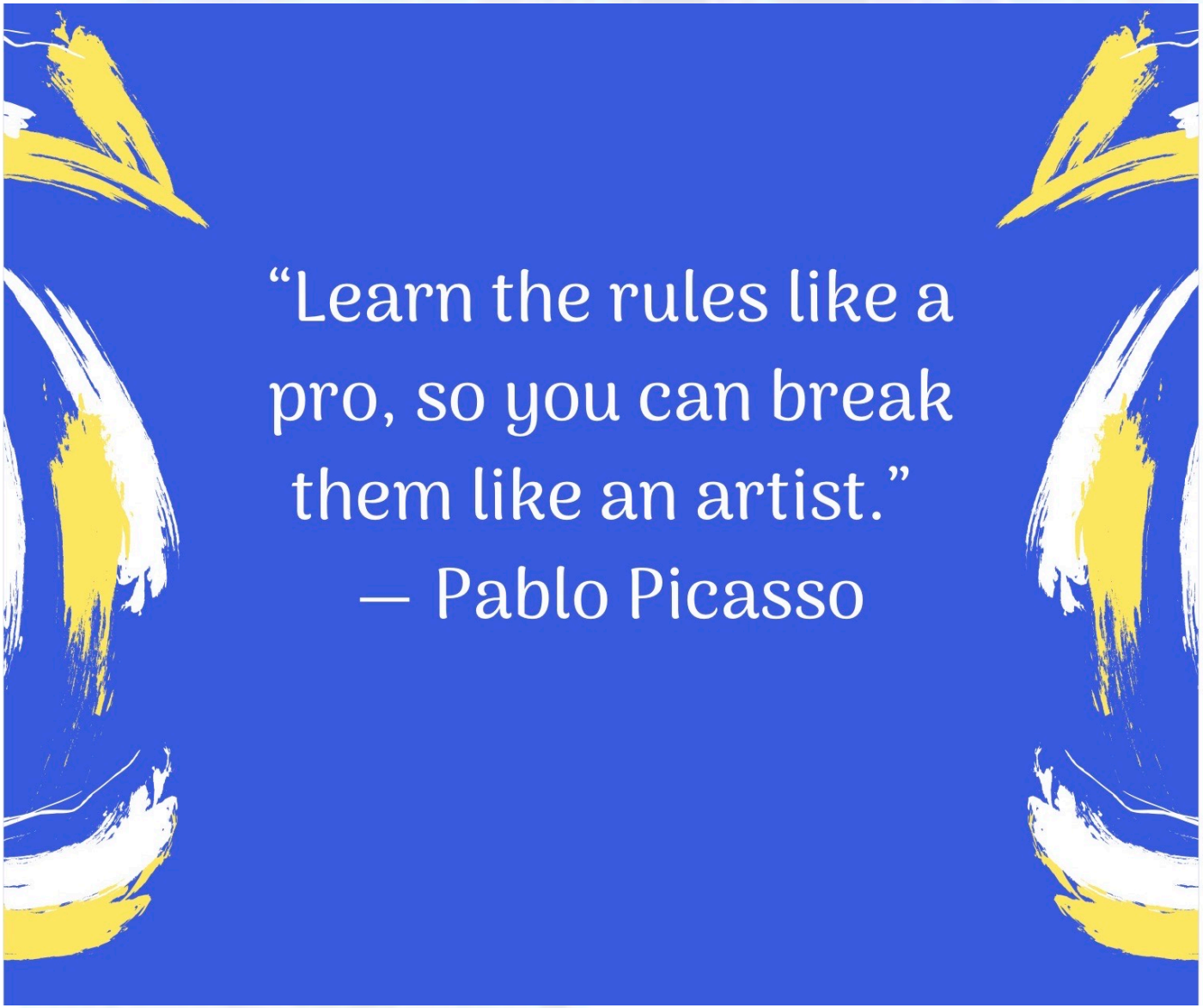
EMDR in the Big Picture



EMDR in the Big Picture

1. Build the alliance (bottom-up, reduces cortisol)
2. Safely enter the body (increase insula activation)
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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

- Phase 1: Target Sequence Planning (or Target Mapping)
- Phase 2: Preparation: Grounding, resourcing, stabilization, explain logistics
- Phase 3: Access and Activate
- Phase 4: Desensitization
- Phase 5: Installation of PC
- Phase 6: Body Scan
- Phase 7: Closure
- Phase 8: Reevaluation

Part V: Phase 1: Target Sequence Planning

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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. **Target Sequence Planning**

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	• Terror	• Apprehension	• ?
• Anger	• Rage	• Annoyance	• ?
• Sadness	• Grief	• Pensiveness	• ?
• Disgust	• Loathing	• 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**

PAST EXPERIENCES (CONTINUED)

(If no, proceed to Positive Cognition; if yes, continue...)

