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UNLEASH YOUR EMDR: RELEASE THE MAGIC

A Guidebook for Attachment-Informed, Integrative, Transpersonal EMDR



EMDR Focus

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1. Introduction

This booklet brings together in simple form some of the key elements of what we have found helpful for work with more complex, attachment-disordered clients - embracing the creative, the intuitive and also the transpersonal.

While Integrative, Attachment-Informed EMDR is largely a non-rational, right-brain experience of metaphor and meaning (and can indeed be a profoundly transpersonal psychotherapeutic approach) that does not mean that anything goes.

Nor does it mean that the established principles of EMDR therapy and the central place of Adaptive Information Processing (AIP) as formulated by its originator Francine Shapiro can be left to one side.

On the contrary.

Breaking the energetic spells that trap clients in the emotional dysfunctions of their past – in effect rewiring their brains and nervous systems with the felt and imagined experience of safe attachment they didn't have as children - requires a tight and clear therapeutic discipline and focus.

EMDR's Standard Procedural Steps, aka the Standard Protocol – the Three Prongs (Past, Present and Future) and the Eight Phases – remain an essential structure within which the best EMDR can be practised and experienced.

When working with complexity (and let's face it, that's mostly what we do), we need to identify where a client was wounded/injured in their early life, and where, in the absence of appropriate attachment, or the presence of dysfunctional attachment, the inevitable ruptures of childhood were not repaired.

After all, if you think about it, no client comes into psychotherapy because of what happened in the past. They come to us because they cannot process, or deal with, the impact that those past experiences continue to have on their present functioning.

It's therefore our job as EMDR therapists to facilitate the essential repair of what Francine Shapiro calls the Presenting Past, enabling our clients (echoing the language of Mindfulness and Mentalisation) at the same time to both *have* and *observe* experiences in the present – a capacity which will allow them to make healthier and more appropriate choices about how they respond to the Now.

In essence, complex trauma (C-PTSD as newly defined in the ICD 11) invites us to ask ourselves three key questions of our clients:

1. How did this person get to be this way? (What's this REALLY about?)
2. What – where, how, with whom, and in what context - did they learn to do (emotionally, behaviourally, cognitively) to manage their emotions and self-soothe?
3. What therefore are the patterns that need to be repaired and rewired. (And in that context, what happened to them?)

Not, in other words, what's wrong with them. But rather, what have been their experiences. These are the stories that generate the most relevant EMDR targets.

As Gabor Maté says, trauma is not the external event. It's the *internal wound.*

In EMDR with more complex clients therefore, we aim above all to identify and repair early attachment ruptures, explicitly encouraging and supporting the client's Adaptive Information Processing (AIP) capacity to rework and rewire their implicit response circuits to stress.

Even if we start out in the client's present or in their future, remember that as a general rule we need (as per Three Prongs) to clear the past, the present, and the future in that basic order, focusing especially on the past as this is what's almost always getting in the way of their ability to be fully and safely themselves today.

Think of EMDR as a dance. You ***have*** to know the basic steps. But with only those basics, you'll never win Strictly Come Dancing. Working as outlined in this booklet, with attachment and creativity, the dance truly comes alive.

We hope that the ideas set out here will help you as clinician to create an empathic, focused and holding space in which the magic - the "weird" as clients often call it – (and, recalling the Findhorn Foundation's definition of a miracle as a simple but existential shift of perception, perhaps even the miraculous?), can happen.

NB: *Italics in the te*xt that follows indicate specific language we invite you to use with your clients as each element of this kind of EMDR unfolds. Non-italic fonts indicate explanations and instructions to you as therapist.

">>>" means BLS (also sometimes referred to here as tapping, whether tactile, eye movements or auditory.)

2. EMDR's Standard Procedural Steps

It's important to see the adaptations suggested in this booklet as complementary to the Standard Protocol (SP), rather than as a whole new EMDR therapy.

As Dr Derek Farrell (Senior Lecturer in EMDR at the University of Worcester and Past President of the EMDR Association UK & Ireland) puts it, the EMDR Therapy Protocol is in essence quite simple:

1. Accessing a distressing memory that generates a presently-held level of disturbance: image, cognitions (beliefs), emotions and body sensations.
2. Stimulating this disturbing memory bilaterally using Dual Attention.
3. Moving the memory – physiologically, in regard to subjective disturbance (emotions/body), and psychologically in terms of meaning.

This is done, Dr Farrell adds, "in regard to eight distinct phases considering the triadic elements of Past – Present – Future."

All the rest, he makes helpfully clear, **is detail**.

Regarding terminology and titles, in developing what we're choosing to call "attachment-*informed*" EMDR, we're grateful above all to Dr Laurel Parnell for her teachings on attachment-*focused* EMDR, set out in her two seminal books on working with developmental deficits from childhood, A Therapist's Guide to EMDR (2007) and Attachment-Focused EMDR (2013).

Dr Parnell describes how she was pleased to adopt the term "attachment-focused" as suggested to her by Dr Dan Siegel at a trauma conference in Boston USA where she was presenting..

It's a good term, also referenced by others in our field including leading EMDR Institute trainer Deany Laliotis (on her website in 2021).

However, for this booklet and for EMDR Focus trainings, partly out of respect for Dr Parnell's "ownership" of attachment-focused language, we prefer the more general term "attachment-informed", making clear that this way of working is a development of rather than a departure from EMDR's Standard Protocol.

3. The Distinctive Elements of AI-EMDR



At the risk of adding new jargon to the compendium of EMDR-specific terminology that's already quite comprehensive enough, we find it useful to understand Attachment-Informed EMDR as having what might be termed **six distinct elements to complement and enhance the eight *Phases* of the Standard Protocol**.

EMDR's Phase One *History-Taking* has in this approach a distinct and central focus on **case conceptualisation,** as this will determine the effectiveness of actual targeting and processing in EMDR's Phases Three and Four.

Good case conceptualisation involves much more than merely identifying a diagnosis, of Depression or Anxiety for example, or OCD or Dissociation or whatever the presentation. What matters is a curiosity about the original evolutionary and survival-informed *purpose* of what is now a dysfunction.

In **Phase Two of Standard EMDR, *Preparation***, an attachment focus invites the therapist to install, or *tap in (*a term we prefer as more client-friendly), a **richer and more imaginal set of resources** than is included in most basic EMDR trainings.

As well as a Safe, or Special or Peaceful or Calm Place (the adjective to be chosen by the client, as "Safe" can often be a triggering word in its own right), in this Phase of AI-EDMR we identify and tap in, routinely with *every* client, Dr Laurel Parnell's now widely-accepted "team" of imaginal support figures.

These usually consist of three or so Nurturers, (imaginary or real, human or animal, contemporary or historical), three or so Protectors, and then a Wise Figure, or perhaps two, though one is usually enough. True wisdom doesn't need a second opinion.

These can prove both useful and essential when processing targets in Phase Four that involve dysfunctional attachment experiences where primary caregivers were either neglectful or actively abusive.

(Note that it's important not to see or use Resource Figures as the primary repair tool in AI-EMDR, or, as explained further down, to deploy them too early or too enthusiastically.

They are in effect transitional internal objects – imaginary or remembered representations in other words of the client's own nurturing, wise and protective qualifies of Self - that allow the client to access evolutionary and universal qualities of nurture, wisdom and protection that haven't been appropriately activated by childhood experience.)

In EMDR's Phase Three *Assessment*, rather than discussing or analysing with the client what might be the most important targets to process, when working with attachment-informed complexity and developmental deficits from childhood, we have the essential option of front-loading the work, directly from the present, with an **attachment-informed, proactive *Bridge.***

Explained fully in the chapters that follow, this is a simplification of the Floatback or Affect Bridge of the Standard Protocol, placing a much stronger emphasis on right-brain intuition than left-brain analytical or remembered assumptions about where and how the client learned their limbic-system survival patterns very much earlier in life.

With many clients, these often-subtle attachment experiences are the reason stress and challenge are not being managed well in the present - whether this involves relationships, self-esteem, work, intimacy issues, anxiety or almost anything else.

Again, we are indebted to Dr Parnell for identifying the value of routinely using bridging as a target identification strategy in Phase Three Assessment.

Still in Phase Three of Standard Protocol EMDR, Assessment in Shapiro's original language, AI-EMDR encourages the therapist to choose the **most powerful and appropriate way of activating** a client's trauma memory network.

This might be in the traditional sequence of NC, PC, VoC, Emotions, SUDs and Body, or for example with the Blind to Therapist approach (choosing just a cue word for the target and leaving out cognitions) or – especially with more complex clients when working with childhood stories – a **Modified or Simplified Protocol**.

A simplification of Phase Three (as advocated by Dr Parnell and Mark Dworkin among others) omits the identification of a Positive Cognition at this point of the work, and also the left-brain numbers of the VoC or SUDs.

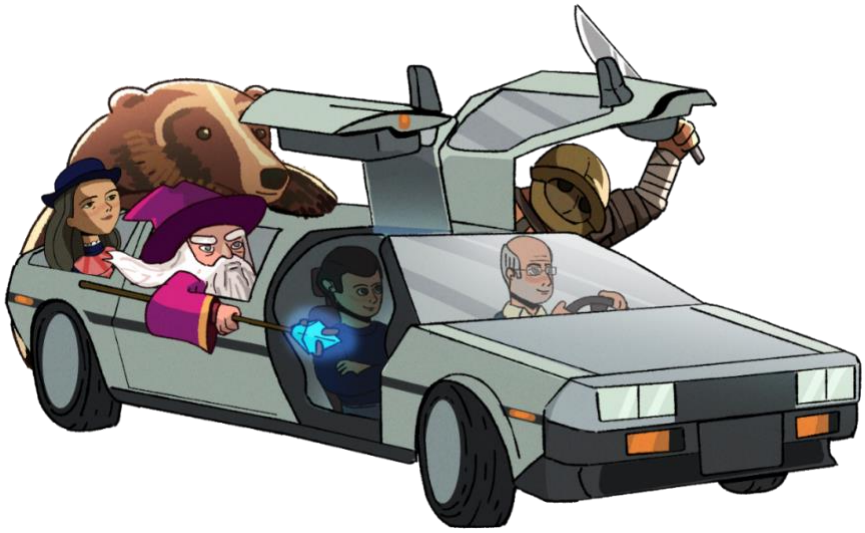
The aim here is to avoid confusing a child ego state with left-brain questions around cognitions and domains, trusting that the appropriate negative thought about self (which sets the frame in which a PC can be identified towards the end of the session) will emerge in the **adjusted sequence of Image, Emotion, Body and only then Belief**.

In EMDR's **Phase Four *Desensitisation (actually Processing)***, the attachment-informed approach invites the therapist to use, where appropriate with attachment-related childhood targets, the widest range of **creative and imaginal interweaves,** working with the client as if the stories were being addressed and repaired in the literal present to heal the wounding of the past.



Clients often enjoy the metaphor here of the movie **Back To The Future**, where Dr Emmett Brown and Marty McFly return to correct Marty's past in Doc's Flux Capacitor-equipped De Lorean time-travelling car.

With thanks to Jonny Hutton for the artwork in this brochure, an EMDR version can be imagined as a modified and stretched De Lorean with space for the client's resource team, taking us back in time to find the client's stranded (or exiled) child ego state to unlock the emotions, thoughts and physical sensations burned into their nervous system by early trauma.



Once the story is found, told and shared, creative interweaves can be used to invite the client, if necessary with the help of their resource team, explicitly to fix and rewire – to *re-do* as it is sometimes described – the old stories that have, for so long and usually unconsciously, compromised the present.

Finally, **AI-EMDR** places very **explicit emphasis on Session Structure**, embracing in effect all the main phases of Standard EMDR including Phase Five Installation of the emerging PC, Phase Six's Body Scan, Phase Seven Closure and Phase Eight reevaluation.

Positives emerging from the work whether complete (with a VoC of 7/7) or Process PCs are tapped in and checked with a Future Template.

The first five elements of AI-EMDR are sequential, so this final piece can perhaps be understood as the framework in which the other adaptations find their place.

When applied with focus and imagination, we find that attachment-informed focusing of the standard EMDR approach means that you very rarely have an incomplete

session (although of course more often an incomplete story which needs further work in further sessions.)

EMDR Focus

4.That's Weird: Imagination & the Neuroplastic Brain

Although short, and hopefully pithy, this is in some ways this booklet's most important chapter.

So let's begin with a reminder of the fundamental notion on which EMDR therapy is based – namely what Francine Shapiro termed the Adaptive Information Processing, or AIP, or the capacity of every human brain to rewire the past.

We're reminded in all contemporary writings that a Potentially Traumatic Event (PTE) becomes a problem only when it doesn't get adaptively metabolised.

In other words, human beings get into trouble when old survival stories remain stuck in the system.

Core evolutionary responses continue to be triggered in the still-traumatised individual, who feels the past - emotionally, cognitively and somatically - AS IF it's happening again in the here and now.

The Past remains the Present.

What's underway is what Daniel Goleman in *Emotional Intelligence* calls a form of *amygdala hijack*, where our mammalian survival system has kicked off in response to a conditioned stimulus, conveying to the adrenal glands far quicker than to the brain's frontal cortex to GET READY for Fight, or Flight, or Freeze, or Flop, or Friend (and many other potential Fs besides, see the chart here.)

It's said that the amygdala is ready to fire that message off within 60 milliseconds of receiving a signal of actual or potential danger.

During that flash of time, just three-fiftieths of a second and *before* the amygdalae (there are actually two of them, one for each hemisphere) say "Oh SH*T" and sound the alarm, this ancient and essential piece of our mammalian, mid-brain, limbic system evolutionary "hardware", has been sifting information rather like a computer's binary Yes-No gate does.

The info needs to be assessed as either Safe, or Not Safe.

For even if it isn't a sabre-tooth tiger, but just someone many years later wearing the red jacket that that tiger wore when it really did attack us, thinking survival it's incomparably better to assume the worst, and respond AS IF that individual really *was* a sabre-tooth tiger.

The way the amygdala (back to the more usual singular) comes to that necessary conclusion, Safe or *Not* Safe, is to reference the full complexity of the incoming signals (both *extero*ception and *intero*ception, info coming from outside the body and from within) against the individual's personal and collective database of experience and learning.

That database contains implicit memories – wait for it – of *trillions* upon ***trillions*** of micro-moments where the brain's experience of self-in-the-world was programmed, especially in the pre-verbal 1000 days from conception to second birthday.

How the body and emotions respond is therefore entirely dependant on the almost instantaneous *meaning*made by the nervous system of incoming information, rendering that response intensely individual and personal.

For if you think of it, we all live in an entirely virtual world. Our brain's job is to reconstruct external reality as an internal narrative.

That means that deep down, until it's moderated (or not) by the frontal cortex, there is no differentiation between the imagined and the real.

The human brain is the most extraordinary piece of biological engineering, with more potential connections *than there are atoms in the visible universe*.

And did you know that if all the empty space in each individual cell and atom of 7.5 billion human bodies on this planet were removed, the resulting absolute mass of matter would be the size of… a sugar cube.

The rest is energy: relationship between particles and waves, between positive and negative charge, between the magnetic north and south, between gravitational mass, between light and dark.

Some might add that where the living world is involved there's also a creative and essential tension between male and female/masculine and feminine, perhaps even (though this is getting admittedly a touch metaphysical and Miltonian) between Good and Evil? Possibly an observation too far for this booklet.

OK, I hear you say, that's all very well but what does all this mean for the practice of Attachment-Informed EMDR.

The key piece to take away is that, given that we all live in a virtual, internally-reconstructed, imaginal world, that now-virtual past is open to being updated and changed. The operating system, even quite deep down, is available for reprogramming – in ways that clients can often experience as thoroughly "Weird".

Indeed, when clients use that W-word, we usually know that EMDR is working...

Special Place and Resource Figures are therefore just as “real” to the brain when summoned up as they would be if also present externally – a sometimes essential point to make to clients who say there’s no point in using imagination, as none of it is real.

Remember that NOTHING is real to the human nervous system EXCEPT imagination.

With this understanding, we can also explain to clients how PTSD and psychosis and OCD and so much more can generate experiences and responses that feel totally real and appropriate/legitimate as if they are happening in the here and now.

This includes flashbacks, smells, images, voices literally “heard” by the auditory cortex, remembering and reconstructing earlier inputs from the actual ears but now purely internal.

Our job in EMDR therefore is to find those dysfunctionally-linked experiences from the past, facilitate with bilateral stimulation the release of trauma-informed energy stored from that time (emotional, somatic, cognitive), and then with our client allow and if necessary *encourage* the nervous system to recast those memories in adaptive form.

Even without an attachment focus, you will know from your practice how clients working for example with childhood physical or sexual abuse will, yes *weirdly*, feel that they are growing in size and that the abuser is shrinking.

Or as the BLS runs they might find one of their Resource Figures – the Dragon, Superman, Mary Poppins – stepping into the actual childhood scene and not just stopping the bad stuff that happened then but soothing the child ego state in ways that should have happened then and didn’t.

Of course, we don’t actually change the past. A child sent to boarding school at eight had to go through and did indeed survive that experience right through to young adulthood.

Our client’s paedophile father might now be in jail for life, but nothing can change the fact that she was used as his primary sexual partner from the age of three to eleven.

However, given the brain’s neuroplasticity and the fact that an individual’s past only continues to exist in their memory and neural circuits in the here-and-now, when we re-imagine those experiences as they should have been dealt with at the time, the impact can be little short of miraculous.

When we talk in the title of this booklet and on EMDR Focus workshops of Releasing the Magic of EMDR, we don't of course mean that we're dealing literally with magic.

We recognise the need for care with language that might imply a need to believe in the supernatural for EMDR to work, and we acknowledge that some colleagues might be discomforted by parallels drawn between EMDR and magic.

It's different terminology, but perhaps when we talk today of EMDR targets as neural networks past their survival-necessary sell-by-date, what we are naming is the same dynamic which in our species' earlier pre-scientific days would have been understood as spells and evil spirits.

If we appreciate trauma in the way that shamans, witchdoctors and holy men have told and responded to these stories through the ages, long before spiritual healing work was recast as psychotherapy, what we're actually doing is, perhaps, not so different from busting spells.

So, as they say in exam essay questions, discuss!



5. Phase 1: Clear, Attachment-Informed Case Conceptualisation

The Standard EMDR which you learned on your basic training is brilliant with single-incident adult trauma.

However, applied in what the Americans call a cookie-cutter approach that uses only the language and structure of basic training (just the Safe Place, 10 worst memories for example, standard NC-PC-VoC-Emotions-SUDs-Body Assessment, staying out of the way in Phase Four), the Standard Protocol is very often insufficient for working with more complex attachment-informed dysfunctions.

In this AI-EMDR approach, we place critical emphasis on the need to **think from the moment a client gets in touch about what their presentation is likely really to be about**, and how they got to be the way they are, as old stories un-metabolised from the past continue to compromise their capacity to be fully and safely in the present.

If you think about it, no client comes into psychotherapy directly because of what happened in the past. **They come to see us because they're finding it *difficult to deal with the present.***

And that's almost always down to the ways they learnt to ***manage*** Self, Other, the World, and the relationships between these, with the emotional tools that were modelled, observed and internalised in childhood.

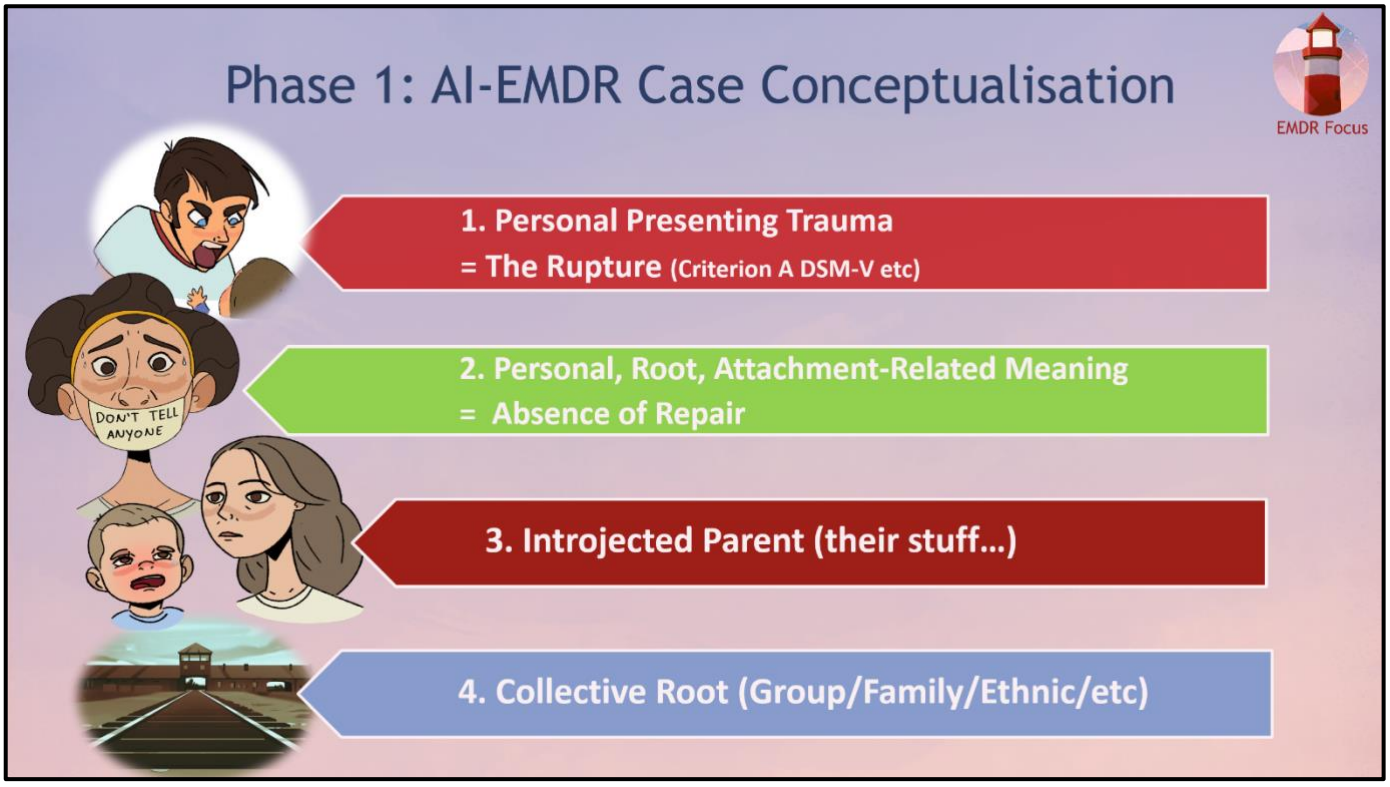
In Phase One of EMDR's Standard Protocol, it's important of course to take a good trauma history, as you've been trained to do, with the help perhaps of the CAPS Extended Checklist and the ACE questionnaire at the back of this booklet.

But most often – especially when working with early-life emotional wounding – the best and most impactful targets are found using the client's presenting distress as a portal, or bridging point, into their core developmental story.

The targets that really make the difference when worked on with attachment-informed EMDR – the loneliness, the humiliations, the absence of soothing emotional repair - rarely figure on a formal trauma list such as 10 worst memories.

Case Conceptualisation - **how did this person GET TO BE the way they are, and how they learnt to manage their emotional experiences in childhood** - and, with that, best possible identification of key targets, is at the heart of all successful EMDR.

The Four Levels of Trauma



Trauma Level One. The RUPTURE/Presenting Issue.

This is what a client comes into therapy for/what they're aware of as Trauma (subjectively Big T) in their lives – sometimes criterion A events in DSM-V terminology, or in the language of the ICD, an experience which would cause distress in almost anybody.

Quite simply, the bad stuff that has happened to them, for example:

- Assault or car crash.
- War zone/refugee experience.
- Sexual, emotional or physical abuse
- Neglect.
- Parental divorce.
- Generally difficult and unresolved attachment experiences in childhood, including birth/arrival/presence of siblings.
- Bullying in the workplace or at school.

- Sexuality – e.g. peer response to coming out as LGBTQ+.
- Experience of for example an eating disorder, or perhaps a psychotic episode, as trauma in its own right to be targeted directly.

Trauma Level Two. The ABSENCE OF REPAIR.

This in many ways is the more important dimension of the client's story, the reason the past continues to compromise the present, in the form of dysfunctional attachment-related meaning activated by present triggers.

To understand the roots of a client's presenting issues, it can be helpful to be curious from the very outset of therapy about what are sometimes termed the "five Fs" – how the client's nervous system learned in the face of existential insecurity much earlier in life, whether Big T or much smaller t, to deploy the survival responses of Flight or Fight, Freeze or Flop, or Friend/Fawn. (See the Polyvagal Response Chart towards the end of this booklet for many more Fs…)

In our experience with the vast majority of our clients, it's essential to factor into treatment an awareness of how early attachment experiences of being soothed or not by primary caregivers continue to manifest in the present.

Because those emotions never got felt, metabolised and released, the client continues to feel them again when they're triggered in the present.

The trauma to target is therefore often deeper than childhood bullying or a critical teacher in their own right for example.

We rather need to continue on downwards as it were into the client's internal affect-regulating response, usually laid down in the context of maternal caregiving which either did or did not allow for that experience to be repaired.

Example targets here (usually identified through bridging) might include:

- Birth of younger sibling and loss of primary relationship with mother.
- Distress at school unregulated by a mother preoccupied e.g. with relationship breakdown, or lost in her own childhood attachment story.
- Being left alone at boarding school at eight, in the context of sibling and parental/caregiver dynamic.
- Self-referential (narcissistic/anxious) parental response to client's feeling different in childhood.

Trauma Level Three. The INTERNALISED PARENT/CAREGIVER.

This can be understood as the observed and experienced modelling of the parent's soothing or stress-response behaviours embedded in the client's nervous system.

In psychodynamic terms, this is **the introject,** internalised in the course of early life/developmental experiences, and continuing in the present to determine affect-regulating responses to life's stresses.

In layperson's terms, this is Mother's or Father's stuff, the meaning *they* made of their earlier life attachment wounding and how that manifested in and was experienced by the relationship with their own children now.

With our Intergenerational EMDR Protocol (see below) we can target and rework Mother's or Father's own childhood in the client's imagination, rendering them in introject form better able and available to soothe the client's presently-felt but childhood-related distress.

Trauma Level Four. The COLLECTIVE EXPERIENCE.

This is the story that goes with the client's ethnic or religious or national or cultural or group identity – the bad stuff that happened in the much wider context of the family's and group's past, handed down in explicit and implicit narratives and conveyed subtly and less so in the interactions the child experiences with caregivers.

It might be the Irish client's inherited story of potato famine, poverty and emigration, loss of identity.

It might be your Jewish client carrying the burden of their great-grandparents' death in the Holocaust/Shoah, or of early 20th century pogroms, as passed down in family narratives, photographs, silences, childhood imagination.

Targets here might be found in your African or African-American client's collective memory of slavery, war and deracination.

An English client might be carrying stories of cold parenting and family suicides, of poverty and loss of family connections, of the emotional burdens of inherited wealth, of wartime evacuation in childhood, of generations sent off and separated from family to boarding school or war or colonial service.

Almost all Germans, and Russians and Chinese, will, in our work with EMDR and whether they know it or not, be powerfully informed by the impact on childhoods and families of world wars, revolution and totalitarianism through the 20th century, with devastating but often unacknowledged and unprocessed financial, material and emotional loss.

Just think too of the stories embedded in the collective stories of First Nation cultures over centuries of colonial conquest, from Native Americans to the First Peoples of Australia, the Māori *Iwis* of Aotearoa/New Zealand and so many more.

Add to that list religious dogma and cults, and the list for collective trauma is a long one.

What's exciting in our EMDR work is how powerfully these stories can be identified and rewritten – obviously not changing what actually happened but shifting the way narratives are stored in our clients' experiences of self in the world, and, it seems increasingly likely, right down to the epigenetic level.

6. Phase 2: Resourcing/Preparation

It's essential of course to install, or *tap in* (easier language for the client), the Standard Protocol's Safe/Peaceful Place. But we find it equally essential, **with *every* client,** to add the extra, imaginal resourcing needed when working at depth in Phase Four of EMDR.



Peaceful Place (Special/Calm/Safe/appropriate term)

> *Close your eyes and go inside. Bring to mind a location, real or imaginary, (or, for younger clients, perhaps an activity) where you can imagine feeling relaxed, at peace, calm, supported etc – it's there just for you.*

Be aware that the presence of other figures, especially family, can carry baggage, consciously or not. It's often good to choose somewhere in nature. While not a complete no-no, be cautious also about childhood-related safe places, as these can also be freighted with other meaning.

Be careful also with the use of the adjective "safe" – just as a word itself this can sometimes be triggering for clients who have quite simply never experienced safety.

Ask client to name the place, and their preferred adjective (special, peaceful, sacred, calm, or if appropriate indeed "safe"….), and make a written note of that.

> *Summon up that place in its sensory detail. Notice what you can see (colours, the quality of the light, the sky, the landscape, the vegetation, the clouds…)* ***Keep the language neutral and simple.***
>
> *Notice what you can Hear…. Touch … Sense (the air on your skin, the ground*

beneath you) …. Smell… Taste…. Let me know when you've a sense of that.

>>> Slow-ish taps. When working in-person, clients like the flat of the therapist's fingers on the outside of the knees – check with them what speed they like. Slow EMs / buzzers. Be careful not to initiate processing, and for detailed guidance on working online, see further down in this booklet…

Let me know (with a nod/open your eyes) when that's well and truly tapped in. (Rarely more than 15-25 secs).

Take a breath. How was that? Another short set? >>>

Let's now tap in one (or two) keyword(s). Like a Hashtag search term. What word would you choose as a hashtag?

So, connecting with your special place, and holding it together with that word, hashtag (beach for example), let's lock those together and tap them in. >>>

Having tapped in the Special Place, it's useful to add a resource team of imaginal support figures – an approach to Phase Two EMDR preparation that comes from the work of Dr Laurel Parnell, now widely accepted in the EMDR world as standard preparatory practice.

Resource Team

We're now going to tap in a support team for the work we'll be doing.

You may wish to use a metaphor that works for the client.

E.g. After all, if you were climbing a big mountain, you would want a team of Sherpas, who could cook, carry and set up the tents, know what mountains are like, have maps and climbing equipment…

We're going to choose some Nurturing Figures, some Protector Figures, and a Wise Figure or two. And maybe, if you like, add some magic too.

Nurturing Figures (NF)

Let's start with three or so Nurturing Figures.

You can add…

Embodying the qualities of care, kindness, tenderness, compassion, love, perhaps even playfulness.

They can be real or imaginary, human or animal, historical or contemporary, from your own experience, from history, literature, mythology, religion,

Hollywood, fairy tales, comics…

Accept if you can whatever comes up. If the client is struggling, be helpfully encouraging with ideas. We have some suggestions further down from previous clients which you can offer should yours be seriously stuck.

Figures from the list that don't work usually bounce off the sides and are rejected, but might trigger another thought by association.

Be careful with family members, especially with primary caregivers from childhood where there could be ambivalence. Don't in general encourage clients to use their own children, even older ones (noting that clients who wish to do this often have their own childhood stories of having emotionally to look after a parent...)

Note also that it can be useful with Nurturers and Protectors to have three at least (rarely more to start with, though the team can always be added to as the work continues.) Clients often find that just one wise figure is enough, though no harm in having a couple.

Always write down these figures in your notes to refer back to, then tap in the members of each category one by one.

> *We're now going to tap these figures in. Close your eyes, ask [NF1] to step forward and join your team. When you have a good sense of their presence, let me know. >>> And let me know again when they're well and truly tapped in.*

Tap this figure/being in, for 15-25 seconds or so, until there's a nod or client opens eyes. Allow enough time – not too short, not too long.

> *Now let's tap in [NF2]. Same routine, close your eyes, let me know when they're ready….* >>>
>
> *Let's tap in [NF3] likewise.*

Protector Figures (PF)

> *Now let's choose three or so Protector Figures.*

You can add this time, with the qualities of strength, courage, steadfastness, determination, ferocity even - a willingness and ability to stand and fight your corner.

Identify all three in a row, then >>> tap each one in as above, one at a time.

Wise Figure(s) (WF)

A figure quite simply with the quality of wisdom – of patience perhaps, perspective, presence, perseverance… Someone, or a being, who just knows, and can be there for you with quiet wisdom whenever you need them.

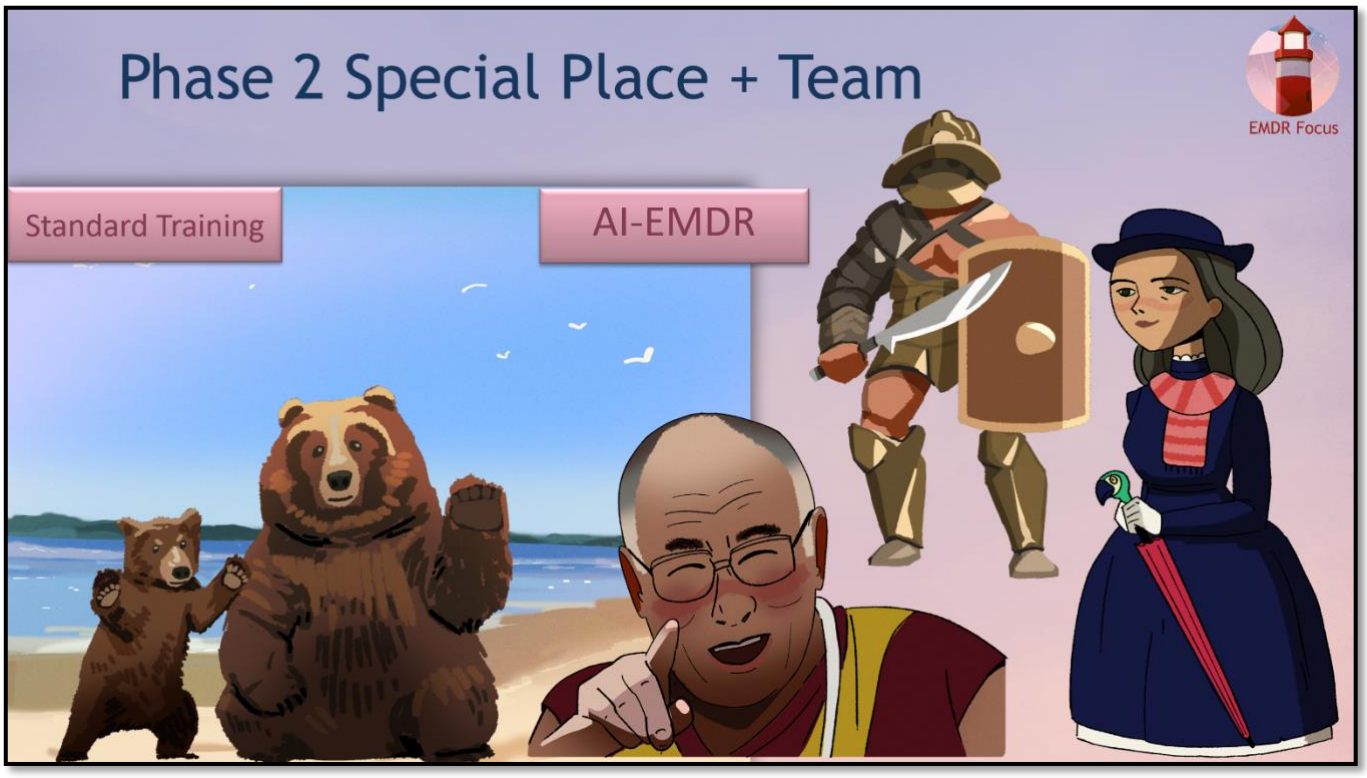
(Optional) Magical Figures/Energies

These can be helpful for clients with severe abuse histories when 'stuck' in processing where there is need for rescue, change but nothing else is workable. So…

If you like, how about a bit of magic as well. Would you like some fairies or fairy dust, a magic carpet perhaps, a fairy godmother, a genie for your lamp?

The Team

And now, I'd like you to summon up, or invite the whole team together, and – perhaps with an awareness of your special place in the background - we're going to tap them in as a team. Close your eyes and when you've got a sense of them all, let me know. >>>

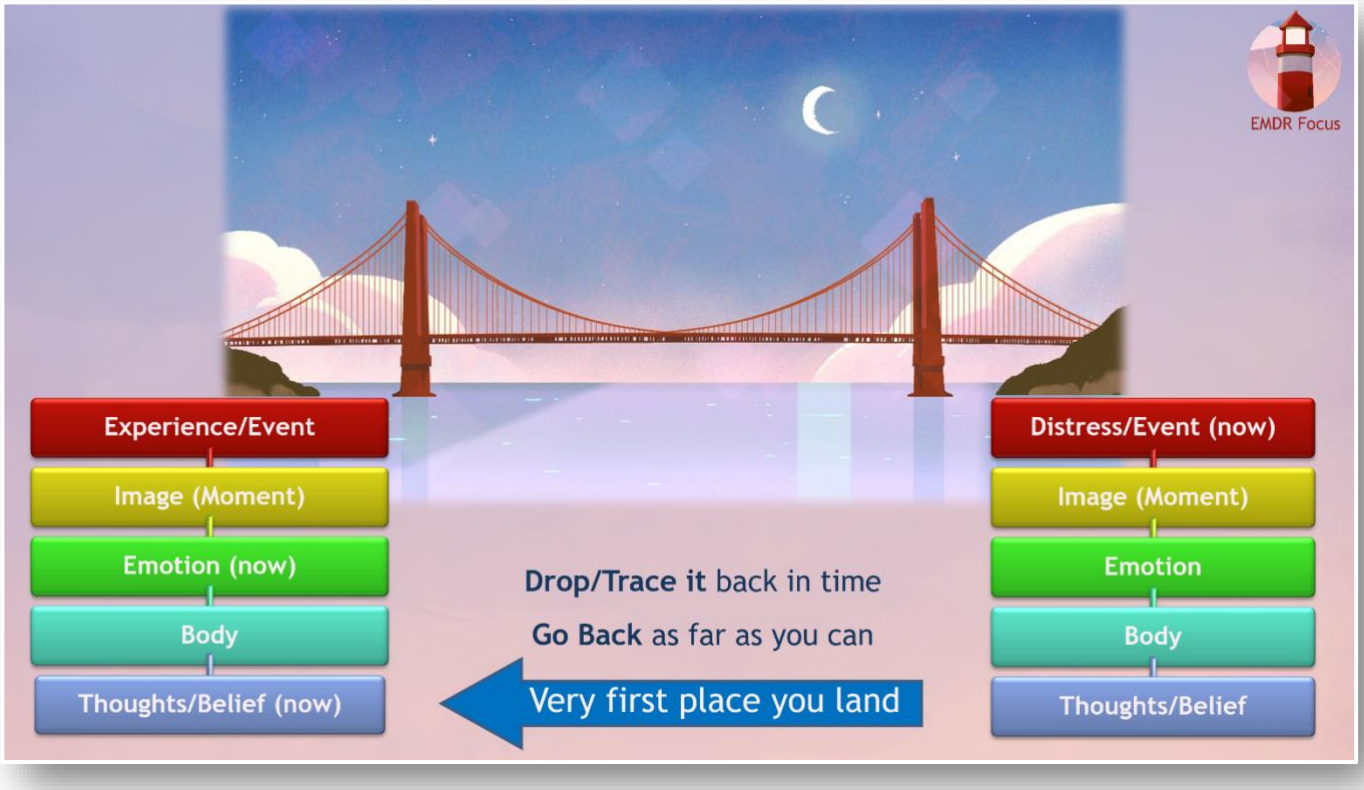


EMDR Focus

Some Resource Suggestions

Nurturing	Protector	Wisdom
Note that all categories can include friends, teachers, coaches, grandparents, special relatives…		
Earth Mother Labrador, collie (or other dog) Wolf Kind aunt Kind sibling Partner (when a good relationship) Elephant Figures from movies Bear Irvin Yalom AA sponsor Virgin Mary/Madonna Ernest Hemmingway Cat Cousin Florence Nightingale/ A nurse An Angel Ideal mother Beloved therapist Horse Sherpa Mummy Otter Mother Theresa Aslan Mary Poppins Dumbledore…	Superman Iron Man Partner Lion/panther Aslan Big oak tree Adult self Wolf Movie figures Gladiator Greek god Mother bear Dragon JFK Bruce Willis Batman Columbus Gorilla Hercules BFG Wolverine Cousin Joan of Arc Archangel Knight Winston Churchill A horse A dolphin Tiger Martin Luther King Samurai Warrior…	Dalai Lama Goddess Dumbledore Monk Gandalf Gandhi Elephant Owl Greek god Grandparent Irvin Yalom Buddha God Jesus A beloved teacher A whale Therapist Priest Yoda (from Star Wars) Rabbi Dumbledore Pope Eagle Socrates Nelson Mandela Galadriel (Elf Queen in Lord of the Rings) A Crow The Sea…

7. Phase 3(a): Attachment-Informed Target Selection



Proactive bridging is in essence the same thing as the **floatback or affect bridge** you will have learned in basic EMDR training. Placed upfront in Phase Three and used with laser-like sharp focus, this is a key tool to identify the target most relevant to the client's presenting distress.