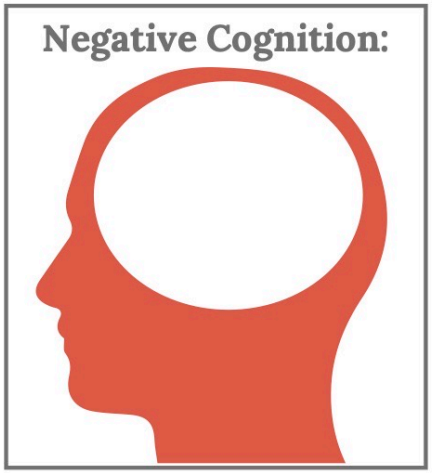
Can you give a couple of examples of when you have felt this way before?

NEGATIVE COGNITION IDENTIFICATION

Is there a theme you can identify with these events, sensations, and/or emotions? What do they seem to have in common? We call this the "negative cognition," and it's usually an "I statement," where the person comes to believe that the issue(s) reflect something negative about themselves...

Examples:

- I am worthless.
- I am unworthy.
- I am not good enough.
- I am destructive.
- I do bad things.
- I am out of control.
- I have to be in control.
- I am bad.
- I can't trust myself
- I can't be trusted.
- I can't protect myself.
- I am helpless.
- I don't deserve to live.



SUMMARY OF NEGATIVE COGNITION

Presenting Problem:

Negative Cognition:

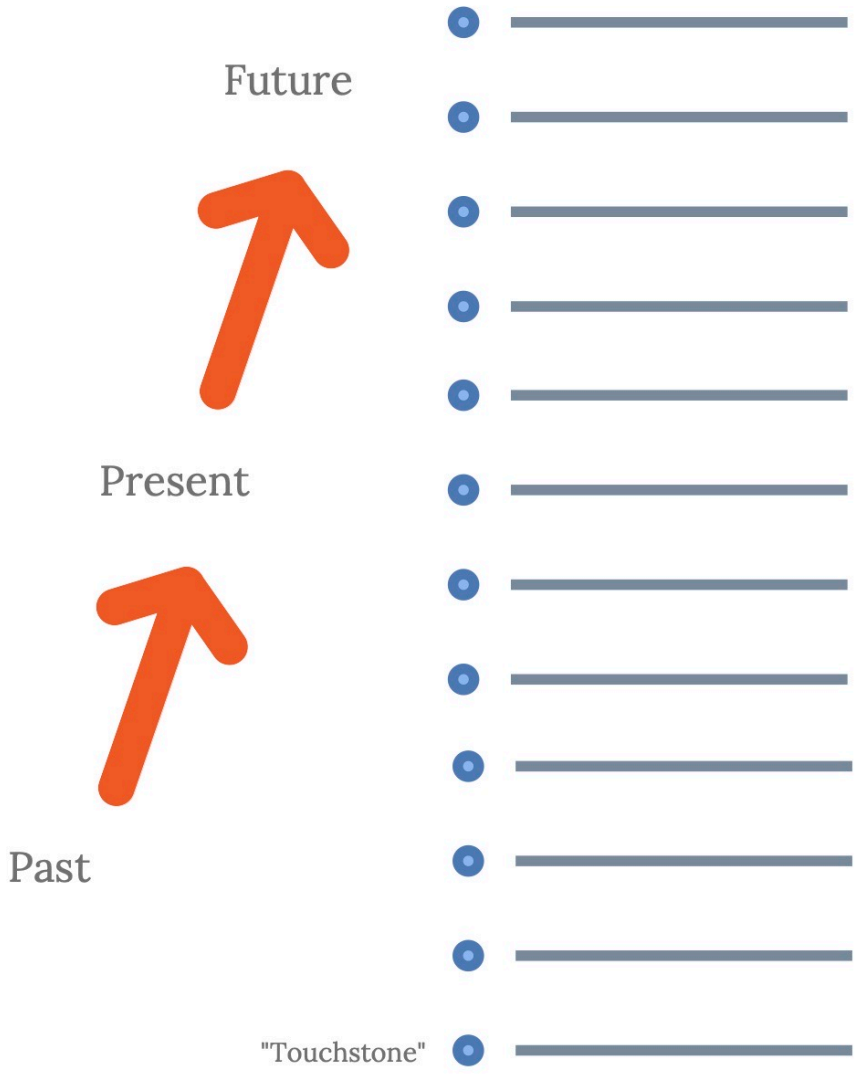
What is the "temperature" (SUDS 1-100) associated with this?