Although "Floatback" has a 30-year+ history as core EMDR terminology for this part of the work, we much prefer the term **Bridging**, as having a solid base on each side of the divide between Present and Past.

While of course working in many situations, the words "float back" when asking a client to go back in time can easily be experienced as a move into thinking, observing, even dissociating, where an invitation/instruction to **Drop or Trace It** back in time is more embodied, right-brain and imaginal.

As Shapiro found when she and her colleagues first laid down the principles of EMD and then EMDR in the late 1980s, linguistic precision and terminology when we build the structure of therapy matters enormously – and it's important also to recognise

that the field has moved on, and, as has been recently discussed by the Council of Scholars in the US, that some early language could benefit from reform.

Returning to metaphors, one can compare finding the best-possible bridging point to a **pinhole camera** or **egg-timer** – finding the *portal* through which you can travel with the client into their attachment-informed formative and developmental experiences that continue to generate maladaptive behaviours and responses in the present.

Alternative metaphors that can work well with clients are the long-jump, where the athlete needs to hit the jumping-off board with precision and power, to ensure the most effective leap into the sandpit/client's past.

Another favourite is that of Alice falling down the rabbit hole and needing to drink from small bottle of magic potion that will shrink her into a small enough size to get through the door into Wonderland – as it were, into her own developmental network.



One can bridge from a present or feared experience (e.g. boyfriend's back turned, the boss's/spouse's angry face, getting up to make that speech), from a feeling, from a thought, or from a body sensation.

A good way to get to the heart of what needs to change for the client, and thereby also to create a perfect structure and focus for powerful EMDR, is to ask them:

> *If there was ONE THING in your life you could change in this very session, over the next 40/50 minutes, what would it be?*

Identify with the client what that goal might be, their presenting distress in other words, which you sense is driven by attachment/"small-t" developmental trauma/experiences in childhood. Then try these words:

> *Close your eyes, go inside, and* ***when you think of that current distress, what's the picture?*** *(If you took a snapshot of the situation and showed me the picture, what would I see?)*

Trust whatever comes up – whatever picture, whatever story. Don't analyse or second-guess or discuss.

As you connect with that moment, **what are you feeling?** (What emotion is happening right now?)

> *Where's that happening in your body?*
>
> *As you look at that picture and feel that emotion, what thoughts or belief go with that?* (No need to specify the word negative – it always is.)
>
> *If no picture, you can bridge from a thought or a feeling:*
>
> *If that thought/feeling had a shape, what shape is it? Allow a moment for client to muse. Size – is it big or small? If it had a colour, what colour. Temperature – hot or cold? Texture – smooth/hard or rough/sharp? Vibration – high-pitched or low-pitched?*

This picture, or this shape with its qualities, is your bridging point from which to go back into the client's developmental story. So continue:

Now (if useful, adding noticing that thought, looking at the picture, feeling that feeling, [or connecting with that shape] and using these exact words, paced appropriately for the intensity of the moment)…

Drop (or trace it) back in time.

Go back as far as you can.

(The) Very first place you land.

And, Wait! Take your time, let the client ponder/reflect. Often something will come up that's around 6/7/8 years old, when pre-frontal cortex and hippocampus come online. Trust the first thing that comes to the client's mind, *even it appears at first sight a positive memory*.

If the client still can't find anything, some suggestions that can generate an event situation might include:

- *Imagine you're flying over the landscape of your past from a birdseye/eagle's perspective. What's the first scene, furthest back, that catches your eye?*
- *If you imagine your past, especially your childhood, as a photo album, and just open it now at a random page, what's the first picture you see?*

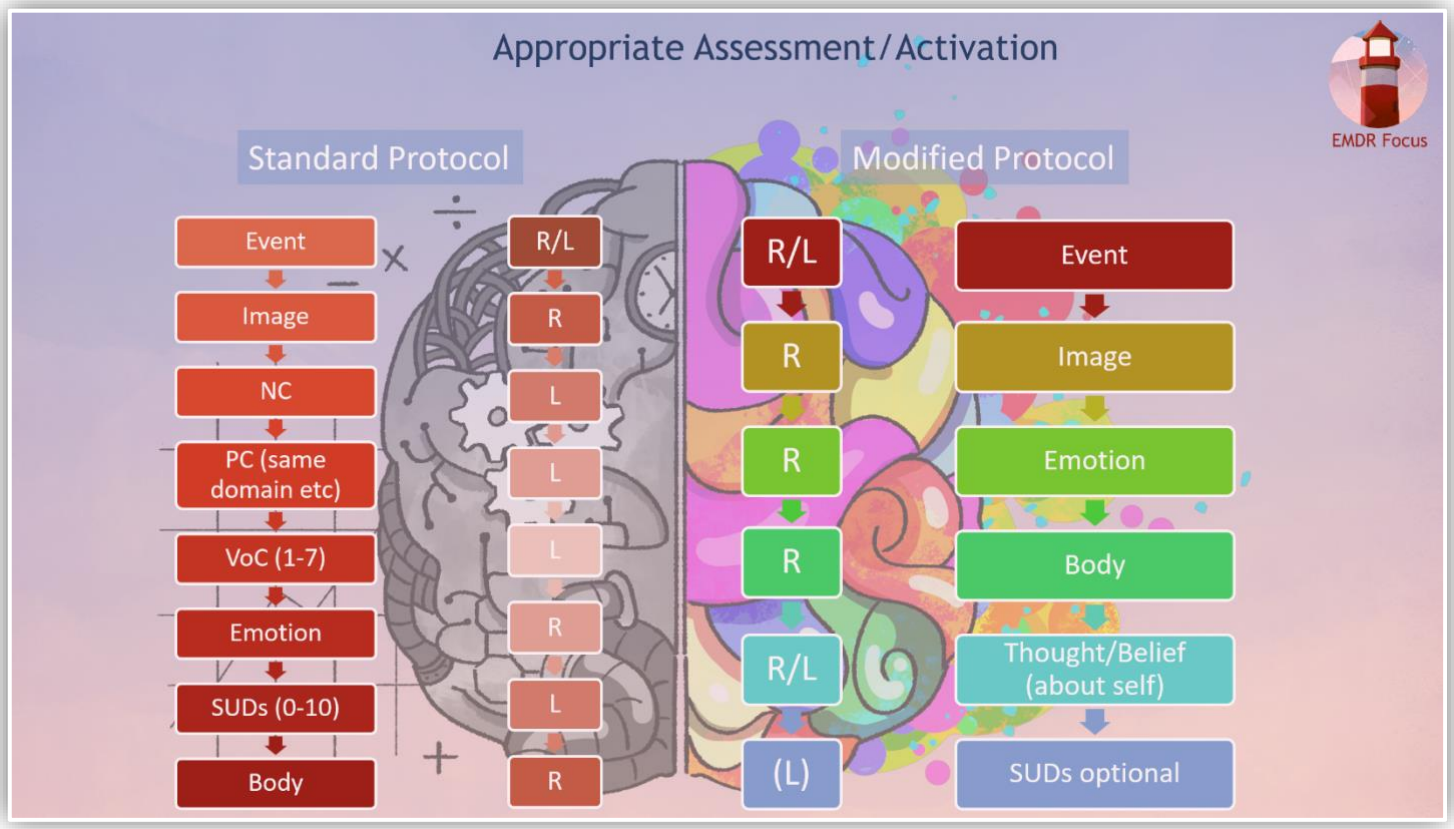
Don't give up! Note that whatever does come up, whether event or memory, that's your portal into the key memory networks, to which you will need regularly to return in the processing, the target or point on the other side of the bridge where you've landed, going out, round and back, out, round and back to target.

Bear also in mind that once on the other side of the bridge, and before starting processing, you will need to RE-assess this new experience/memory, complete with emotion, location in the body, belief about self, as all might now be different from the bridging point in the present.

Try to be as clear as you can where your client has landed in space and time.

- *How old are you? Where are you? Who else is there? Who isn't there? Do you have a clear picture? –* classic EMDR freeze frame moment.

8. Phase 3(b): Appropriate Client-Focused Assessment/Target Activation



It's important when working with complexity that Phase Three of EMDR therapy focuses on the client's right-brain experience of trauma, firing up event/image, emotions, body and belief in that order, usually leaving the explicit identification of an appropriate Positive Cognition to the end of Phase Four.

As with the Standard Protocol, ask the client to identify the tightly focused event/ experience, **positioned clearly in space and time (and age),** often, when working with attachment, identified using Bridging (which to remind tends to be a preferrable term to EMDR's traditional language of Floatback.)

> *Connecting with that incident/event/experience (perhaps running a video of it in your mind),* ***what's the picture/moment*** *that represents the worst or most intense part of it, as you get it now? Or, What's the picture that has the most energy?*

NB – Note down the key words the client says, securely anchored and positioned in space and time, to which you can return when you go back to target. E.g.

"**Top of the stairs** listening to my parents argue in the kitchen."

"Standing alone on the playground on my **first day at school**."

"By the Christmas Tree at nine, not getting **the Barbie doll** my little sister has."

At this point, it is important to choose which form of Assessment in EMDR's Phase Three is best suited to activating the client's trauma-informed Emotions, Body Sensations and Beliefs/Cognitions.

Readers will of course be familiar with the Standard Protocol, running in its classic form thus:

- *Negative Cognition NC*
- *Desired alternative Positive Cognition PC*
- *Validity of Cognition VoC (on scale 0-7)*
- *Emotions*
- *SUDs (0-10)*
- *Body.*

This more left-brain approach, with its heavy focus on numbers and cognitions, can work extremely well with single-incident adult trauma, or with clients whose trauma responses involve a lot of thinking.

However, with more complex clients, an overly rigid insistence on these steps in this order can interrupt activation of the necessary target experience, losing focus and momentum for both therapist and client.

One research-endorsed alternative to the Standard Protocol's Phase Three Assessment is what is called the **Blind to Therapist (B2T)** protocol, in which the client is not asked to identify the detail of the experience being targeted, but to use a cue word with activation of emotions and body sensations only before BLS is started.

When working with attachment trauma and childhood ego states, we find it generally more appropriate to use what Dr Laurel Parnell calls the Modified Protocol, sticking closely to the following clean, uncluttered, and effective language.

- ***Connecting with that picture/image/moment, what are you feeling, NOW? (Or, What's the emotion?)***
- ***Where's that happening in your body?***
- ***As you connect with that picture and feel that emotion in your body, What thoughts or belief go with that?***

In this approach, it's usually more effective not to get overly hung up on correcting a client's cognitions, but to go with whatever they say about themselves. SUDs are optional here, though sometimes useful.

There's no need in this way of working with more complex clients to ask at this point for an alternative PC, or the VoC. Note that this is the Modified Protocol's main departure from Standard Training, and the issue that causes perhaps the most controversy when colleagues unnecessarily assess AF- or AI-EMDR as inconsistent with the Standard Protocol.

> *Now, noticing that thought, looking at the picture, feeling the feeling, just let whatever happens, happen. >>>*

And you're away - process as normal.

9. Phase 4. Desensitisation/Reprocessing. Rewiring the Past

The Therapeutic Relationship

For all its structure and neurobiological underpinnings, EMDR therapy is much more than a technique. No psychological treatment can work if the relationship between clinician and client is not safe, containing, supportive, kind and warm.

Research over the years has consistently confirmed that ultimately (assuming a client's fundamental capacity to do the work) it is the *relationship* that heals.

Throughout AI-EMDR work especially, it's essential therefore to attune to what might be termed the *dance* between therapist and client, and to allow the client to experience you as a an empathic, connected, engaged human being, of course with appropriate boundary between self and other.

Appropriate and powerful *relational interweaves* emerge in the moment, often intuitively, always warmly, for example just with a facial gesture of kindness, an audible wince of empathy when the client reveals a particularly painful and shocking detail of what happened to them.

Recalling Carl Rogers's three core conditions of person-centred therapy, namely **Empathy, Congruence and Unconditional Positive Regard**, it's essential at the same time that our empathy does not shade into intrusive sympathy.

Pay attention to intuition. Although therapists differ in how intensely they co-experience their clients' stories, note how you may find yourself replaying what you are hearing in your own imagination.

Use that intuition – carefully – to inform what interweaves/ encouragement/invitation might be needed.

- If an idea or picture or thought occurs to you once, zip it.
- Twice – keep it zipped.
- If the idea/picture presents itself a third time, you might consider venturing to name that with the client, as it might be about them.

As long as they're done cautiously and consciously, it's hard to damage a client with interweaves. But if an interweave doesn't fit or land, drop it.

For more ideas about the role of relationship in EMDR, and for inspiring chapters on how the dance can actually work, Mark Dworkin (2005) has written the definitive book on **EMDR and the Relational Imperative**.

Interweaves link what needs to be linked, and de-link what's wrongly connected – unravelling and releasing what Shapiro calls dysfunctionally-linked memory, or neuro-networks.

However, in Phase 4 of EMDR's Standard Procedural Steps, even with AI-EMDR, it's essential not to intervene or interweave too quickly, or to try to fix the client before the story is clear.

Clients first have to be able to *feel and tell/communicate* what's been held by their child ego state, often for many decades**.** It's when the client isn't moving towards an organic, natural adaptive resolution of the stories they're holding – and that's often the case with complexity – that we need to get busy with interweaves.

That said, **whatever you do** (and this is a common criticism in EMDR circles of the attachment-focused approach), **don't rescue the client's wounded childhood ego state too quickly!**

As a rule, use interweaves when processing is stuck, and especially to help in session closure. The idea to get processing under way again, in Shapiro's metaphor to get the train back on the track. Offer the interweave, then move out of the way.

Thinking Shapiro's three cognitive domains of Responsibility (including also Self-Defectiveness, though often separated out these days into its own domain), Safety, Choice/Control try to match interweaves to the quality of the client's stuckness.

- If a client loops in *It's my fault*, then the best interweave will relate to **responsibility/self-blame.**
- If they insist that they are a *bad person*, then interweaves will need to focus on **self-defectiveness** and survival-informed childhood responses to parental messaging.
- If they're saying, *I might die* or *I'm in danger* (or similar), a **safety**-related interweave might be *Are you safe now/Did you survive/Are you alive now*?
- If about **control**, as in *I'm powerless/helpless*, the interweave might be, as an adult, *Do you have agency/choices now*?

Keep It Simple – intervening/interweaving as much as necessary but as little as possible.

Don't interpret - *inquire*.

Use simple language, and few words. Remember you're often working with very young

ego states. Respond to - *be with* - the client as you would if you were with a hurting child. Use language and concepts a child would understand.

Curiosity/Inquiry Interweaves (including Socratic)

These can be the questions you ask where you, and also the client's adult self, know the answer but where the client's own networks and perspective aren't linked up.

For example, it's common with AI-EMDR when bridging to land in the experience of the seven-year-old, for example, being bullied at school or feeling alone and left out on the playground.

The reason we've landed there, however, isn't because the playground or the bullying are the root cause of the client's current and presenting distress. It's almost always the absence of repair of that experience, that needs to be targeted, as the relational and attachment *context* in which that story unfolded.

Just the words *I'm curious….* can powerfully link up memory and relational circuits which needed to be interrupted and kept separate by the child's survival response to overwhelming experience.

For example, given that so much in this work goes back to the primary attachment relationship with mother, an effective and simple interweave that often lights up the necessary observational circuits is just this:

> *I'm curious about Mum. (And how her response might have been when you got home and told her, or didn't tell.)*

We can also say, for example,

> *I'm confused. So you're saying that you should have fought back when your father hit you when you were six. But I guess he was a lot bigger than you?*

A standard, classic EMDR Socratic interweave is of course,

> *So as you say you deserved that punishment. Would that still be true if this were your own child . . . best friend, client, sponsee . . .*

The Video Interweave

This is one of our favourites, especially when a Bridge has taken us into the edge of a client's formative trauma – playing on their own outside the house at five, for instance,

or alone and miserable in the bedroom (very common), where the actual story that needs reprocessing is the client's response to inter-parental dysfunction or violence.

The idea therefore of the video interweave is to help you and the client to process the story in its wider context, now with an adult's brain processing capacity, complete with frontal cortex and meaning-making hippocampus which of course wasn't available at the time of the usually childhood experience.

It's worth remembering, and explaining to the client, that pre-frontal cortex and full access to language and meaning and the narrative capacity of the higher-level limbic system only comes online at around the age of seven.

This is also why children start to read and write properly at that age, illustrated by how Chinese children for example are able from seven to learn and memorise the enormous complexity of a language written in characters rather than sounds.

The language to use here to put a close-focus childhood memory in its wider context can run like this:

> *Looking at the scene, imagine you're viewing it through a video camera, with the capacity to zoom in and out, and to wind the recording forwards and backwards in time. Using that, what do you notice? Who do you see? Who isn't there? What's just happened? What's about to happen?*

Containing/Distancing Interweaves

Here we can use a book, a photo album, a vault, a desktop computer workstation for example to load individual traumatic experiences into working memory, while keeping other material safely stored away, under control and available to be brought into play when appropriate.

> *Would you like to imagine that scene as a file/video sequence on your computer, with a beginning, middle and end. You have the controls to make that picture bigger/smaller, brighter/duller, colour/black and white etc, and you can pause or fast forward/rewind etc.*
>
> *You have CGI (computer graphics) tools to turn this scene into whatever you would like it to be.*

The iPad Interweave.

> *I guess there are things that little boy/girl doesn't yet know about the future that he/she is going to have, and where you are now. (Out of that situation, an adult,*

struggling perhaps but no longer helpless etc.)

Would you like to imagine taking out an iPad and showing your younger self pictures of his/her future, like a photo album? Notice what happens when you do that. >> >

What some call a **non-dual interweave** can be **used** to hold opposites which are both true but don't mesh - two different realities, coexisting if contradictory, which need to be survived. E.g. an abusive grandparent who also loved you.

Can you find a space big enough to hold those two incompatible truths – for example, the Grand Canyon? The Universe? >>>

Educational Interweaves

These classic EMDR interweaves provide information that the client, or the client's child ego state, still lacks. For example a common one might be:

Did you know that it's very normal for an older sibling to feel existentially left out, or to experience even murderous resentment and rage towards a new-born rival for mother's affection and attention?

Or:

Did you know it's normal for the body to experience pleasure when the genitals, even a child's, are touched in a certain way?

Repair and Rewire Interweaves

When we're working with wounded childhood ego states, as the therapy goes deep our clients' adult (prefrontal cortex/left brain) parts are often offline, incapable of providing the nurture, soothing, perspective and containing experience the child needed but didn't get at the time.

So, rather like a kindly social worker, we can find ourselves as therapists working with embedded and early adverse childhood experiences, using tone of voice and soothing reassurance explicitly to give that child ego state in the therapeutic here-and-now the reparative experience they didn't have as a kid.

This is to be used with care and compassion, **and not too early in the processing session**.

Where you sense the client's adult self is incapable of mediating the necessary experience for their wounded and usually very young child ego state, be prepared to use your shared imagination to step into the scene with quiet, gentle coaching language and guided imagery to reimagine the event/experience **as it should have been managed.**

Where clients push back that this isn't what happened, you can gently point out that the only place the memory and experience is being stored and activated is in the here and now, in the imagination, so why not change that. You didn't get that experience at the time – so let's just see what difference imagining it now might make.

Positive, imaginal resourcing and reconstruction can be used as an explicit therapeutic tool, not just as a support for standard processing.

So, a client might be encouraged to re-imagine, with BLS, past events/ experiences ***as if*** they had had a good-enough, loving mother (we prefer not to use the term perfect, as that would be an impossible ideal for the child to have to live up to) able to give that infant/child the attention and attachment they deserved and needed.

For clients whose attachment trauma goes back to birth or even earlier, it can be very powerful to ask them, again with BLS, to reimagine their pregnancy and their actual birth as they wish these had been, with appropriate encouragement from the therapist.

Nurturing figures, protector figures, wise figures and others can be called upon (they often step in naturally anyway, without being asked) to care, shield, rescue, explain, and help.

Resources can also be brought in for significant others, such as mother, father, and siblings. Be very careful though, on the whole, not to let your client use their own resource team, or their adult selves, to rescue/sort their parent.

Clients who do this too enthusiastically (and some do) often have a childhood narrative of having needed to put their parents' emotions first. Doing the same in the here-and-now imagination quite simply won't resolve what needs changing in the past.

You can ask the client to create an imaginary scenario or solution to a problem. They can rewrite the scene:

> *Knowing what you know now, what would you do differently? Or, if you could redo this scene, what would you do/what should happen? >>>*

Or they can express sometimes violent thoughts - not always necessary, but don't be frightened if you client feels the need to do this in their imagination.

> *Yes, go for it – blow up that old school chapel, let that samurai warrior use his sword/your ray gun, go ahead and do to [or let be done to] that abuser what you wish someone had been able to do at the time. >>>* Be prepared for metaphorical blood on the carpet…

And always, once you've together identified the necessary resource, ask *Would you like to imagine that? >>>*

Especially towards the end of the session if things are getting stuck, you can ask:

What does the child need?