Associated Emotions:

Associated Sensations:

TIMELINE OF EVENTS CONSISTENT WITH NEGATIVE COGNITION

Now, I'm going to ask you more about times in the past when you've experienced this negative cognition, and perhaps times when you experienced similar sensations and emotions. I'll begin by asking for the earliest memory, called the "touchstone memory," where you experienced this thought. I'll also ask you about times in the future when you believe you might experience this again...



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.)

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."
- Start with most activating/intense/distressing network, OR touchstone memory, if multiple targets are identified.

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

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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

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)."

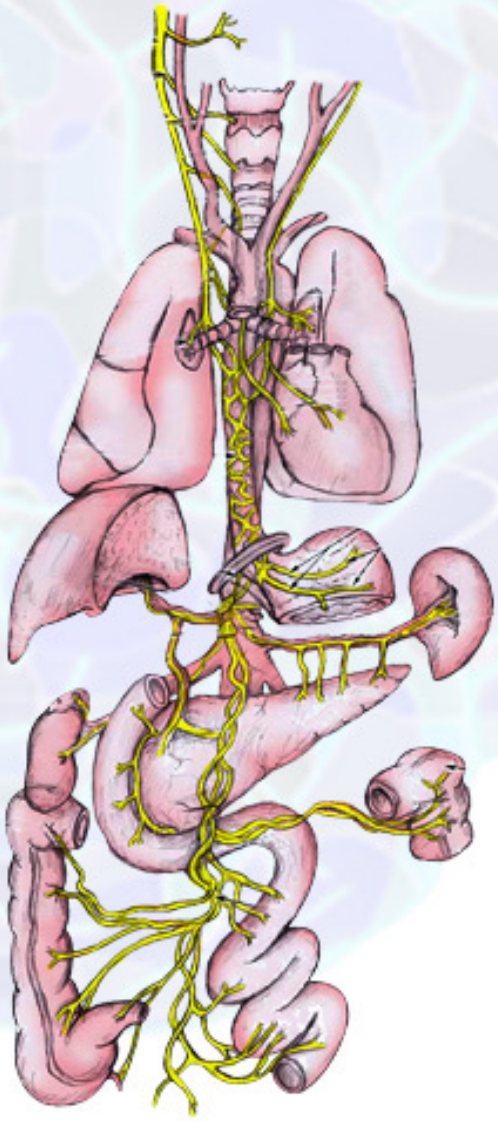
Breathing techniques are recommended for anxiety management (Davis et al., 2008) due to their ability to reduce autonomic arousal and amygdalar activity.

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!



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Diaphragmatic Breathing: Vagus Nerve

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

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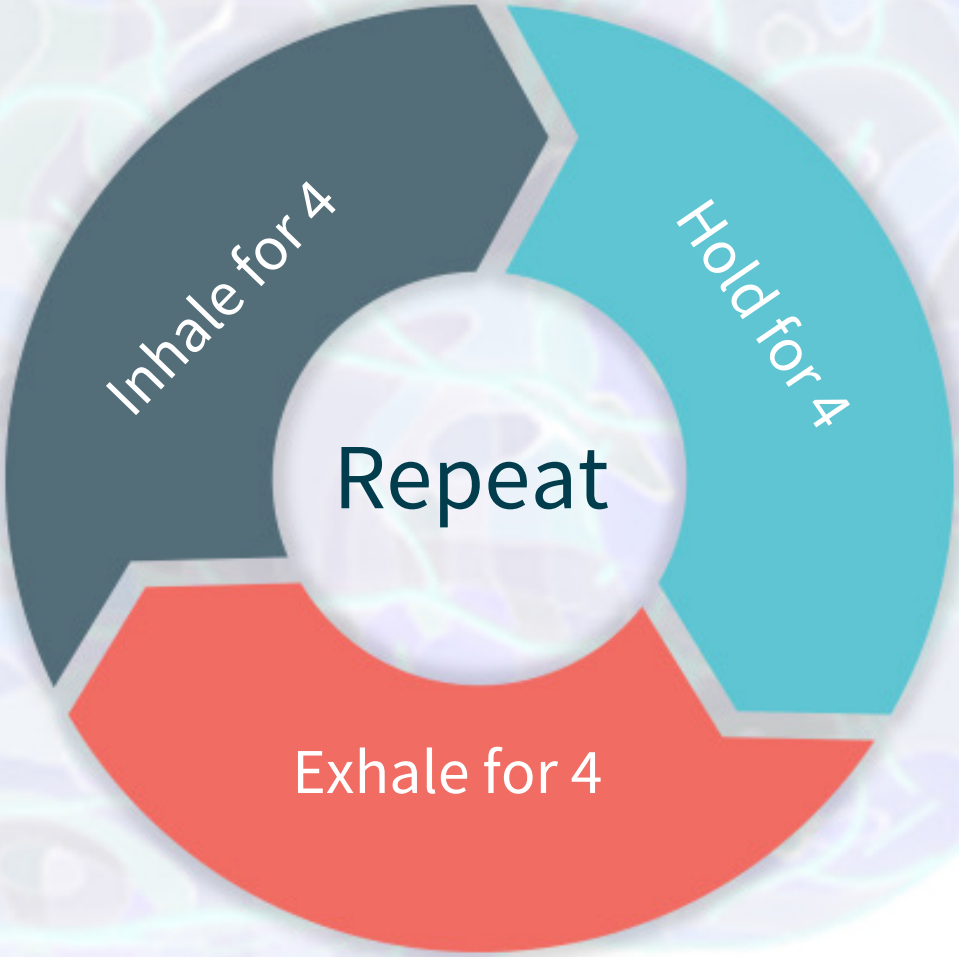
Diaphragmatic Breathing: Four Count Breath



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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.

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!

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:

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:

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:

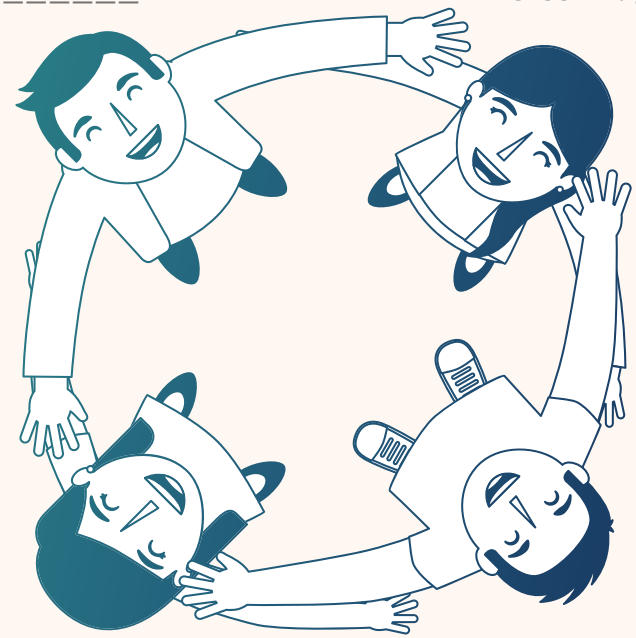
CIRCLE OF SUPPORT

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

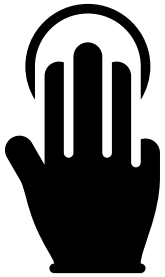
Build Attunement

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...