Who can do that?

Would you like to imagine that?

Often, but not always, that will be someone from the client's resource team, or their adult self. **Only suggest something yourself if the client is stuck.** Listen very attentively to what they say and go with that.

Sorting Interweaves

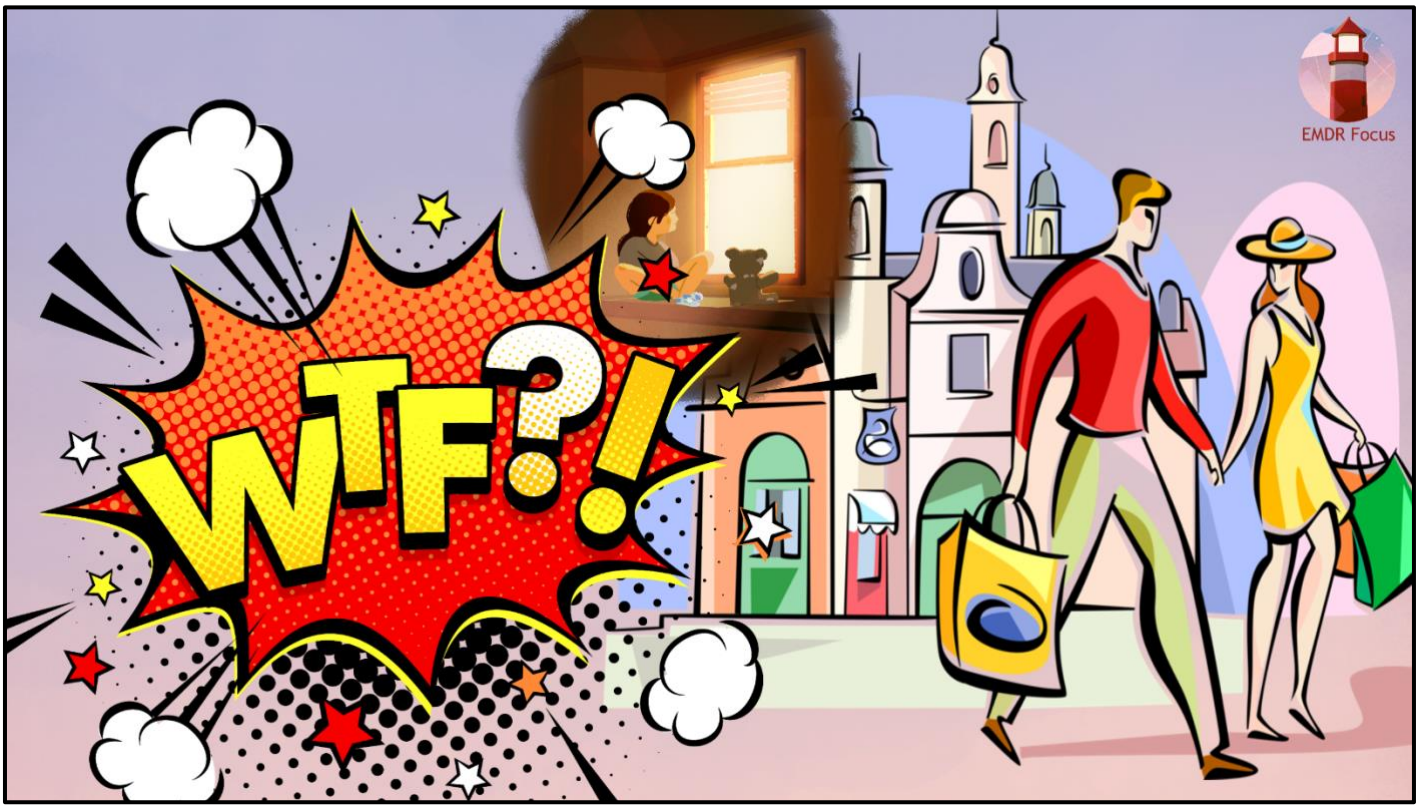
Split-screen interweave:

> *Imagine putting that [childhood] situation on one screen and the adult situation on the other. That childhood person/abuser on one screen and the present trigger scene on the other.*
>
> *Notice what's the same and what's different. >>>*

Two-handed interweave (as popularised by Robin Shapiro):

> *Put one option in one hand/closed fist, the other perspective/ option in the other. >>> (You can also invite client to imagine dialogue between the two.)*

WTF Interweave



This is a rather cheeky new one for us, invented on-the-hoof during a live demonstration session for colleagues in Australia in 2020.

The idea is relatively simple. If you, as a social worker or a policeman or someone in appropriate authority, were to walk in on the client's childhood scene, where parents are failing in what's often some spectacular way, what would you actually do in real life?

The parents might for example (as has emerged in actual client work) be arguing at full-volume and throwing things at each other outside their child's bedroom door.

They might have left their six-year-old all alone at home and looking after a vulnerable younger sibling while they go out shopping or for dinner. Or something very much worse might be happening.

In which case, ask your client first to make sure that their younger/childhood self is safely OUT of that situation, being looked after in a safe place of their choice by the client's imaginary support team, and perhaps tap that briefly in.

Make clear to the client that their younger self does not need to witness or experience what's just about to happen.

Then, with your client as their present-day adult together with you the therapist, invite the client to imagine you both walking firmly in on that childhood scene, STOPPING what's happening and making FIRMLY clear that this stops NOW.

Depending on the client, feel free to use forceful language – which is where the WTF interweave comes in handy. As in, What the f**k is going on here!

In essence, you as therapist are taking take firm charge of the narrative in the client's and your own shared imagination, changing it proactively, with the client's adult self looking on, on behalf of their disempowered/terrified/traumatised child ego state.

Very often, the client will, in real life, grin from ear to ear at how, AT LAST, someone competent is stepping in and stopping, once and for all, that childhood narrative of trauma and helplessness.

You can then tap the story through to completion, as the client resumes authority and charge of their own narrative.

The WTF interweave shouldn't be attempted if you're new to this attachment-informed approach, but it's a useful one to keep in your back pocket once you get the hang of how it works.

Rescue Interweaves.

Repair and Rescue interweaves are particularly valuable towards end of session. **They should not be used too soon.** It's preferable if the client can get there on their own.

Never end a session leaving a vulnerable child in an abusive situation.

Using imagination, you can ask:

> *Who can get you/that little boy/girl out of there?*

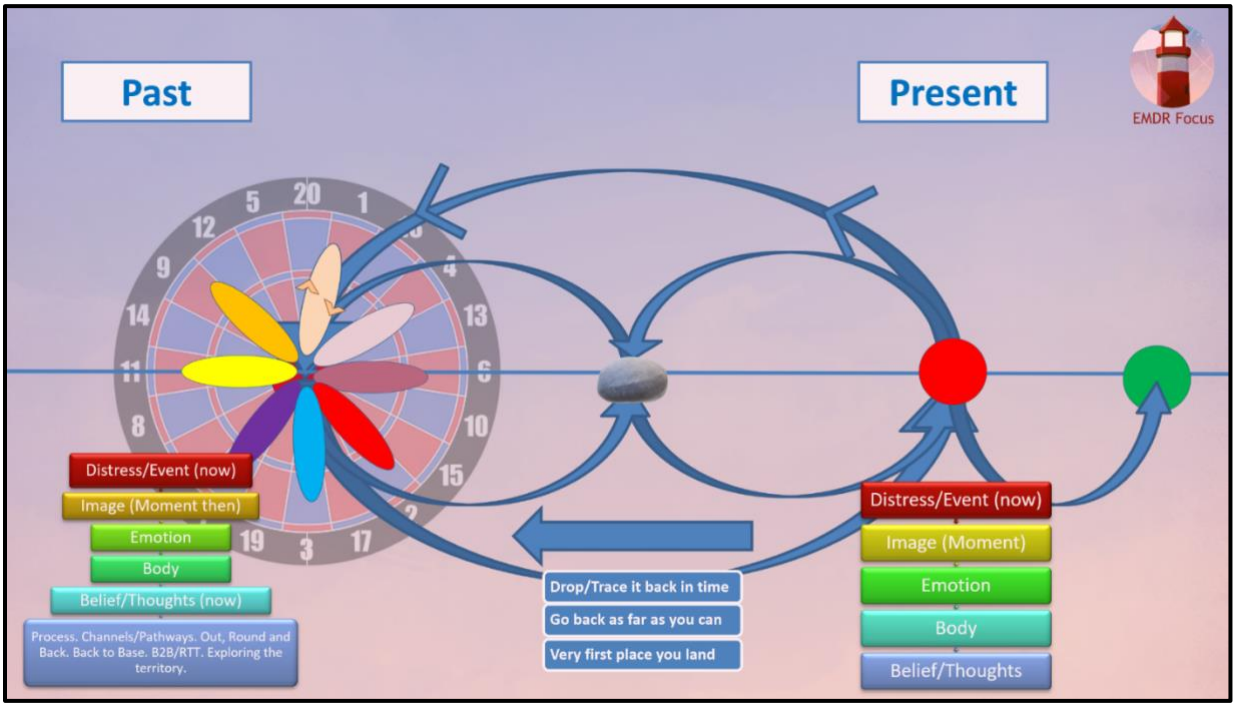
If the client is unable to imagine that, then you might need to suggest that you yourself, together with the client if possible, step into the memory, saying:

> *Let's get you out of there. Where would you like to take that child?*

You can bring them into your office, to the client's peaceful/special place…

10. Phases 3-7(+8): Session Structure

We have positioned this as the last of the six defining principles of Attachment-

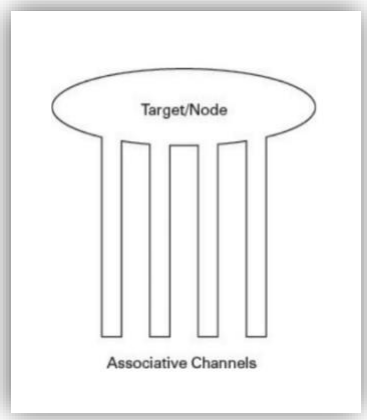


Informed EMDR because it embraces not only Phases Three to Seven of Shapiro's Standard EMDR Protocol (Desensitisation/Installation/Body Scan), but in effect all eight phases of the Standard Procedural Steps which give EMDR the structure and focus that make it distinct from other forms of therapy.

To re-emphasise the point, it's therefore often helpful to **use the client's presenting distress** (which is why, after all, they've come into therapy) as the ***portal*** through which to access the key/root/source memories and experiences that drive present maladaptive behaviour and responses.

Bridging will then usually take us into the often-surprising and unexpected memories and experiences where the dysfunctional emotional management responses were laid down.

There may be **two or more bridges,** with or without processing as you head back in time, before you get right across the river to the side where EMDR gets to conclusive and effective work. Mixing metaphors, it can feel rather like using **stepping stones across the river** (see the stone in the middle of the diagram).



Francine Shapiro uses the hand-and-fingers analogy to illustrate the channels that need to be cleared, but we also like the idea of allowing the work to circle out, round and back from the target, out, round and back as often as necessary to clear all the channels relevant to that touchstone memory.

Session structure also allows us to complete each session, even when the past is not entirely cleared and needs to be revisited next time.

A client's presenting distress, carefully explored with an intense focus on case conceptualisation, can be understood as the **Bridging Point** (the red dot on the right of the diagram above) from which to set off into the past, to explore **the Map, the Territory** of how the client got to be the way they are/the way they manage experience in the present.

The point where the client lands (the left-hand red dot under the colourful loops) can be understood as a **Portal** into the territory that needs to be explored.

This memory or moment may be a **Target** in its own right. But in the AI-EMDR way of working, where a client lands in the bridging exercise is often their childhood's *response* to dysfunctional attachment experience, and therefore less the story itself than a way into unpacking what the actual story was.

Note that EMDR can easily fail if the point to which you bridge is always understood and processed as the target in its own right. Be really careful at this point to engage with the deeper meaning of what's coming into consciousness.

On the way across to the other side/into the past, many clients land first in a later memory, often in early teens, where the earlier attachment traumas are either being acted out or experienced with intense awareness and memory.

This next point is VERY IMPORTANT.

However distressing the immediate memory coming up may be, for example bullying at school, self-harming, feeling inadequate in social groups, or becoming aware of sexual identity, this is very rarely the reason the client is now in therapy.

The reason these memories remain so intense and determining of the present is that they remain unrepaired, almost always because of attachment patterns already "burned in" to the nervous system in the client's family system, in the experience

primarily of mother but also of father (and his relationship or otherwise with mother) and siblings.

These interim memories can be seen as **Stepping Stones** (or perhaps arches of the bridge) on the way over to the other side of the bridge and the past.

Once processing from the Portal or Target, we can default back to EMDR's standard language of **channels**, or perhaps **pathways**, taking care not to allow these to continue for too long, or be interrupted too soon.

In Attachment-Informed EMDR, we remain much more focused than you may have learned in your initial basic training on returning to target, to ensure that the key developmental experiences are processed and rewired as far as is possible in the present session.

Once the root target has been effectively processed, with SUDs down to a zero, a good PC identified and the VoC up to a 7/7, then it's important as we come back to the present in time for the end of the session ("**Coming back over the Bridge**") to recall any portals or stepping stones identified on the way over into the territory we've been exploring, and check for any residual disturbance.

Previous trainees on EMDR Focus workshops will have heard the term "**Petalling**", reflecting how the process of going out round and back can look like a flower with petals.

If that's a metaphor that works for you, great.

But we're no longer teaching it on the workshops as many colleagues found themselves confused – after all, if we're going across a bridge, what's this stuff about a flower on the other side...?

Length of sets

You will recall on your standard training being invited initially to count your sets, practising initially with Shapiro's long-preferred eye movements up to 25 or so.

That's a useful starter length with clients, but in this AI-EMDR work, it's essential, with empathy and radical curiosity, to observe closely and resonate with the client's experience, allowing sets to run for a length that works.

Sometimes sets in this work can be quite long, even into a number of minutes (clients once they get the hang may ask for this). And sometimes, you might find yourselves

tapping all the way through the work, without a break as the client reports back and keeps you up to date with what is unfolding.

Here however, as in so many things, Shapiro was onto something important.

While we discourage you from counting your sets, it can be useful to keep an eye on the time. Even working with attachment, whether eye movements, clicks in headphones or tactile buzzers, 30 seconds is, we find, a really useful baseline for length of set.

The key is not to let the set run too long, or be truncated too soon – some clients can be quite challenging in this latter regard.

Note that in AI-EMDR – and this is a key departure from standard training – we don't generally wait to return to target until the client experiences either two sets of positives or two sets of nothing happening.

With single incident trauma, that approach works well. When working with early childhood attachment, you as therapist and the client can easily get lost in the sometimes thousands upon thousands of formative moments which come back into memory.

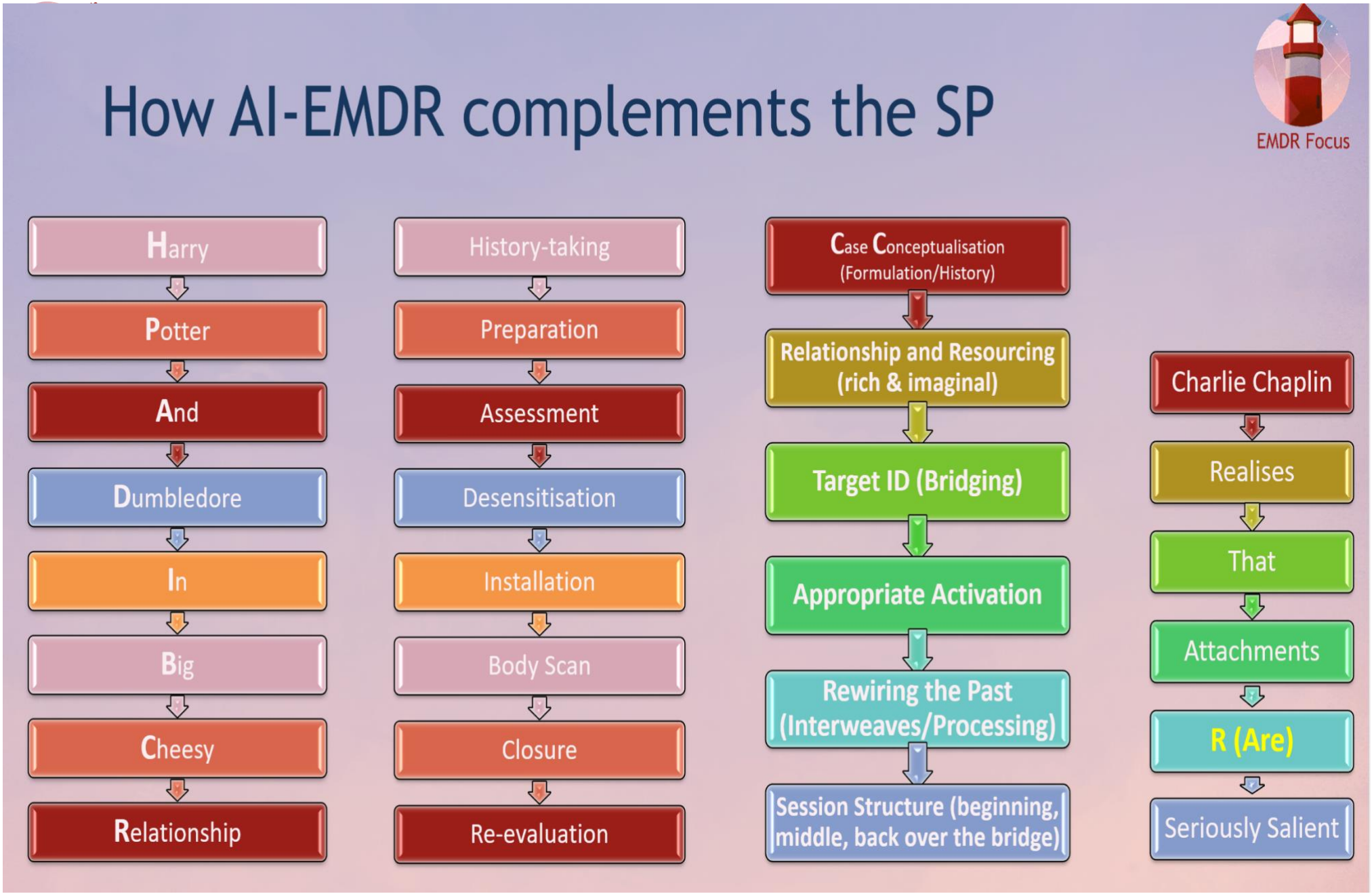
So, keep focused, and... **when in doubt, return to target**.

And on the next page, we hope you might appreciate a very simple way of remembering the core structure of EMDR as basically trained, and against that the six distinctive elements of the Attachment-Informed approach.

If the eight phases of the SP can be summarised as **Harry Potter And Dumbledore In Big Cheesy Relationship** (History, Preparation, Assessment, Desensitisation, Installation, Body Scan, Closure and Reevaluation), then the AI-EMDR additions can run thus:

Charlie Chaplin (Case Conceptualisation) **Realises** (Resourcing) **That** (Target Selection) **Attachments** (Appropriate Activation) **Are** (R, or Repair and Rewire) **Seriously Salient** (Session Structure).

How AI-EMDR complements the SP



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10. AI-EMDR SIMPLIFIED PROTOCOL

AI-EMDR SIMPLIFIED PROTOCOL

Phase 1: Case Conceptualisation

- How did this person get to be the way they are?
- How learned to affect-regulate/self-soothe?
- What's the story? (Think 4 Levels of Trauma).

Phase 2: Preparation:

Special/Calm/Peaceful/Safe Place. (SP)

- *Location, real or imaginary, where as adult you can imagine feeling relaxed, at peace, calm…*
- *Notice what you can see (colours, quality of the light, sky, clouds, time of day, landscape…)*
- *Notice what you can hear / touch / sense (air on your skin, ground beneath you) / smell / taste.*

Knee taps/EMs/buzzers/headphones (>>>).

As they tap, maybe *notice where it feels good in your body and breathe into that space. Let me know when you have a good sense of that.* ("Nod", "Say When"). #HASHTAG/Cue Word? Tap that in too.

Resource team. *Real/imaginary, human/animal, historical/contemporary, from own experience, history, literature, mythology, religion, Hollywood, fairy tales…*

3 x Nurturing Figures: *Qualities of Kindness, Gentleness, Tenderness, Compassion, Care…* Identify all, then, inviting each to step forward in turn tap in 1 by 1.