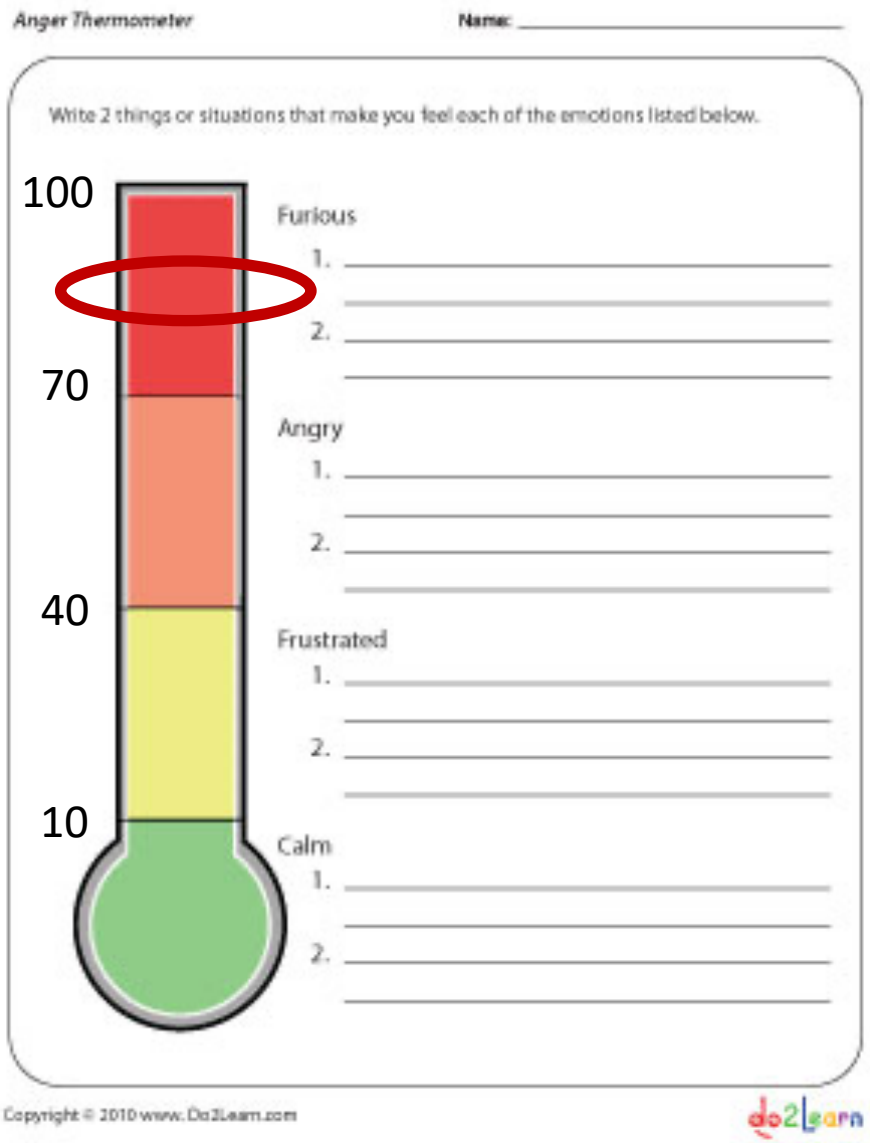
Place your feet flat on the floor. Have client mirror you, placing their feet flat on the floor as well. Next, gently begin alternating tapping your toes, keeping your heels on the floor, and instruct the client to do the same, in tandem with you. Be sure to tap very slowly (about 1 tap per 2-3 seconds).