3 x Protector Figures: *Strength, Determination, Courage, Steadfastness, and yes, Ferocity…*

1+ Wise Figure: *just Wisdom: Indivisible*

Tap in as team *(w/awareness of SP in background)*

Presenting Issue *e.g. If there's one thing you could change today, in the time we have.*

Phase 3 Assessment/Targeting:

What's the picture that goes with that? Or picture/ image of most intense/ or charged/worst? moment. Thinking case conceptualisation, be curious what's the most appropriate point.

1. IMAGE *Looking at/connecting with that picture..*
2. EMOTION *What's the emotion? Or, What are you feeling?*
3. BODY *Where's that happening in your body?*
4. BELIEF *What's the thought or belief about yourself that goes with that? (e.g. I'm….)*

If bridging, if no picture but just a feeling, can bridge from impulse/emotion/ body sensation. *Shape, size, colour, temp hot/cold, vibration high/low, texture hard/soft, rough/ smooth.*

NB NO BLS at this point.

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Bridge (cf Floatback)

- *Connecting with all of that (that image, emotion, in your body, thought…)*
- *Drop back in time,*
- *Go back as far as you can,*
- *Very first place you land.*

WAIT!! (Maybe, rpt *VERY 1st place*.) *How old are you? Where are you?* Note whether Target, Portal, Stepping Stone.

Re-Target, positioned in space & time.

Bridge words: Image/Emotion/Body/ Belief: GoI

Now, connecting with all of that (can remind if needed), notice what/ let whatever happens. >>>

Phase 4: Desensitisation/Repairing

Sets not too long or short. (Baseline ≈ 30").

What are you getting? What do you notice?

- If things moving, *Go with That/Notice That.*
- When narrative unfolding, *Follow That.*
- Think about That *in response to an insight.*
- If a new emotion, *Stay with That.*

Interweaves: e.g.

- Inquiry. Truth. Sorting. Education. Curiosity.
- Video. Zoom out/Rewind/Play.
- Repair/Rescue, but only once affect & meaning fully accessed, or ending session.
  1. *What does the child need?*
  2. *Who can do that?*
  3. *Would you like to imagine that?*

Important regularly, esp when in doubt, to return to target. *What getting now?*

Phase 5: Installation/Tapping In

SUDs to a zero. *Any distress left?* If stuck at 1 or more, *What's keeping it there?* >>> Once emotions clear, identify PC. *What's the belief about yourself that goes with that now? VoC to 7? Holding target as get it now, tap in. >>>*

Phase 6: Body Scan

Note the target and the new PC. *Scan body. Any disturbance?* If ANY sensation, tap till resolves.

Phase 7: Closure.

Return via key "stepping stones" to initial bridging point in the client's present. Check the PC / tap in. Conclude with check on future template, and tap that in too.

Phase 8: Re-evaluation.

Check last session's / previous target. How is that now? New target?

11. Metaphors

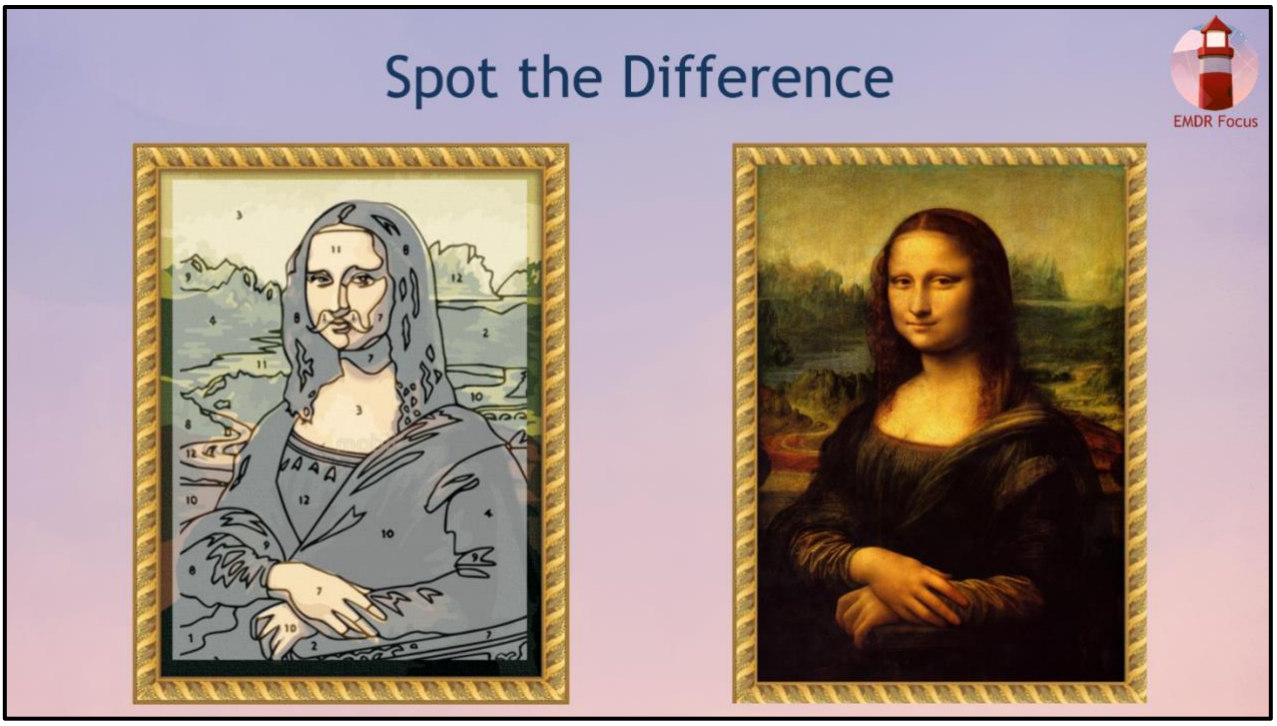
There are many useful metaphors for why and how best-practice Attachment Informed Integrative-EMDR works.

Therapists will have their own favourites for sharing with clients - Shapiro's **train passing through the landscape**, for example, or keeping your **foot on the accelerator** as you head through the tunnel, the **computer software/operating system** that needs updating.

Another might be a flooding/out-of-control river, or a weed system.

Cutting off all the weeds at the surface, or damming the river, may look great for a while. But it won't (usually) last.

That's why many standard therapies often don't work – whether Standard Protocol EMDR, or CBT, or psychodynamic therapy or person-centred counselling, Gestalt, or whatever, if applied in a painting-by-numbers, intellectual/left-brained, trauma-history-driven way.



If clients are to get truly well, we as EMDR therapists need to get down to the deepest roots or up into the very source headwaters of the weed system or the flooding that's

messing up their emotional flood plain or their garden, and then make sure that these get thoroughly identified, worked with, removed, restructured and rebuilt adaptively.

Two particularly useful metaphors, we find, are the **jigsaw puzzle** and **(see further down) the watermelon.** Adjust the following words to make them your own…



> *Think of the work we're going to do here as akin to assembling a jigsaw puzzle. You come to therapy in bits, as it were, with a box of stories and troubles but little idea how the pieces all fit together.*
>
> *Before we get to work on the jigsaw itself, we need to make the working space - the table, as it were, the chairs, the setting and the context - safe and sufficiently comfortable.*
>
> *Then we tip the contents of your box gently out onto the table and turn the pieces over so we can see what's on the coloured face.*

In Standard EMDR terminology, this is Phase One Trauma History, the Case Conceptualisation for which the **ACE, PCL-5, ITQ** and **CAPS** questionnaires can be very helpful. These are included towards the end of this booklet.

We begin the EMDR processing with those pieces that most obviously and brightly call our attention. The corners and the edges. The cluster of colours around a flower, a building, a recognisable shape.

Once a first cluster is largely done, we shift our attention to the other pieces, looking for patterns that look and feel as if they belong together.

We can't do the whole jigsaw in one go, just as no-one can eat a whole watermelon in one mouthful. We identify and work on the elements of your trauma story piece-by-containable/manageable-piece.

Just as the purpose of a jigsaw is to assemble broken pieces into a coherent picture, that's what we're aiming to do with you in EMDR therapy. Which is to put you, your story and your experiences together as best we can.

As the work progresses - as with a jigsaw - the work becomes increasingly intuitive and flowing, until many of the bigger clusters are joined up and the overall picture emerges more and more clearly.

Note that the more complex a client's presentation, the more tightly focused and targeted the EMDR therapy will need to be on individual, *digestible*, representative experiences which, as they are resolved, generalise their healing effect out into the wider dysfunctionally-linked memory network.

Clients can find it useful to look at – and smile about – this image of the scary watermelon (which no-one can eat in one go) reconfigured as a tasty shark.



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12. Phase 4/5/6 Processing Tips

Empathic listening. Use a soft voice, be warm, supportive, kind, authentic.

Don't (on the whole) repeat client's words. Keep it Simple. Less is More.

Identify session target with "If there's one thing you could change in the next 40/50 mins, what would it be? What image goes with that? Emotion/body/belief – Bridge!

Get INTO the childhood emotion, letting the part tell and feel the emotion

Rescue only if stuck, or approaching end of session.

Trust the brain/nervous system's capacity to manage its own healing. As ever, know when to stay out of the way, know when to interweave/intervene.

Once processing is under way, the standard phrase is, of course, ***Go With That***. However, it can be seriously valuable to tune your language to the quality of the process that's unfolding.

> ***Notice That*** (for when you want the client just to pay attention to what's happening.)
>
> ***Follow That*** (when a narrative is unfolding).
>
> You can also use ***Think About That*** (in response to an insight).
>
> ***Stay with That*** (esp. an emotion that's come up for someone who doesn't do feelings).

Don't count your EMs/BLS. Follow the client. Watch their skin colour, the big sigh, and on the whole, once they get the hang of this, you can let them determine the length of sets. Not too short, and not usually too long. 30 seconds is a good baseline. Once they're up and running, some clients might want to go for minutes at a time. Let them (but thinking Goldilocks, not too long either, and not too short.)

Make sure you take notes as you go along of important realisations/ cognitions/ targets/moments to which to return.

When working in-person, you don't have to sit to one side like ships passing in the night. When using tappers/headphones or knee taps, much better to place yourself directly in front of the client, so that when they open their eyes between sets, they look directly into your own eyes – in itself, a form of attachment repair.

Don't sit with crossed legs. Encourage client to place both feet on floor when processing. (This is true when working online also.)

When in doubt, check the body.

When still in doubt, return to target. Better to overdo than underdo that.

As the processing ends and distress abates, Phases 5 and 6 can unfold efficiently and speedily as per Standard Protocol.

Check the SUDs, ask for the current cognition. *What's your belief about yourself now?* (No need to use the word Positive, as it always will be). Check the VoC.

Tap it all in (better word than install, but the same thing) as per Standard EMDR training.

And, Phase 7 Closure as usual, ready for Phase 8 re-evaluation at the start of the next session.

13. Some Common Phase 4 Mistakes

Intervening too quickly. Conversely…. not using interweaves when they are needed. Many therapists forget that they can intervene with interweaves. Clients are left to **loop in abreactions for too long.**

Allowing memories to chain endlessly onwards, without returning to target. Again, when in doubt, return to target. Better too much than too little.

Talking too much. Don't interpret or discuss things with the client unless you are trying to create an interweave. Otherwise it derails the processing.

Bringing in a resource too quickly. A very common mistake for those learning the attachment-informed approach. When the client is abreacting, don't assume they need to go to their safe/special place, or to a resource.

Neglecting to use interweaves to close sessions. If you are running out of time, or cannot get the SUDS significantly down, begin to use interweaves proactively as session end approaches to link networks together.

Accepting too rapid a processing resolution. Clients can have powerful and sophisticated (of course unconscious) defence and emotional self-protection systems to keep them away from attachment-informed emotional distress from childhood.

Watch for the "spiritual bypass" or the rapid and too early self-rescue or recourse to imaginary self-soothing figures. Remain curious as to what this target is REALLY about, and stay patiently present to the child's story until you're both clear that this has truly been told and shared.

Taking too long to get going with EMDR. Spending weeks, months, sometimes years, waiting for the client to be "ready" for EMDR (as in, actual bilateral stimulation and processing.)

While it's important not to rush in, it can be deeply disempowering and counterproductive to let concerns and fears about the client's capacity to do the work (and your own as therapist to hold that space) block what's wanting and needing to happen.

Remember that the greatest single gift we can give our clients is the capacity gracefully and with continued connection and empathy to survive their experiences, however intense.

14. Working with Ego States/Blocks - Transfer of Perspective (ToP).

"When children feel pervasively angry or guilty or are chronically frightened about being abandoned, they have come by such feelings honestly." **John Bowlby**

Critical to working with attachment is the understanding that pretty much ALL emotional dysfunctions with which our clients present (fears, terrors, nightmares, flashbacks, addictions, compulsions – the works) were **honestly acquired.**

They came into being to serve a life-saving survival purpose, when the infant/child/ individual was not able to metabolise emotional distress arising from their experience – in relationship with caregivers and others, in their daily life, in the experience of major adult trauma.

The emotions therefore became split off, with a protector/defender/ manager part stepping in to keep the child's conscious psyche and body safe.

Either co-conscious (with what Onno van der Hart, in the context of Structural Dissociation Theory, calls the Apparently Normal Part of the Personality, the ANP), or out of conscious awareness, these become Ego States, or Emotional Parts (EPs), which have their own agendas and needs.

So, whether it's a dream, the memory of a perpetrator, an inner critical voice, intrusive/maladaptive behaviour, a compulsion – anything, really – it can and must be worked on with compassion, openness, a willingness to explore and accept, and an awareness that the survival-related *intent* of this dysfunction was *always,* initially, positive.

Being the Part

The aim here is simply to invite the client to shift their perspective, their point of view, from the observer into the split-off/dissociated (Emotional) Part so that they can *feel* and identify intuitively what the purpose of that part was.

Identify the part which needs work. It might be a monster, a dark bog, a black-clad man with a gun, gunge or water in the cellar in a dream, an introjected abuser, a voice on the shoulder, a wall blocking access to feelings or facts. Trust what the client presents.

Ask the client (their having first given permission to do this work) to close their eyes, turn within, and bring their attention to the shape/object/figure/stuff. Then use the following words, or close to.

> *When you look at that object, notice what you notice. Now, imagine your conscious awareness - your point of view or perspective - rising upwards as it were, crossing the space between you as dreamer/observer and the object/shape.*
>
> *Now, looking down on the scene, as it were from a drone, notice the object on one side, and you the observer on the other, and notice that they are separate.*
>
> *Now imagine yourself dropping down gently, into the body and being of the shape/object/person/thing…*
>
> *From within that being, and now with access to that part's eyes, emotions, sensations and memories, look out back across the space at you the dreamer/ observer.*

(If the client is resistant to the idea of being asked to identify with something so negative, you can emphasise that they are not literally becoming that being, rather just being granted access to its state and perspective).

> *Notice what you notice. (Optional >>>)*
>
> *And now, I want to ask you (name the being), what is your benevolent / kind-hearted / compassionate intent towards …[add client's name.] What might be your message, or your gift? What do you know that [name] might need to know?*

Allow space for the client to connect with the wisdom of that part.

Whatever the client says, tap on it. >>> Gently, allowing whatever it is to unfold. The tapping merely deepens the connection with what is wanting to be known.

Always return client to their observer/dreamer self before completing this work. This can be done simply ("*come back to your observer self"*) or in more detail, as follows.

> *Now, noting what you have noticed, I'd like you to imagine your conscious awareness rising **back** up over the space between the [shape] and yourself as observer*
>
> *Look down, and with the knowledge that you now have, notice what you notice.*
>
> *Now drop gently back down into your dreamer/observer self, and look back out across the space at [the being/object].*
>
> *How are you now experiencing that situation, that object, that being?*

Notice what you notice, and what is it like to receive the gift/message. (Optional: Allow yourself to convey gratitude for what has been shared.)

Tap if necessary and useful.>>> Discuss.

Bridging from the Part

You can also use the internal object identified in this way to (affect) **bridge into the client's root attachment experiences** that might not have been accessible going back in time from the present.

Being the part, looking at [client's name] as observer/dreamer on the one hand, now turn your attention to how you got to be this way, to what you know from the past, looking back, way into [name client]'s story as far as you can go.

Where do you land?

What's happening?

As with standard bridging from a present experience, that's your new target.

EMDR Focus

ToP Protocol

Transfer of Perspective (ToP)

All parts – even the most suicidal and self-destructive - come into being in an individual's psyche with an initially survival-related purpose.

The purpose of this EMDR tool is to invite clients to shift perspective/point of view into split-off/dissociated (Emotional) Part, from within which they can process to adaptive resolution.

1. **Identify the part which needs work.**

   A monster, perhaps, or dark bog, black-clad man with a gun, gunge or water in the cellar of a dream. An introjected abuser, a voice on the shoulder, a wall blocking access to feelings or facts. Trust what the client presents.

   If the client is resistant, you can emphasise that they are not literally becoming that being, but just being granted access to its perspective.

2. **Access the Part (having secured permission to do this work):**

   - *Close your eyes & turn within, bringing your attention to the shape/object/being.*
   - *Notice what you see, and imagine that shape inviting you now to explore its experience.*
   - *Imagine your conscious awareness – your perspective, your point of view– rising upwards, looking down on the space between you as dreamer/observer and the object/shape.*
   - *Looking down on the scene* (optional: *as it were from a drone), notice the object on one side, and you the observer on the other, and that they are separate.*
   - *Now imagine yourself dropping down gently, into the body and being of the shape/object/person/thing…*
   - *From within that being, with access to its eyes and senses, look out back across the space at your dreamer/observer self.*
   - *Notice what you notice. Thoughts/feelings/ physical sensations.* Optional >>>
   - *Now, let me ask you [name the part] What is your benevolent / kind-hearted / compassionate intent towards … [client]?*
   - *What might be your message, or your gift?*
   - *What do you know that [client's name] might need to know?*

3. **Allow space for the client to connect with the wisdom of that part.**

   Whatever the client says: >>> Gently, allowing whatever it is to unfold. Always return to observer/dreamer before completing this work.

   - *Now, noting what you have noticed, I'd like you to imagine your conscious awareness rising back up over the space between the [shape] and yourself as observer*
   - *Look down, and with the knowledge that you now have, notice what you notice.*
   - *Now drop gently back down into yourself as dreamer/observer, and look back out across the space at [the being/object].*
   - *Notice what you notice, and what is it like to receive the gift/ message. (*Optional: *Allow yourself to convey gratitude for what has been shared.)*

   Tap if necessary and useful.>>> Discuss.

4. **To conclude this piece, return to the dream or the point from which the work set off.**

   - *What are you getting now?*
   - *How are you now experiencing that situation, that object, that being?*
   - *If helpful, identify PC and tap in.*

   You can also use the internal object identified in this way to bridge into the client's root attachment experiences that might not have been accessible going back from the present.

   - *Being the part, looking at [client's name] as observer/dreamer on the one hand, now turn your attention to how you got to be this way, to what you know from the past, dropping back into [name client]'s story as far as you can go.*
   - *Where do you land?*
   - *What's happening?*

That's your new target!

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15. EMDR with Intergenerational Trauma

Trauma/Narrative Levels 3 and 4 targeting

When you sense that a parental introject is blocking adaptive resolution of a childhood/attachment-related target, you can use steps roughly as follows, making the language your own as appropriate. The earlier in life the target you're working on, the more relevant this approach can be.

In essence, what's suggested here is a kind of "session-within-a-session", where you do EMDR on the client's introjected parent *in their imagination*. AS IF, in other words, you were doing perfectly standard AI-EMDR with the client in person in the session with you, just using your actual client's imagination and your own intuition and mirror-neuron resonance to co-create the imagined scene – which may, or may not, reflect what actually happened in the parent's/introject's childhood.

An intergenerational EMDR session may not sort a client's parent or introjected attachment figure in one go, and the work will relate to this one target only. However, as ever with EMDR, one hopes for and often experiences a powerful generalising/ domino effect across the networks.

The protocol is captured in single-sheet A4 form in the next chapter, but these are the steps.

- Start EMDR in the normal manner, first installing or reminding the client of their **peaceful place and resource team**, and then (usually), **using a floatback or affect bridge** from a presenting distress to identify the most relevant target.
- Begin **Phase Four processing as normal** on that earlier attachment-related experience (usually before the age of 10 or so).
- When it becomes clear that this target probably involves more than the client's own childhood response, identify with them the key, single attachment figure generating a blocking/maladaptive experience in their process.
- In the following script [mother] stands for whichever Introject is being worked with, but it might also be father, sibling or other significant attachment figure. Adjust as appropriate.
- Note that some clients are able easily to imagine themselves in the body and identity of their parental introject. Others find themselves more detached.
- "You" in the following script will therefore refer sometimes to the client,

sometimes to the introject, in effect however always to both. As you choose your language, you will need to tune very carefully into your client's experience.

Suggested Sequence

Secure the client's permission to switch the focus of EMDR.

> *It does seem that your experience of your [mother] might be getting in the way of sorting this memory. So shall we take a pause on you, as it were, and do some work with them…?*

Assuming agreement, ensure the child part is safe and separate from the parent.

> *Before we do this work, let's make sure little [client's name] is safe, and remove him/her from this situation.*
>
> *Imagine pausing that scene we've just been working on – we'll be back in a moment – and see your little self now being safely looked after by your resource team elsewhere (in another room? at the playground? where your little self would like to be?)*

Take a moment to let the client imagine their child self in that place. **BLS optional (short set only).**

Once that's secure, return to the scene of the childhood target (in the kitchen, the living room, wherever) **making sure you have a physical location in time and space**. Explain to the client what their role will now be.

> *I'd like to ask you, as your adult/present self, to come with me back to that scene with your [mother] in the [e.g. kitchen]. I now need you to be, as it were, my interpreter. I can't see or hear your [mother]. You can.*
>
> *I need you to convey my questions to him/her and relay their answers and experience back to me. Does that make sense? (Optional: It might seem a bit weird but trust your imagination for this – it usually works.)*

Ask the client for their [mother's] name and ask them to check with [name] that it's OK to proceed.

> *We're now going to do some EMDR with your [mother] on what just happened, so please ask them if they're ready to do that.*

Having secured permission, we set the scene for EMDR therapy.

> *Now, please ask your [mother] to sit down, and I will sit opposite [her] in your imagination, just as I am sitting opposite you here now.*
>
> *Imagine yourself giving your [mother] the headphones/buzzers, and that the taps are being administered to [her].*

We can now work directly on the [mother's] experience and role in the client's remembered or imagined scene.

Note whether this is a Level 1 target for the introject needing direct processing, or the [parent's] own Level 2 childhood experience to which to bridge.

If the former, targeting the event and resourcing the parental introject and/or reworking their experience is all that needs to be done, using the usual Simplified Protocol.

If, however, the [mother] is her/themselves being triggered in the client's remembered or imagined experience into a childhood-driven ego-state response, that needs to be cleared.

We can now do a classic AI-EMDR bridge from the client's target scene [e.g. kitchen], as efficiently and quickly as possible (not to lose the energy of the moment), addressing [mother] directly by name and bridging back into *their* [mother's] childhood experience, as imagined by the client, with these words.

> *Now, [mother's name] I'd like you to go back a few moments to that scene [e.g. kitchen] where your little [client's name] was having the experience we've just been working on.*

- *In that moment, what are you [mother] feeling?*
- *Where are you feeling that in your body?*
- *What is your belief about yourself?*

  Noticing that thought and that feeling in your body,
- *Drop/trace that back in time, (way back into your own childhood).*
- *Go back as far as you can as [mother],*
- *Without censoring what comes up.*

Identify as always a clear target in time and space, often the parent's experience at roughly the age your client is in this session's targeted memory.

Work with the emerging memory/imagined scene as per the Simplified EMDR Protocol, now with BLS, noting that you might need to clarify gently as you proceed that it is the *parent's* experience that you are exploring.

- *In this experience, what [mother's name] are you feeling.*
- *Where are you feeling that in your/their body?*
- *What's your belief about yourself.*

Use knee taps/headphones/buzzers (or EMs if the client requests), allowing for a few sets, but prepared to interweave quicker than usual, with supportive/rescue interweaves.

> *E.g. In this scene, what does that child need. Who can do that? Would you like to imagine that? >>>*

Note that the client should normally be discouraged from using her own imagined team to resource her [parent]. Remember that this team is currently busy looking after the client's child part back in the original target.

Process the [mother's] memory to full resolution (SUDs 0/10 and an appropriate PC, though VoC is rarely needed). This does not usually need a great deal of time. Tap the PC in as usual. >>>

(If necessary, you can bridge with the client even further back, to grandmother/ father and up the family line, to a Level 4 target, though keep the processing on whatever comes up there as brief and tightly-focused as necessary, so you can get right back out into the present before the end of the session.)

Return to target, either addressing the [mother] directly or asking the client what they get, and the original distress/triggering should now be much attenuated.

> *Coming back to the [location of the original target, e.g. the kitchen], bring your attention to where we began (optional: with that PC) and check what you get now. (Standard EMDR Steps…) >>>*

There will usually be a significant change, and the [mother] is much less distressed.

> *Thanking your [mother] for her good work with this story, ask [her] now whether it would be OK now to bring little [client's name] back into the scene. If so, let's imagine that, and just notice how that is. >>>*

Often, the client's introjected parent will want to apologise to their little one and give them a hug. It can be very moving.

Once all is thoroughly embedded (usually quite rapid), check in with the client and their original EMDR process.

> *So, [client's name], now as your present self and switching attention back to yourself from your mother, when you think of that scene, what are you getting. How distressing does that scene feel now (SUDs if useful)? What's your belief about yourself now?*

Tap in/reinforce the PC, add the body scan as usual. Once the target is clear, make absolutely sure that in time for the end of the session, you bring the client completely, in appropriate stages, back out into the present.

EMDR Focus

IG EMDR Protocol

IG- EMDR simple script

TO BE USED IN EMDR PHASE FOUR WHEN CLEAR THAT WORK NEEDED ON INTROJECT.

1. **Identify key, single attachment figure generating blocking/dysfunctional experience in client's early attachment story for an imaginal "session-within-a-session".**
2. **Inviting client to close eyes, ensure child part is safe and separate from the parent.**
   Let's make sure little [client's name] is safely away from this situation, looked after by your resource team elsewhere (In another room? Playground? Special place?) **Gentle BLS optional to consolidate.**
3. **Return to scene of the client's childhood target.**
   *Together with you as your adult/present self, (*can add*, dressed as you now are) I'm going to come into that scene, with your [mother] in the [e.g. kitchen]. I can't see or hear [her]. You can. Can you be, as it were, my interpreter, conveying questions and relaying answers back to me, including feelings, stories and experience?*
4. **Ask client for [mother's] name and ask them to check with [name] that it's OK to proceed.**
   We're now going to do some EMDR with your [mother] on what just happened, so can you ask them if they're ready to do that. If "parent" resists, point out this isn't the literal parent but a part of self, and that the answer needs to be yes.
5. **Set the scene for EMDR therapy.**
   Ask your [mother] to sit down. Let's choose where that is. In your imagination, I will sit opposite [her] as I am with you now. You [client] are, as it were, sitting to one side, like an interpreter.
   We're going to use bilateral stimulation (whatever way you do that) *and I'd like you to imagine this being experienced directly by [her].*
6. **Phase Three target Assessment.**
   Now, [mother's name] let's go back a few moments to that scene [e.g. kitchen] where your little [client's name] was having the experience we've just been working on.
   Note that following questions need to be paced – not too rapid.
   When you [mother] connect with that moment, through [client's name], tell me what you're feeling. Where's that happening in your (in effect in client's) *body? And, [mother's name], what's the belief about yourself that goes with that?*
7. **Then bridge, as per normal AI-EMDR with a client literally in the room ("session-within-a-session").**
   Connecting with that moment, that emotion, your body and that thought about yourself (addressing parent in the client's imagination),
   Drop back in time, Go back as far as you can, Way back into childhood. In [name client]'s imagination, what's the first place you land?
8. **As with standard AI-EMDR, identify the IG moment with a clear freeze-frame image, anchored in time and space. This is your target, to be processed in the usual manner.**
   If necessary as the story unfolds, you can go further back up the family line, to grandparents & beyond, keeping processing tightly focused.
9. **Be prepared to intervene quicker than usual (though not too soon) with supportive/repair interweaves.**
   E.g. In this scene, What does that child need. Who can do that? Would you like to imagine that? >>> NB: take care that client doesn't use their own resource figures.
10. **Once target cleared/processed (no distress left, good PC if helpful, tapped in, body scan clear) ask [mother] in client's imagination to return to first target (see 3 above).**
    Coming back to the [location of the original target, e.g. the kitchen], I'd like you to bring your attention back to where we began (with previous step's new PC). What do you get now?
11. **Usually, there is a profound new perspective on that event/scene. When ready, it's time to bring client's Child Self back into the story.**
    With this new perspective, is it OK to bring little [client's name] ***and his/her team*** *back into the scene?* **Allow brief space for this to happen.** *Is there anything you [mother] would like now to do or say? >>>* Usually, [mother] wants to apologise, to make amends. Tap on that.
12. **Returning now to the client's own narrative, we're back on track with standard EMDR.**
    So, [client's name], now as your present self and bringing your attention back to yourself here and now, when you think of that original target scene, what do you get now?
13. **Check SUDs/new PC/VoC. Tap in, adding body scan as usual.**
14. **Once the target is clear, make absolutely sure that in time for the end of the session, you bring the client completely, in appropriate stages, back out into the present. ("Back over the bridge/stepping stones/back out into to the present…")**

16. AI-EMDR & Addiction

Worldwide, addiction is probably *the* most formidable health problem: excess alcohol alone kills more than three million people a year. Having EMDR tools to tackle addiction is essential, whether we're helping clients with life-threatening addictions through to everyday addictions.

Put simply, addiction means 'continued use despite adverse consequences', so that could mean a client is addicted to anything. They could be using alcohol, drugs, sex, relationships, shopping, spending, debt, gambling, binge-eating, starving, vomiting, overworking, rage, self-harm, over-caring, compulsive-helping, computer games, or looking at their phone too much.

All serve to help avoid uncomfortable feelings and generate feelings of pleasure.

One key indicator is, how compulsive is this behaviour? How much choice does the client have over what they are doing?

This is shaped by the habit loop, the link between the positive feeling and a memory of how to recreate a positive feeling - eg see food (we can substitute any of the behaviours above here), eat food, feel good (dopamine is fired in the brain to mark this memory).

As addiction really takes hold, embedded survival feelings get locked in with the behaviour. This is what we are trying to unlock with the addiction protocol. Behaviours sit like a lid on the trauma, so we have to get underneath to shift things.

Clients are often afraid to lift this lid, so first we offer them hope by inviting them to **Tap in Positive Future/Goal.**

- *Imagine a day in the future where you feel your best healthy self. Picture it vividly & specifically, where are you, what are you doing? Notice what you feel in your body*. Tap it in >>>>.

This desired, ideal future state, with sobriety and health, is a hopeful motivating image. It is a resource, a bit like the safe place, which can be returned to many times when they're struggling or at the end of a tough session.

Next we want to desensitise the buzz, the pleasure from the **addiction memory.**

- **Moment:** *Run a movie of using, from planning to finishing. Locate that best moment of max rush/buzz/ euphoria.*

1. **Body:** Locate sensation in the body.
2. **Beliefs/Thoughts**: Help client name what they're seeking, both the sensation & belief. This is linked with survival, feeling safe, or bonded, successful or alive. Robert Miller calls these Assured Survival Feelings (ASF). See table for ASF ideas, as these can be quite unconscious and hidden. It's a bit like finding **a false positive cognition** that we're trying to shift, bust, or wreck so it's clearly negative.

Ideas for beliefs (Assured Survival Feelings ASFs):

1. ***Safety***: safe, secure, in control.
2. ***Relational***: bonding; connected, important, special, powerful, strong, invincible, acknowledged, "I exist", "cared for", whole.
3. ***Winning*** (status): "the man"; "big man on campus"; superhero; masculine, feminine, smart, winner, approval, reward, "I deserve it"; "I can have what I want".
4. ***Sensation-alive***: excitement, danger, aliveness, euphoria.
5. Note the following are NOT ASFs, but what clients experience when the feeling/belief is met. E.g. comfort, relaxed, calm, peace, happiness, joy.

Next measure the intensity of the connection between the client's addictive behaviour and this ASF along with its body sensation. ***The Link of Positive Affect? (LOPA 0-10).***

What number would you put on link between that wonderful feeling & your addictive behaviour (smoking, eating, drinking, looking at their phone etc)?

If they can't measure the link, just go with the Level of The Positive Affect (LOPA 0-10), it will still work. Add >>>>>

A few tips when processing the addiction memory:

- **Limited, focused, processing.** The client is not free associating, that comes later. EMD (without the R). Keep returning to target until LOPA = 1 or 0.
- **Fast BLS** as they replay that best buzzy moment until LOPA = 1 or 0.
- **Between BLS sets**, ask: *Is that link increasing or decreasing?*
- **Often LOPA increases** before shifting quickly to unpleasant sensation, eg to healthy nausea in reaction to excess food or alcohol.

Next you want to explore **the Urge or need** for the feeling (the ASF), not the behaviour itself. This often clears quickly or may not even be there at all. We're being diligent.

- *Feel the need (urge) for that feeling (repeat ASF) as intensely as you can.*

- Body: *Where is that need/urge for that feeling happening in your body?*
- Level of Urge: LOU 0-10. Ask the client*: How strong is this need or urge for the feeling?*
- >>> Desensitise until LOU = 1 or 0.



The addiction memory with its LOPA and ASF sits like a lid on top of the trauma. So lifting this with the addiction protocol will metaphorically open the client's can of worms, making it easier to move to the trauma phase of the protocol, so don't be surprised by how much deeper they can go.



- **Belief***: What does it say about you that you can't be safe; can't win; can't be adored, etc? (repeat the ASF they gave you for the target).*
- **Emotion:** *What's the feeling as you say that?*
- **Body:** *Where is that in your body? Colour? Shape? Sound?* (this is effectively your picture).
- **Bridge from here.**
  - ***Trace it/drop back in time.***
  - ***Go back as far as you can.***
  - ***Very first place you land. (WAIT) How old are you? Where are you?***

  If this doesn't work or you're struggling use the conventional AI-EMDR approach by finding the **picture** of the moment **<u>just before</u>** using: Image; Emotion; Body; Belief. ***Trace it/drop back in time. Go back as far as you can. Very first place you land.***

  Make sure that the **early life target** is positioned specifically in space and time: Image; Emotion; Body; Belief. Desensitise as per AI-EMDR >>> to SUDs = 0; install PC; VoC = 7; until clear body scan.

  We now need to help the client find **a healthy way** of achieving that good feeling, the positive affect**, the ASF.** This is a kind of future template:

- **Find a healthy behaviour to access positive affect (ASF)** being sought. Eg *Can you think of a healthy way to feel safe, connected, winning or alive such as meditating, journaling, hugging a pet, without the addictive behaviour/ using/consumption?* Tap it in >>>.

- **Install Positive State**: locate in body the affect/feeling that they seek, so it's part of them and they don't have to DO something to feel it, eg *Imagine feeling powerful/safe/adored **as part of you**, feel that in your chest.* (Wherever client names). Tap it in >>>.

  Finally we need to check our work, check that original addiction memory target.

- *E.g. "If you think about that first sip of wine now, how positive does that feel?"*

  Usually the client is quite repulsed and disbelieving that there can be any positive feeling or link with the addictive behaviour now!

  In future sessions it's really important to **repeat this process** for other addiction memories: for recent using; the very **first time** they got this ASF and the very best memories of this buzz/high.

  You may also need to repeat the process with the same memories with different ASFs. This again can be in different sessions, and can also be for different moments. Once the client is used to finding an ASF with an addiction memory you can do this quite quickly each session then get to bridging.

  Do persevere and make suggestions to clients because they're often dissociated when they use: they may not get this straight away.

  Here are a few **Troubleshooting** tips to help.

- **If LOPA does not shift,** perhaps wrong target or ASF?
- **If client is worried about being abstinent,** a life without smoking/drinking/ porn/alcohol? Flash Forward on this fear. Tell them we're not asking them to be abstinent, we're just trying to wreck their unhealthy pleasure so they won't want to binge, purge, drink or use porn.
- **Go back to preparation phase.** More resourcing (Goal Image/ Absorption Technique/ Adult Skills/ Boundaries).
- **Process Shame** of being an addict, in present and in relation to bridged targets.

  "**Connecting the Consequences"** from Laurel Parnell can be quite useful:

  - Check LOU 0-10.
  - *Run a movie from beginning of eg urge, buying, the use, the high on the one hand, and the consequences on the other. Notice emotions and body sensations*. Continuous >>>.
  - Run movie several times until LOU = 1 or 0
  - Tap in a negative future: *Imagine what your life will be like if you keep doing what you're doing? >>>*

- Tap in a positive/goal future. Clean vs. negative worst future. *Imagine what your life will be like if you maintain your sobriety and healthy lifestyle. >>>*

For more ideas and protocols to use, think about what stage of recovery is the client in. Look at **EMDR and Stages of Recovery** handout from the Unleash 3 course and in the back of this booklet.

AI-EMDR Addiction Protocol

As per R.Miller, A.J.Popky, J.Knipe, L.Parnell.

NB these steps offer framework for continuing therapy, unlikely all to be needed in one session.

1. Tap in Positive Future/Goal.

Imagine/picture vividly/specifically & tap in the desired, ideal future state, with sobriety and health.

2. Locate addiction memory.

a. **Moment:** *Run movie of using, from planning to finishing. Locate moment of max rush/buzz/ euphoria.*

b. **Body:** Locate sensation in the body.

c. **Beliefs/Thoughts:** Help client name what they're seeking, both sensation and belief.

Ideas for beliefs (Assured Survival Feelings ASFs):

1. ***Safety***: safe, secure, in control.
2. ***Relational***: bonding; connected, important, special, powerful, strong, invincible, acknowledged, "I exist", "cared for", whole.
3. ***Winning*** (status): "the man"; "big man on campus"; superhero; masculine, feminine, smart, winner, approval, reward, "I deserve it"; "I can have what I want".
4. ***Sensation-alive***: excitement, danger, aliveness, euphoria.
5. **Note the following are NOT ASFs,** but what clients experience when the feeling/belief is met. E.g. comfort, relaxed, calm, peace, happiness, joy.

d. ***Link of Positive Affect? (LOPA 0-10).*** *What number would you put on link between that wonderful feeling & your addictive behaviour (smoking, eating, drinking etc)?*

3. Desensitise addiction memory.

a. **Limited, focused, processing.** Client not free associating, that comes later. EMD (without the R).

b. **Fast BLS** as they replay that best moment until LOPA = 1 or 0.

c. **Between BLS sets**, ask: *Is that link increasing or decreasing?*

d. **Often LOPA increases** before shifting quickly to unpleasant sensation e.g. to healthy nausea in reaction to excess food or alcohol.

4. Urge: Process need for the feeling.

a. **Body:** *Where is the need/urge for that feeling happening in your body?*

b. **Level of Urge:** LOU 0-10. Ask: *How strong is this need or urge for the feeling?*

c. **Desensitise** until LOU = 1 or 0.

5. Bridge into trauma from NC under LOPA.

a. **Belief:** *What does it say about you that you can't be safe; can't win; can't be adored, etc? (cf 2c above).*

b. **Emotion:** *What's the feeling as you say that?*

c. **Body:** *Where is that in your body? Colour? Shape?*

d. **Bridge** from here with steps in red below.

(If that doesn't work or you're starting a new session)

Bridge as per AI-EMDR: from picture of moment just before using, or from shape: Image; Emotion; Body; Belief.

i. *Trace it/drop back in time.*
ii. *Go back as far as you can.*
iii. *Very first place you land.* ***(WAIT)*** *How old are you? Where are you?*

6. Desenstise early life trauma.

Early life target (positioned in space and time), and again: Image; Emotion; Body; Belief.

Desensitise as per AI-EMDR to SUDs = 0; install PC; VoC = 7; until clear body scan.

7. Return to (2) & tap in healthy behaviour.

a. **Find a healthy behaviour to access positive affect being sought**. E.g. *Can you think of a healthy way to feel safe, connected, winning or alive such as meditating, journaling, hugging a pet, without the addictive behaviour/ using/consumption?*

b. **Install Positive State**: locate in body the affect/feeling which they seek, >>>, e.g. *Imagine feeling powerful/safe/adored as part of you, feel that in your chest.* (Wherever client names).

8. Check addiction memory.

a. **E.g.** *If you think about that first sip of wine now, how positive does that feel?"*

b. **Repeat process:** for recent, first and best addiction memories. This can be in different sessions, and can also be for different moments and different beliefs.

9. Troubleshooting.

a. **If LOPA does not shift,** perhaps wrong target ASF?

c. **If client is worried about being abstinent,** a life without smoking/drinking/ porn/alcohol? Flash Forward on this fear.

d. **Go back to preparation phase.** More resourcing (Goal Image/ Absorption Technique/ Adult Skills/ Boundaries).

e. **Process Shame** of being an addict, in present and in relation to bridged targets.

10. "Connecting the Consequences" (Parnell).

- **Check LOU 0-10.**
- **Run a movie from beginning** of e.g. urge, buying, the use, the high on the one hand, and the consequences on the other. Notice emotions and body sensations. Continuous >>>.
- **Run movie** several times until LOU = 1 or 0
- **Tap in a negative future:** *Imagine what your life will be like if you keep doing what you're doing? >>>*
- **Tap in a positive/goal future.** Clean vs. negative worst future. *Imagine what your life will be like if you maintain your sobriety and healthy lifestyle. >>>*

17. Dreams

Sigmund Freud famously described dreams as the Royal Road to the Unconscious, and they lend themselves powerfully to work with EMDR.