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.**

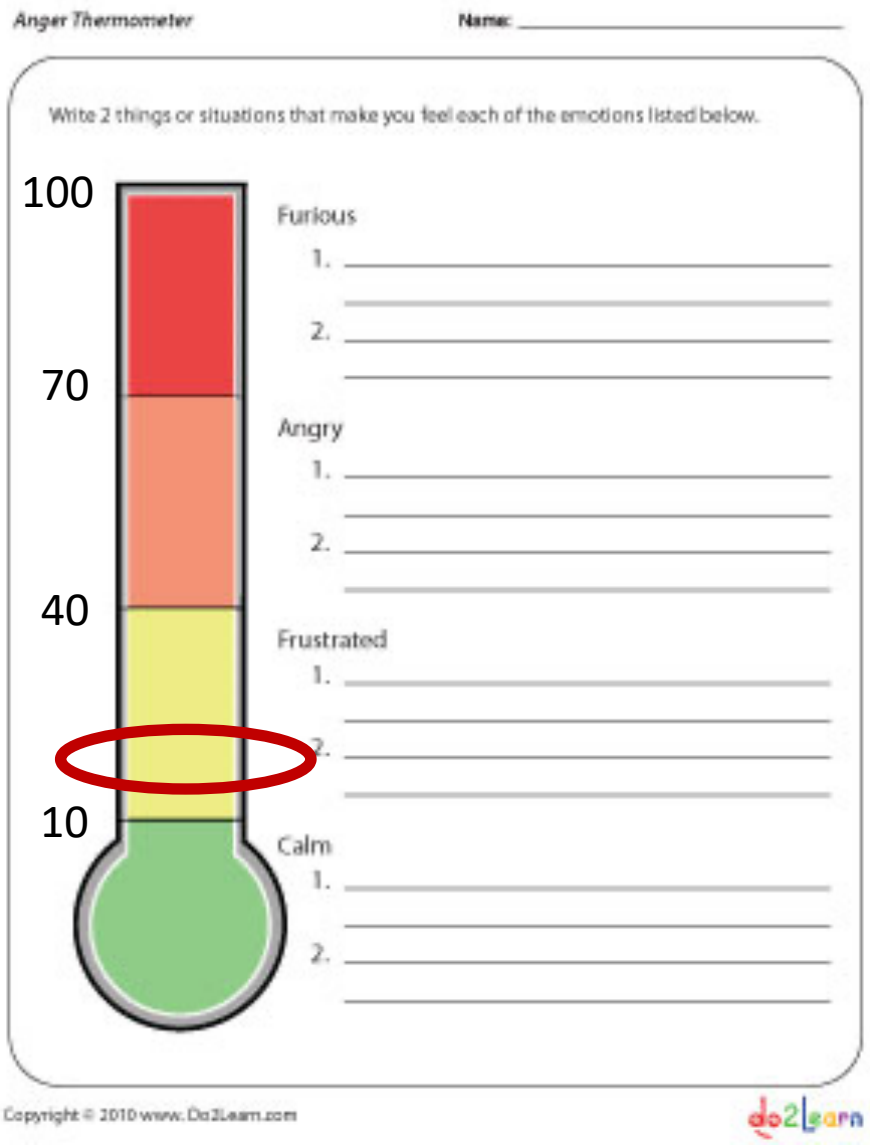
Distress Thermometer

- 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

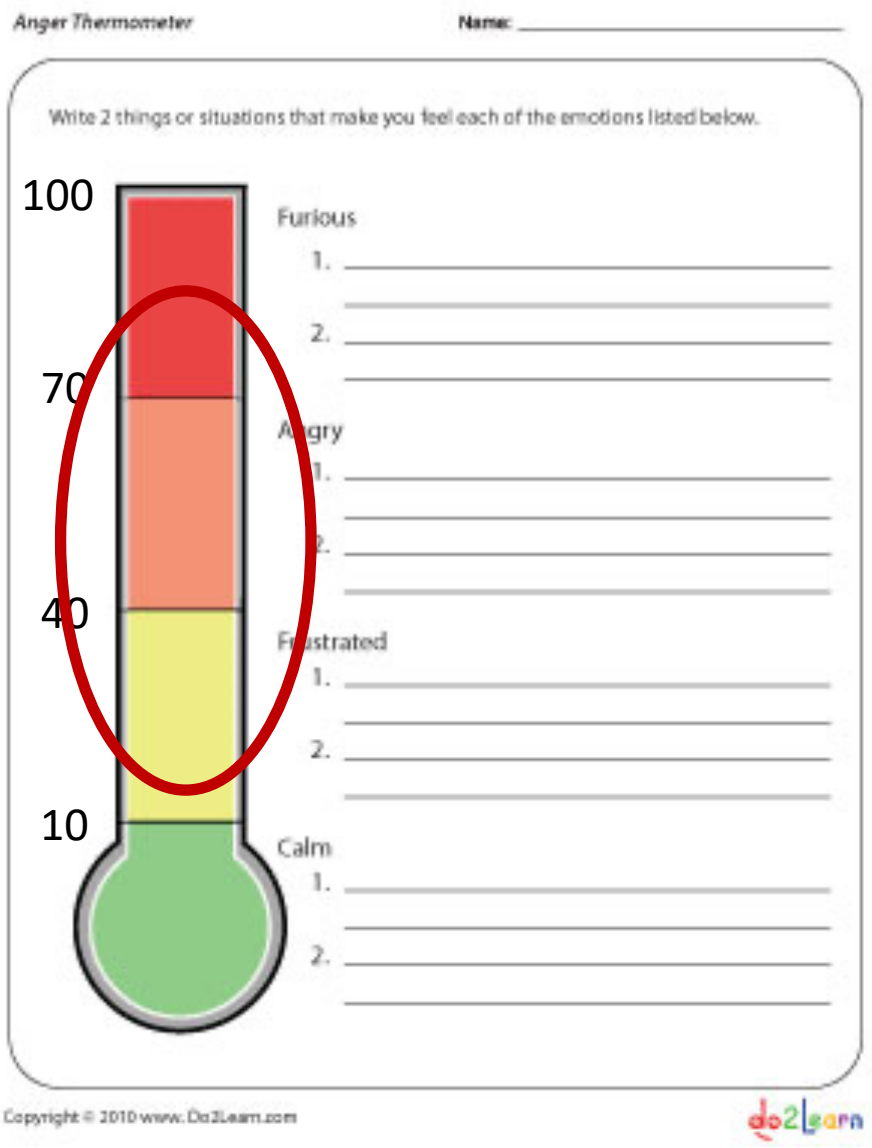
- Ask, *"Do you have a sense of where your own 'freezing point' is, the point at which you feel disconnected, dissociated, or frozen?"*
- *Define the downward "anchor" as an example of this.*



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.***



Part I: Phase 3: Access and Activate

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

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. Bring to mind an image of the worst part of the memory.
3. Access NC along with image
4. Associated emotions
5. Associated sensations (unless doing EMD, then no sensations)
6. Temperature Check 1-100 (should be at 30+)

(Follow instructions on Access & Activate Worksheet)