When human beings dream (and probably most mammals too), our eyes move rapidly from side to side in what is termed Rapid Eye Movement (REM) sleep. That is of course (EMDR 101) what we at some level replicate with the bilateral left-right brain sensory stimulation of our trade, whether using literal Eye Movements, or headphones, buzzers or butterfly taps.

While it's difficult to prove scientifically, EMDR may well work at least in part by kick-starting the brain into the experience-processing work that is otherwise done by dreams, with the essential difference of now having the brain's left pre-frontal cortex consciously online.

It's very likely that we sleep not so much to rest but to dream, to allow the brain to make inward narrative sense of stuff we've been through and differentiate what needs to be sorted and retained for survival purposes (think Richard Dawkins's Selfish Gene), and what can safely be discarded.

Dreams are catnip to the attachment-tuned EMDR therapist, and much longer books could and should be written about how rich this form of EMDR can be when we welcome dreams into the work, as so much more than just nightmares to be stopped and banished or the result of eating too much cheese for dinner.

During our waking hours, our nervous system takes in millions of bits of incoming sensory information every second, transformed by eyes, ears, skin, nose, tongue into electronic signals to the relevant parts of the brain to be reconstituted as image, taste, sound, sensation, and referenced against a personal and evolutionary database of previous experience to generate responsive emotion and meaning.

At night, there's a tiny fraction of that incoming information, so the brain has space in REM-sleep hours to turn its attention to the trillions upon trillions of stored moments and render them into explicit – whether remembered or not – inward narrative, which as we all know can often have the brilliance and cleverness of the best Hollywood movie.

Each story that gets constellated that way is of intense and deep personal relevance to the dreamer, waiting and longing to be known. That's the whole point of dreaming.

All human beings dream, whether they remember them or not, and clients (and therapists) can be trained and encouraged to remember their dream stories, with a notebook and pen/pencil by the bed and the instruction to write down even the smallest fragment on waking (including in the middle of the night).

Most dreams stay accessible in the conscious mind for just seconds after waking, so need to be caught before they go. Clients will find that with a bit of practice, more and more of a dream's multiple layers and scenes can be captured.

Explain to your clients that ALL parts of any dream – the monsters, the houses, the vehicles, the players, the landscapes, the fog, the sticky mud, the missed train, the naked guest at the cocktail party, literally everything - are aspects of the dreamer themselves that however repulsive or frightening or undesired *want* to be known.

It seems, across global cultures (and Carl Jung has written perhaps best about these things), that certain symbols in dreams have universal meaning.

A house or a building is the dreamer's containing self, with rooms, attics and cellars holding fragments of meaning which the dream needs the dreamer to piece together.

Water in the basement for example (and yes, some of this will sound very cliched), is almost always unprocessed emotion from the past that is flooding the client's unconscious in the present.

A cluttered attic almost always symbolises a cluttered connection with higher reaches of the Self – the spiritual if you like, the shared connection with universal meaning (or for those of a religious bent, with the Divine.)

Excrement is emotional and unpleasant stuff to be sorted, and that's why most languages have a version of the admonition to "sort your shit out" as a metaphor for resolving your personal emotional dysfunction.

Dreams will draw on the archetypes of Masculine and Feminine, both as reflection of the dreamer's actual experience of Mother and Father in childhood or of partner and opposite sex in the present, but even more importantly in echo of how the Universe is built on the tension of opposites – of light and dark, of negative and positive energy, of north and south magnetic poles, of gravitational pull and push.

There isn't space here to unpack these things in great detail, but (without entering a debate about gender and sexuality), there are in our experience absolute truths about the masculine and the feminine in human experience that manifest in dreams in what

Carl Jung identified as the Anima (the Latin for Soul) for the male dreamer and the Animus for the female.

Indeed, from a transpersonal perspective it can be argued that the whole journey of psychotherapy for the male is the journey towards healing of the wounded internal feminine, just as the female's archetypal journey is towards the healing of the internal wounded masculine.

Jung wrote also of the Shadow, that difficult dimension of an individual's (or a society's) experience pushed out of conscious awareness but again holding difficult stuff that is also wanting to be known, drawing attention to itself in dreams by sometimes literally wanting to kill the dreamer.

Dreams of birth, death and marriage can almost always be explored as metaphors for what needs to die and be let go of, or of opposites that are needing to be joined, or of the new that is wanting and trying to be born.

EMDR Focus

Simple AI-EMDR Dream Protocol

Working with Dreams

EMDR and BLS can be easily adapted for use with dreams.

Points to consider:

- Dreams are signals from the unconscious and the past that there is stuff and there are stories that *want* to be worked on. **Take them seriously, and often, literally.**
- **Every aspect of the dream** - every object, every part, every dimension, every character, every projection, every building and room - **is best understood as a part of the dreamer's self**. Also wanting to be known. (That's why we dream).
- Freud called dreams the **"Royal Road to the Unconscious"**. He may have been wrong on some things, but on dreams, Freud was on the money.
- Buildings in dreams especially are houses of the self, with their various rooms, attics, cellars, wanting to be explored.
- Water in dreams is always a metaphor for emotion.
- Female dreamers when dreaming of the masculine - any male figure - can be understood as working on their **Animus** in Jung's language - the energy of the opposite sex. Male dreams of the feminine/the female are an exploration of the **Anima** - the soul.
- Shit often comes up in dreams. It is always a metaphor for messy psychological stuff, and trauma, that's hanging around from the past, again wanting to be processed.
- Monsters and pursuers and dark spaces are expressions of what Jung calls the Shadow. As ever, yes, wanting to be known and integrated, and holding richness and magic.

In this way of working, follow these steps:

Ask the client to relate the dream in as much detail as they can. Don't make any interpretations, or ask them what they think it means, or signal anything other than your curiosity what the dream might be wishing to communicate. Just take it seriously.

Write their words and narrative down as faithfully as you can in your own notes.

Read the story back to them, exactly as written, asking them to notice, as you read, where the energy is (and allowing for any corrections, which need also to be noted down).

- *Which single scene in the dream holds the most energy*. If there are several powerful moments, then note them down (not too many), and ask, *which of these is the single most powerful*. You need one, not more, in order to start the processing.
- *Focus on the image of that moment. What are you feeling as you connect with that moment of the dream? What is happening in your body? (Optional -* Is there a belief that goes with the image?)

Use knee taps (or standard BLS, though not necessarily EMs) for a set of 20-30 seconds, or longer if the client so wishes.

- What are you getting, what are you noticing?

Discuss! With further taps as required.

The meaning of the dream will usually emerge spontaneously.

Work with whatever comes up as you would with any other client experience coming into awareness, and using AI-EMDR session structure (targets, portals, channels).

Note that with elements of the dream (monsters, men in dark coats, a sea of black grief - whatever it is animal, vegetable or mineral) you can use the Working with Parts exercise, asking client to drop into the body/shape of that object/being and view the dreamer from that perspective.

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18. Resourcing with Qualities

(AKA Arne Hoffman's Absorption Technique)

Identify with the client an event or experience in the future which is causing stress and apprehension now.

> *Close your eyes, imagine it, how stressful does this feel on scale 0-10?*
>
> *What are the three key **qualities** you would need to allow you to manage that situation well. **WRITE THEM DOWN!***
>
> *Now let's park that future event and look to the past. Think of a time in the past where you manifested that quality in full measure.*

With each quality in turn*:*

> *Close your eyes, go back there, truly inhabit that space again, doing that, being there, feeling really good about having that quality of …. Notice where this feels good in your body, breathing into that space.*

Now gently tap that in, just 20" or so.

> *Give me a nod when that feels really strong.*
>
> *Now, let's move on to quality 2…*

Repeat, and likewise with Q3.

> *Now, with all three qualities tapped in individually, I'd like you to bring all three past experiences together, imagining yourself manifesting all three, and, closing your eyes, let me know when you have them all in mind.*

Then install this collective experience in with a further 20"-30" of BLS.

> *Now, I'd like to bring your attention back to the future experience of…… When you think of doing that/being there now, bringing to this the qualities of 1, 2 and 3, how distressing does it feel on a scale of 0-10? (It will almost always be significantly lower than at the outset).*
>
> *So finally, what I'd like you to do is close your eyes, imagine this happening, you doing that, being there. Tap that for a further 20"-30". How is that now?*

Taps can continue until the imagined future plateaus at maximum positive.

19. Adverse Childhood Experiences (ACEs)

The questions below cover all 10 ACEs and were originally designed by researchers at the Center for Disease Control and Prevention in Atlanta, USA, and Kaiser Permanente. They should be understood as a guide for case conceptualisation with your client, and not a determining diagnosis.

Before your 18th birthday:

1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt? Y/N
2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured? Y/N
3. Did an adult or (other) person (**optional:** at least 5 years older than you) ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you? Y/N
4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other? Y/N
5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? Y/N
6. Was a biological parent ever lost to you through divorce, abandonment, or other reason Y/N
7. Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Ever repeatedly hit for at least a few minutes or threatened with a gun or knife? Y/N
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs? Y/N
9. Was a household member depressed or mentally ill, or did a household member attempt suicide? Y/N
10. Did a household member go to prison? Y/N

Further ACE Considerations

The above 10 points were developed first for a research project rather than for diagnosis and are a far from comprehensive list. In recent years (this being written in 2021) the ACEs approach has attracted some criticism for its narrow scope.

A client may for example (point 3 above) have been sexually molested by another child much closer to them in age than five years older, possibly themselves being abused in their own family. Parental violence (point 7) may also indeed usually be directed by the male towards the female, but abuse can be experienced by either parent. Also, the 10 points capture a range of extremes that leave out many childhood experiences that leave deep and lasting scars.

A further list has been drawn up as follows:

11. Were you bullied, taunted or shunned at school?
12. Did you experience racism or homophobia or similar forms of hate abuse?
13. Did you experience a serious physical trauma, illness or accident in childhood which required hospitalisation?
14. Did you experience a difficult or traumatic birth?
15. Did you witness violence or abuse of a sibling, parent or family member?
16. Did an important family member or caregiver die during your childhood?
17. Did you experience homelessness during childhood?
18. Did your family experience significant adverse financial events during your childhood such as loss of job, financial stability or home?

A certain amount of adversity in childhood can help build resilience for later life, tuning an individual's emotional immune system not to be overwhelmed later by the inevitable disappointments and ruptures of being human. People with no ACEs at all, or very high ACEs, may have the most adverse reactions to an ACE.

The absence of outside support, or a family system that required and expected secrecy around a child's disruptive experiences, is shown by research to compound longer-lasting attachment trauma quite significantly.

Set against that, research is also clear that having just one reliable adult to speak to about experience can have a profound reparative and long-term effect on a child, enabling them later in life to benefit sometimes quite profoundly from EMDR.

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Benevolent Childhood Experiences [BCE's]

(Narayan et al., 2018)

To get a BCE score, the survey-taker is asked how many of these ten items he or she experienced before the age of 18. Would you respond "yes" or "no" to the prompt, ***"Growing up, I had..."***

Item	YES	NO
1. At least one caregiver with whom you felt safe?		
2. At least one good friend		
3. Beliefs that gave you comfort		
4. Enjoyment at school		
5. At least one teacher that cared		
6. Good neighbours		
7. An adult (not a parent/ caregiver or the person from *1) who could provide you with support or advice		
8. Opportunities to have a good time		
9. Like yourself or feel comfortable with yourself		
10. Predictable home routine, like regular meals and a regular bedtime		
Total YES's = BCE Score		

Narayan, A. J., Rivera, L. M., Bernstein, R. E., Harris, W. W., & Lieberman, A. F. (2018). Positive childhood experiences predict less psychopathology and stress in pregnant women with childhood adversity: A pilot study of the benevolent childhood experiences (BCEs) scale. *Child abuse & neglect*, *78*, 19-30.

Positive Childhood Experiences [PCE's]

The seven items on this PCE test include answering "yes" or "no" to a prompt, "Before the age of 18, I..."

Item	YES	NO
1. Was able to talk with the family about my feelings		
2. Felt that my family stood by me during difficult times		
3. Enjoyed participating in community traditions		
4. Felt a sense of belonging in high school		
5. Felt supported by friends		
6. Had at least two non-parent adults who took a genuine interest in me		
7. Felt safe and protected by an adult in my home		
Total YES's = BCE Score		

(Bethell et al., 2019)

20. EMDR With Couples

For EMDR colleagues already versed in working with couples, and especially for those working with an emotionally focused/psychodynamic/attachment-informed approach, adding an EMDR dimension can make a powerful difference.

If you're not explicitly trained in working with couples, take great care when deciding whether to do so. Working with couples is VERY different, as the focus of therapy shifts from two individuals to the *relationship* itself as client.

This means that with more than one person in the room, you as therapist will need to be very careful to stay neutral, focusing on process rather than content and avoiding the beartrap of being pulled into their dynamics.

Harville Hendrix in particular explains this well in his *Imago* model of relationship therapy, describing how couples co-create between them what is best understood as a third entity, the whole being more than, and distinctively different from, a simple sum of the parts.

The term in physics, when two elements are combined to create something different, is *emergent properties.*

Think how dramatically distinctive the taste of cheese and grapes is when the two are put together (an analogy for which I am grateful to Little Chef in Pixar's move *Ratatouille*, as our hero rat tries to explain gourmet taste to his gourmand brother).

Or, think of two atoms of hydrogen paired with one atom of oxygen, creating H2O which in its own manifold manifestations (a solid as ice, a liquid as water, a vapour as mist, cloud or steam) is radically different from the gases from which it is constituted.

A dysfunctional relationship can of course be experienced as rather less than the sum of its parts, especially when a couple turns up for therapy in deepest crisis.

But the point here with the toolkit of EMDR is to facilitate for our couple, wherever they are on their journey, a shared appreciation for how powerfully their relationship has been, and continues to be, impacted moment-by-moment by their individual pasts.

John Grey (*Men are from Mars, Women are from Venus*) writes of how 80% of whatever we are experiencing in the now has nothing to do with the present.

That's particularly relevant in couples relationships where, as Hendrix sets it out (similar ideas in John Welwood's *Journey of the Heart),* individuals have been drawn together by what can be understood as each other's "ideal wound".

After all, why, among the thousands of people we might meet, are we drawn to one person in particular.

Why does someone from an abusive childhood so often and so repeatedly find themselves attracted to partners who also carry stories of early life trauma, so often then acted out between them as adults?

One can get a touch misty-eyed and New Age about this, but we do find it helpful to be at least curious about what it was in the personal trauma stories that the couple bring to the work that drew them together, and where therefore their individual nervous systems are being triggered to heal.

As Solomon and Tatkin (*Love and War in Intimate Relationships*) emphasise, a couple is in effect the interplay of two nervous systems dancing with each other, microsecond-by-microsecond in intimate connection, profoundly informed by how childhood connections were experienced with primary caregiver.

By tuning into that dance, we as therapists can help couples acknowledge where their responses to each other, consciously and unconsciously, in behaviour, gesture and words, are implicit responses to how they needed to survive in their earliest formative years.

Even more than in individual psychotherapy, and before we get stuck into EMDR, we need to bring bucketloads of psychoeducation to couples work.

Alongside the trauma- and attachment-focused work, couples need coaching in how to catch and name moments where the past is suddenly and often dramatically present, and in basic listening and mirroring skills, for the teaching of which we'd strongly recommend explicit training in couples therapy.

Such moments are of course perfect bridging points for AI-EMDR (best experimented first with each of them at the same time to avoid otherwise inevitable splitting and secret-sharing.)

Check the contents list at the front of this booklet for current page numbers and see further down for our suggested protocol for how to use EMDR in couples work, inviting the client whose story is waiting for the next session to be the BLS technology, as it were, for their partner, providing the physical knee taps that we as therapist would use in-person.

EMDR Focus

AI-EMDR Couples Protocol

AI-EMDR COUPLES PROTOCOL

1. Preparation:

Psychoed – as appropriate. Explain how couples work. E.g.

- **Ideally wounded**.
- The **presenting/attachment-informed past.**
- Each the other's **primary adult att'ment figure**.
- **Rupture**, and the opportunity for **repair**.

2. Mirroring:

Coach, and practice mirroring:

- **One at a time ("talking stick").**
- **Speaking from the "I", not the "You".**
- **Partner LISTENS with interest – NO verbal or behavioural response, other than curiosity.**
- **Short bursts of meaning.**
- **Reflects back – as accurately as possible. NO interpretation, repeating/paraphrasing.**
- ***Have I understood that right.***
- ***Is there more?***
- **Until the meaning is conveyed & understood**
- **Partner gets turn, maybe next time.**

3. Setting the scene for mutual BLS:

- Facing each other.
- Close – able to tap other's knees.
- One at a time.
- Partner sits, as it were, on hands. "Zip it!"
- The partner is the technology.
- Guide them through a practice set working on each other, to get the pace and the pressure.
- Usually better not to process (BLS) with both partners in one session. Take your time.

4. Joint Bridge/Target ID:

From moment of relational tension in the present. Either past/more distant, ideally more recent, or a trigger moment in the session.

Once under way, neither party talks or shares.

- ***Make sure you're sitting appropriately, comfortable, facing each other so I can see you both on screen.***
- ***Each of you, settle into your chair. Close your eyes/turn within/go inside.***
- ***Notice your breath. Pause.***
- ***I would like to invite you now each separately, keeping your eyes closed, to bring your attention - your awareness - to a moment of frustration, difficulty in your relationship.***
- ***It might past, it might be present, something that's alive for you.***
- ***Trust whatever comes first to mind. When you have got a story an experience, give me a nod.***
- ***Now, connecting with that story, that experience, if you run a video of that in your imagination, pause the memory on the frame that most bothers you, that triggers the most intense response.***
- ***Picture that moment. When you've got a picture, give me a nod. If you can't get a picture, that's ok too.***
- **a) If image is there, then prepare for bridge** as per normal AI-EMDR protocol (neither partner talking):
- ***Notice what are you each feeling? Where are you feeling it? What's the belief that goes with that?***
- **b) If no image, identify just the feeling** - shape, colour, texture, temperature, vibration.
- As usual, identify **Image/Emotion/Body/Belief**.
- ***Keeping eyes closed, connecting with that picture/ feeling, what's happening in your body, the thought/belief that goes with that: Drop back in time; Go back as far as you can; The very first place you land.*** **And wait.**
- If client has a hard time, they can imagine a **photo album of childhood** flipping the pages or being an **eagle in flight** looking down on earliest years.
- Clients the **tell each other their story**, one by one.

Process as appropriate

Only one at a time. Partner taps. Normal EMDR, guided by therapist, the tapping partner keeping quiet. Process to resolution of target memory (0/10, 7/7), return to presenting trigger, conclude with sharing from both.

5. SBIR. One at a time.

- **Situation:** (i.e. the facts, not the meaning or the interpretation. Just communicated one-way and NOT discussed.)
- **Behaviour:** I did this. You did that. Just describing.
- **Impact:** What I felt when this happened/what happened to me in terms of emotion/thought/ personal meaning.
- ***(Optional:*** *And it reminds me of situations when I was a child. Bridging points for possible EMDR processing.)*
- **Request:** Three points maximum. One at least must be deliverable, in a specified time frame. Partner must agree to at least one.

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21. EMDR Online

The Corona virus starting in 2020 catapulted the global EMDR community into sudden and, for us very gratifying, acknowledgement that EMDR can work extremely well online.

At EMDR Focus, long before Covid struck, we had been providing therapy (including full-on EMDR) for years to erstwhile colleagues and organisations in the journalistic field, where Mark Brayne was for 30 years correspondent and editor for Reuters and the BBC World Service.

The following suggestions draw from our own experience as well as – with thanks – from ideas shared in the EMDR UK community in the early pandemic days by colleagues including especially Naomi Fisher.

Before You Start

Bilateral Base and RemotEMDR are platforms which comes highly recommended, fully security-compliant and working on a browser, offering therapist-driven Eye Movements and bilateral sounds at the client end.

Zoom is of course used by many, and free for one-to-one work. You can schedule your whole day in advance. Clients do not need an account to use it. You can also use a virtual background, ideally with a green screen behind you as in the picture of Mark's workstation at home, and best done with a decent-sized monitor.

Clients are often anxious about meeting online. So be confident that this can be a good option for them and that it won't be difficult.



Always have a back-up way to contact people. Mobile and landline phone numbers are best because they aren't reliant on the internet. If there's a problem with logging on, ring them quickly, don't wait for them to become anxious. You may need to talk them through the details of how to connect, with correct camera, sound and mic.