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

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

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

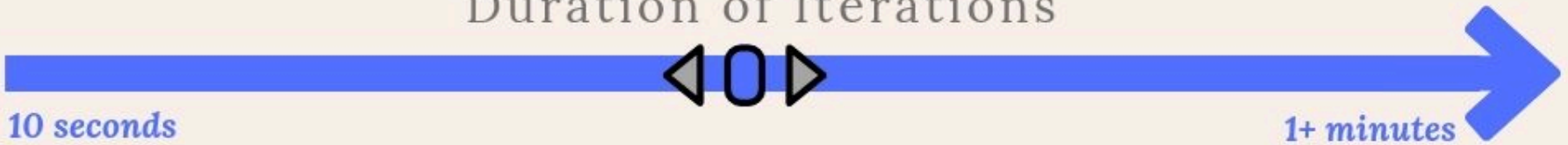
The EMDR Processing Continuum

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?"

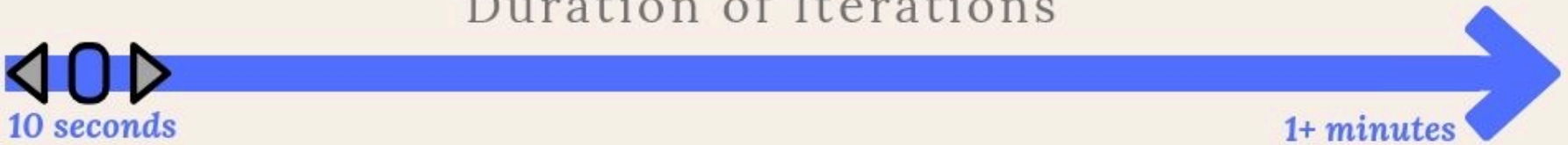
The EMDR Processing Continuum

EMD
(Restricted)

EMD(R)
(Contained)

EMDR
(Unrestricted)

Duration of Iterations



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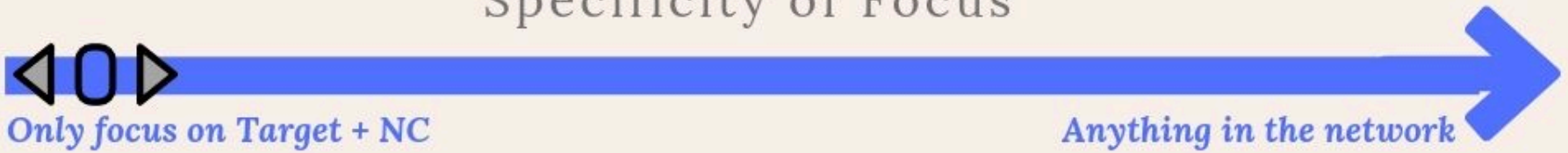
1+ minutes

Specificity of Focus



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Anything in the network

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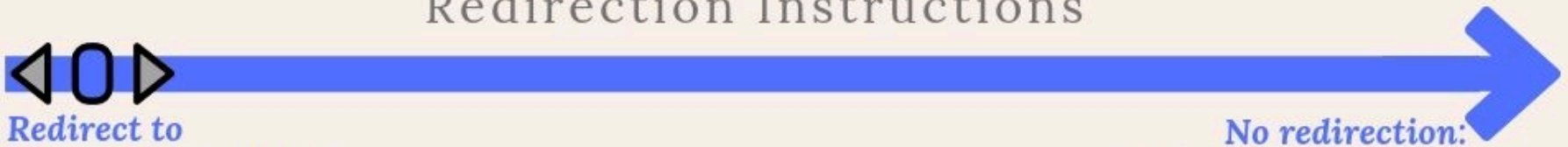

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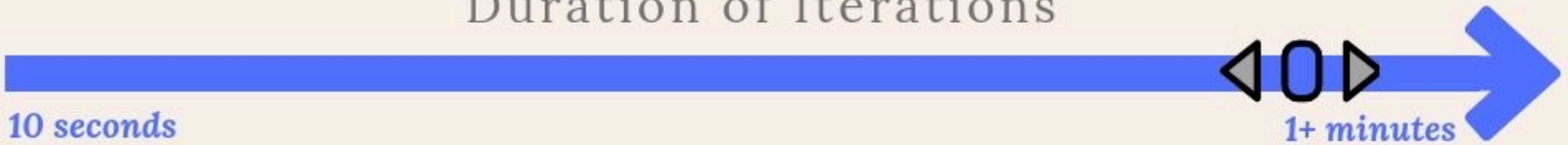
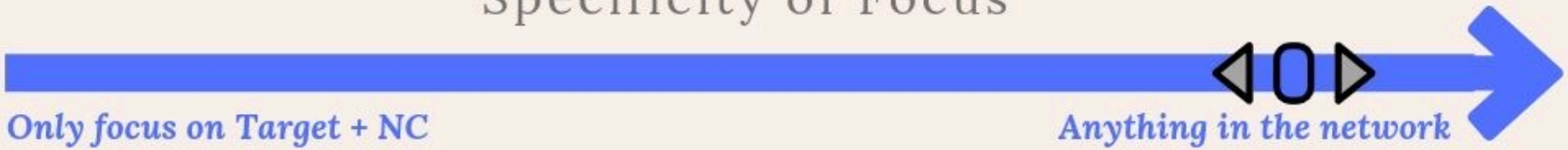
Duration of Iterations



10 seconds

1+ minutes

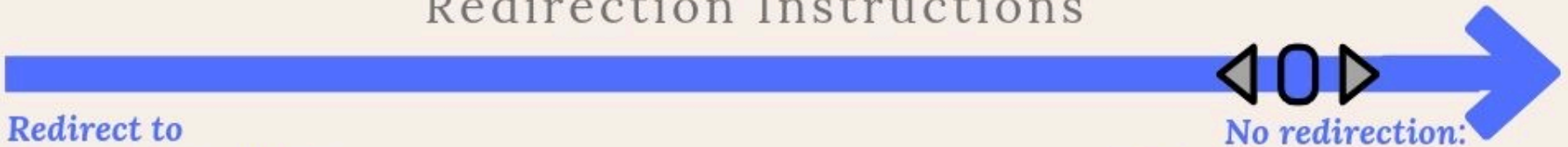
Specificity of Focus



Only focus on Target + NC

Anything in the network

Redirection Instructions



Redirect to
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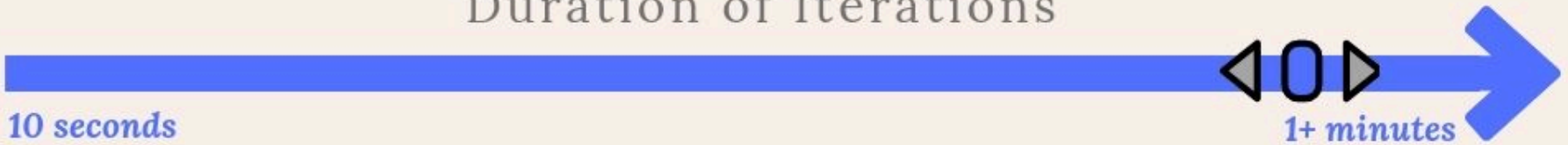

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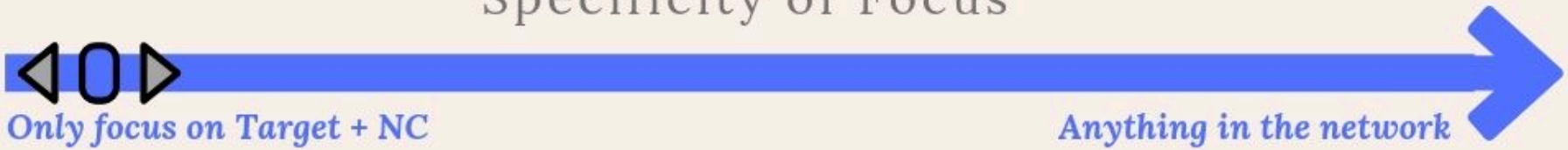

Only focus on Target + NC

Anything in the network

Redirection Instructions

Redirect to
Target + NC + SUDS

No redirection:
"What do you notice?"

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

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…”
- 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: Phase 6: Body Scanning

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

BUT

- I’m going to switch this up. We are going to do Phase 6 BEFORE Phase 5. This isn’t “classic 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 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…

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.

Part IV: Phase 5: Installation

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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. When the client gives the Voc (1-7), repeat BLS/DAS, *slowly*, for about 15+ seconds.
6. Ask for VoC after each iteration; when it stops changing, you’re done with Phase 5.

Follow the Installation Handout instructions…

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:

- 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!

Phases 7 & 8: Closure & Re-evaluation

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

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/Window of Tolerance.
- 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.
- 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.

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.

Demonstration:

Desensitization Preparation, Phase 3, and Phase 4

(and maybe more ☺)

Contact me!

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www.facebook.com/drjsweeton

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Materials that are included in this course may include interventions and modalities that are beyond the authorized practice of mental health professionals. As a licensed professional, you are responsible for reviewing the scope of practice, including activities that are defined in law as beyond the boundaries of practice in accordance with and in compliance with your profession's standards.

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

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.