Getting the connection is part of the therapeutic contract, and – making sure you know how best to advise them – it's a good idea to explain that to your clients so they don't resent, as some will, the time spent.

The Setting at Your End

Make sure your laptop/camera is at horizontal height so that the client is not looking up your nostrils. (Think how triggering that might be for clients who were sexually abused by a tall male looking down on them from above in childhood…)

A handy guide is that the picture of you that goes out should not show either your room's ceiling or floor.



Mark in front of his virtual background, a photo of his actual bookshelf in the room next door to his office.

Check your outgoing picture before you start. Your eyes should be about one third of the way down from the top of the screen.

Do not sit too close to your camera. The client should be able to see your upper body down to roughly between breastbone and navel, and to see the room behind you.

Make sure too that your background is neutral and appropriate, perhaps with pot plants in the picture.

It's essential that you do not put yourself in front of a light source, either a window or a lamp. Position your camera so that the source of light in the room falls on your face.

Experiment with lighting to ensure the client has a good, professional view of you as therapist.

The First Session

Online therapy is powerful, but different from working with a client in the same room.

Check what device they are using. iPads will have the client looking to one side of the screen. Mobile phones positioned in portrait view will generate an image that is tall and thin. A laptop is often positioned too low for good work, with the client peering down at the camera – you can ask them to prop it up on some books.

Zoom and Bilateral Base can of course be used on smartphones, tablets and computers. But this does mean that clients may be sitting on the sofa rather than at a desk. If so, make sure that the device there is handsfree, propped up if necessary against a cushion.

Check with them that their battery will not run out half-way through. Check the same at your end too.

Make sure there is no-one else in their room. People interpret "a quiet uninterrupted space" in all sorts of ways. You may need to problem-solve with them how to find a private space where they will not be overheard, and this might require some creativity.

Mark has actually done a highly effective EMDR session with a client literally lying, clothed, in her bath, as there was nowhere else private. Several colleagues have also done excellent EMDR with clients sitting in the safety and confidential space of their car.

Risk

Be aware that you may not be able to create a safe space for processing. If your client can be overheard by other people, if they live with people who are abusive to them, if they can't find someone to care for their young children – then you can't do trauma processing. Use your judgement.

If you keep the first session fairly open, clients are more likely to be honest with you about their family environment and what's possible. If you send an exacting list of things that they've got to get right in advance, then you may find they don't feel able to tell you that actually they live in a studio flat with their children and the only private space would be the bathroom.

One thing that's a challenge online is physical grounding. You can't throw a cushion to your client, you can't give them a squeeze ball and you can't wave essential oils under their nose. You can't touch them. This means that if they dissociate, you have fewer tools than usual for bringing them back.

You can however ask them to stand up, to stretch, to look around them and identify colours and objects, to throw a screwed-up ball of paper from one hand to the other, and much more - just as you would in the room with them. With a child's party-bubble tube you can blow bubbles at their screen which they can pretend to pop.

If you are concerned someone will dissociate and that you may not be able to bring them back, you might still be able to do the work if there is a supportive person in the house with whom you can talk in advance about grounding techniques.

If your client dissociates, call or text the other person, get them to come in and talk them through physical grounding techniques. Again, this is not necessary for more straightforward clients or those who can bring themselves back if they dissociate.

If you want to record the sessions, it's very easy using either BB or Zoom. Obviously, they have to consent, and they will know that you are recording because the screen tells them so.

Do your usual risk assessment and make a plan if necessary. This is no different from in-person work. If they are living alone, who else might they be able to ring after a session with you?

It's preferable for both client and therapist to be using headphones, rather than speaker and mic in the laptop or computer.

Headphones at each end create an at times powerfully intimate therapeutic bubble, with the therapist speaking, sometimes whispering, directly into the client's ears. This can make online work even more powerful than EMDR in person.

It's helpful to include a stop signal, such as saying 'Shall we take a pause', holding your hands up or moving your hands.

Therapeutic Issues

The unexpected will happen. Things will go wrong. The sound will cut out. The picture will freeze. There will be people who can't log on. The WiFi will drop out. These are all teething issues and not a big deal unless you make them so.

Pets will walk into shot. These days, urgent deliveries will often arrive in the middle of a session. It's best to name that possibility, and it interferes less if you let them go and then just pick up again. The same applies to you as therapist.

Children may interrupt. (Click that link for a hilarious real-life example of how that can happen...) Ask your client to try to make sure this isn't likely to occur, but if it does, again, take it into your stride.

Pause, give your client time to take the child out and settle them, and then pick up where you left off. Letting them deal with it causes fewer problems than if you and they try to ignore it.

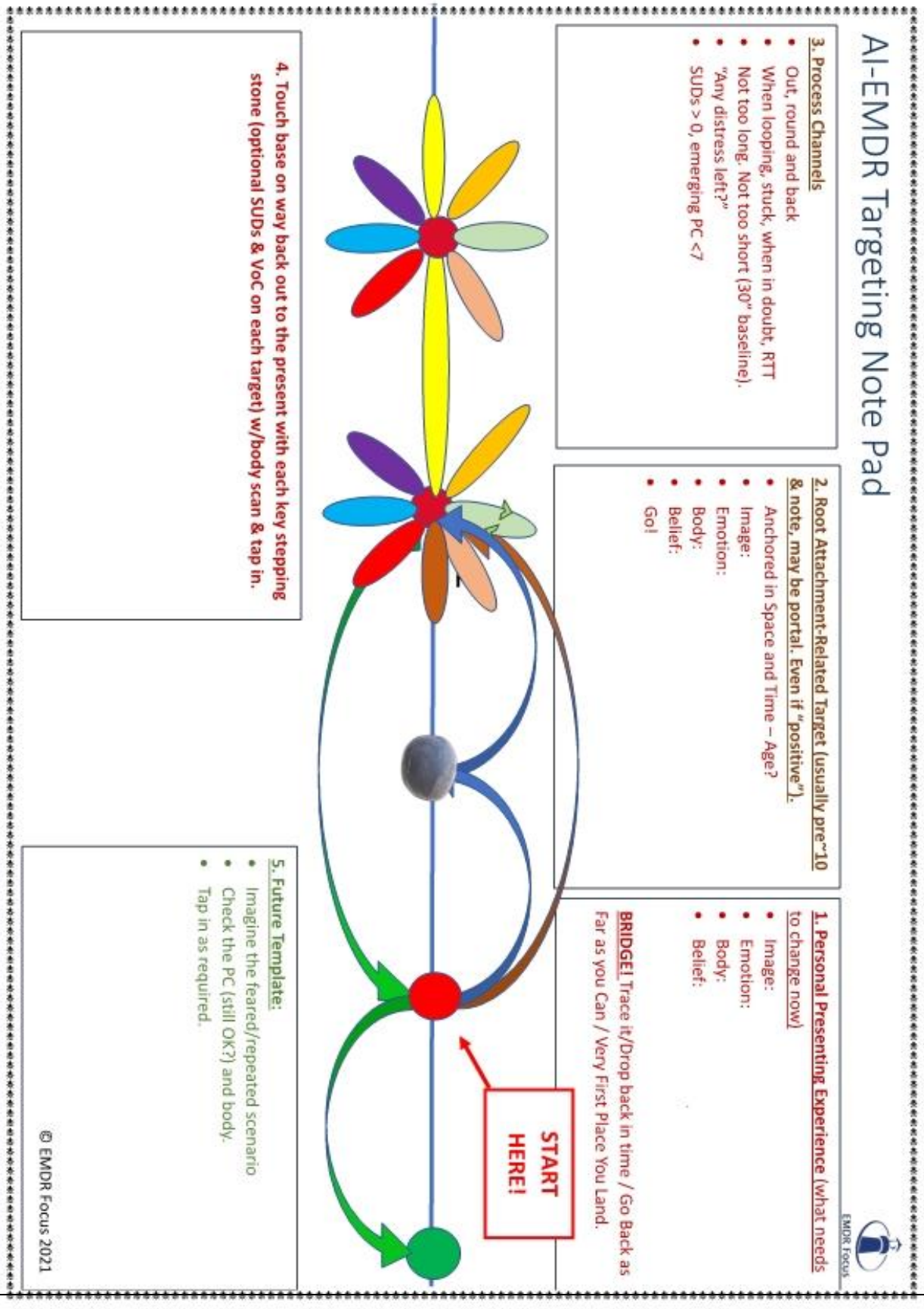
When stuff happens, note it, apologise where appropriate, and do your joint best to get the session back on track.

Make a buffer zone between therapy and home life.

You can encourage your client to take ten minutes after the end of a session before opening the door, particularly if they are caring for children. They can use that time to write down their reflections, do a breathing exercise or listen to a visualisation.

22. Support Forms – A Selection.

AI-EMDR Basic Bridging Notepad



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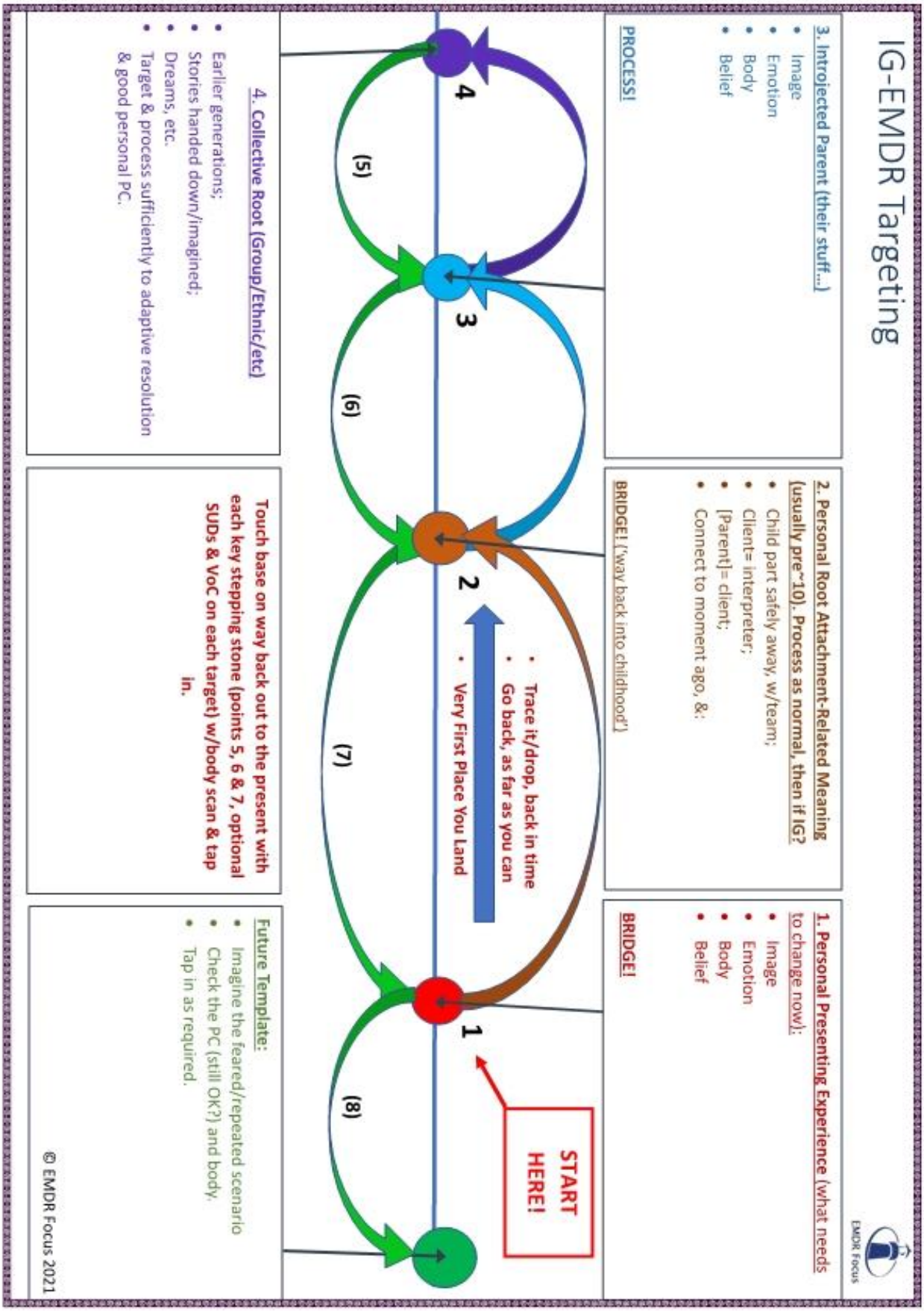
Intergenerational Targeting Notepad



EMDR and the Stages of Change

Precontemplation Stage. (Denial & resistance to change)

- **History taking:**
  - What made you start?
  - History of use (times quit, what caused the relapse?)
- **Affect tolerance:**
  - Ways to manage feelings.
- **Resource Development:**
  - Nurturers; Protectors; Wise Beings.
  - Resourcing with qualities (absorption technique).
  - Internal resource state.
- **Connecting the consequences:**
  - ***Run a movie*** *from beginning of urge, buying, using, the high, & consequences. Notice emotions & body sensations.* Cont. >>>
  - **Run movie several times** until LOU=1 or 0.
  - **Tap in a negative future:** *Imagine what your life will be like if you keep doing what you're doing.* >>>
  - **Tap in a positive/goal future** clean v. negative worst future using. *Imagine what your life will be like if you maintain your sobriety and healthy lifestyle.* >>>
- **Two hand interweave:**
  Negative future in left hand versus positive future in right hand.>>>
  - **Ego state work with parts** (in **Internal Family System** language, addictions are always firefighters). Maybe parts need a meeting place, and their own resource teams? Map parts? Some may want change others don't. Dialogue.

Contemplation (motivating change). Continue steps above.

- **Bridging** to access early life trauma with AI-EMDR. Some clients are unable to recover without first dealing with their trauma.
- Some unable to process trauma without initial period of recovery.
- Measure **Level of Motivation** (LOM) for change as a %.
- **Two hand IW:** Negative versus positive future + BLS to increase LOM.
- Flash Forward to lower fear of abstinence.
- Ego state work with parts.

NB countertransference: clients at this stage may act out their ambivalence, cancelling sessions, being late, forgetting to pay, etc.

Preparation/Determination. Decision made to change.

- Desensitise the Positive Affect in addiction memories (see **AI-EMDR Addiction Protocol** handout).
- Help client develop a **relapse prevention plan** looking at emotional, physical, mental and spiritual resources.
- **Change of environment**: In-patient or out-patient treatment centre; new recovery friends; 12-Step programmes; SMARTrecovery.org etc?
- **Tapping in further resources:**
  - Inner sponsor
  - Sober, healthy self
  - Role models
  - Recovery support dream team
  - Memories of being successful
  - Strengthening successes
  - Reasons for recovery
  - Imagining your goals are actualised.

Action. Process of change begins.

- Consider intensive EMDR for withdrawal e.g. daily 90-minute sessions for first week, then stepped down frequency of meetings.
- Go to in-patient or out-patient treatment centre; attend 12-Steps, AA, NA, OA etc.
- Continue to desensitise the positive affect in addiction memories (see **AI-EMDR Addiction Protocol** handout).
- Make sure the very **first and most euphoric** addiction memories are desensitised.
- Continue **bridging** to early life trauma with AI-EMDR.
- Use EMDR to process memories around **past major relapses**.
- Use EMDR to process **addiction identity**, negative self-belief e.g. *I'm a loser; I'm a useless drug addict.*

Maintenance. Healthy life.

- Client enjoys healthy routine & lifestyle.
- *Discipline is the gift I give myself when I'm well.*
- Continue processing **early life trauma** with AI-EMDR.
- Continue **processing triggers** using parts of AI-EMDR Addiction Protocol.

Relapse. As part of recovery.

- Compassion & learning
- **Target relapse** with EMDR: the shame of relapsing & the triggers.
- Positive Affect in addiction memories (see **AI-EMDR Addiction Protocol** handout).
- **Check stage of change** has client gone back to precontemplation?
- **Check LOM** for change using EMDR resources to increase motivation.
- Use **Connecting the Consequences** protocol.

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Extended CAPS checklist

In this questionnaire you are being asked to think about events in your entire lifetime. Listed below are a number of difficult or stressful things that sometimes happen to people. For each event, check one or more of the boxes to the right to indicate that (a) it happened to you personally, (b) you witnessed it happening to someone else, (c) you learned about it happening to someone close to you, (d) you're not sure if it fits, or (e) it doesn't apply to you. Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed It	Learned about it	Not Sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)					
2. Fire or explosion					
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)					
4. Serious accident at work, home, or during recreational activity.					
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)					
8. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)					
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force, or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					
10. Combat or exposure to a war zone (in the military or as a civilian)					
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
12 Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden, violent death (for example, homicide, suicide)					
15. Sudden, unexpected death of someone close to you					
16. Serious injury, harm or death you caused to someone else					
17. Any other very stressful event or experience					
18. Self harm (for example, attempted suicide, cutting, other...)					
19. Any major or minor surgery or hospitalisations					
20. Termination of pregnancy, miscarriage, or difficult birth					

Blake, Weathers, Nagy, Kaloupek, Chamey and Keane (1990 and 1997) in Stuart Tamer and Deborah Lee (Eds) Measures in Post Traumatic Stress Monier A practitioners outdo. Windsor NFER Nelson. 1998.

Dissociative Experiences Scale (DES-T)

1. Some people have the experience of finding themselves in a place and having no idea how they got there. Circle a number to show what percentage of the time this happens to you.

   0%10 20 30 40 50 60 70 80 90 100%

2. Some people have the experience of finding new things among their belongings that they do not remember buying. Circle a number to show what percentage of the time this happens to you.

   0%10 20 30 40 50 60 70 80 90 100%

3. Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something and they actually see themselves as though they were looking at another person. Circle a number what percentage of the time this happens to you.

   0%10 20 30 40 50 60 70 80 90 100%

4. Some people are told that they sometimes do not recognize friends or family members. Circle a number to show what percentage of the rime this happens to you.

   0%10 20 30 40 50 60 70 80 90 100%

5. Some people sometimes have the experience of feeling that other people, objects, and the world around them are not real. Circle a number to show what percentage of the time this happens to you.

   0%10 20 30 40 50 60 70 80 90 100%

6. Some people sometimes have the experience of feeling that their body does not seem to belong to them. Circle a number to show what percentage of the time this happens to you.

   0%10 20 30 40 50 60 70 80 90 100%

7. Some people find that in one situation they may act so differently compared to another situation that they feel almost as if they were two different people. Circle a number to show what percentage of the time this happens to you.

   0% 10 20 30 40 50 60 70 80 90 100%

8. Some people sometimes find that they hear voices inside their head which tell them to do things or comment on things that they are doing. Circle a number to show what percentage of the time this happens to you.

   0%10 20 30 40 50 60 70 80 90 100%

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PCL-5 (for DSM-V)

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: *I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous*?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (*for example, being unable to feel happiness or have loving feelings for people close to you*)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Date		PTSD?		PTSD?		PTSD?
Intrusion (PTSD=at least 1 moderately)	/20		/20		/20	
Avoidance (at least 1 moderately)	/8		/8		/8	
Negative alterations in cognitions and mood (at least 2 moderately)	/28		/28		/28	
Hyperarousal (at least 2 moderately)	/24		/24		/24	
Totals (33 indicative PTSD cutoff point)	/80		/80		/80	

PCL-5 (8/14/2013) Weathers, Litz, Keane, Palmieri, Marx, & Schnurr – National Center for PTSD

ITQ 2018 (for ICD-11)

ITQ 2018

Below are a number of problems that people sometimes report in response to traumatic or stressful life events. Please read each item carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
P1. Having upsetting dreams that replay part of the experience or are clearly related to the experience?	0	1	2	3	4
P2. Having powerful images or memories that sometimes come into your mind in which you feel the experience is happening again in the here and now?	0	1	2	3	4
P3. Avoiding internal reminders of the experience (for example, thoughts, feelings, or physical sensations)?	0	1	2	3	4
P4. Avoiding external reminders of the experience (for example, people, places, conversations, objects, activities, or situations)?	0	1	2	3	4
P5. Being "super-alert", watchful, or on guard?	0	1	2	3	4
P6. Feeling jumpy or easily startled?	0	1	2	3	4
In the past month, have the above problems:					
P7. Affected your relationships or social life?	0	1	2	3	4
P8. Affected your work or ability to work?	0	1	2	3	4
P9. Affected any other important part of your life such as parenting, or school or college work, or other important activities?	0	1	2	3	4

Below are problems that people who have had stressful or traumatic events sometimes experience. The questions refer to ways you typically feel, ways you typically think about yourself and ways you typically relate to others.

How true is this of you?	Not at all	A little bit	Moderately	Quite a bit	Extremely
C1. When I am upset, it takes me a long time to calm down.	0	1	2	3	4
C2. I feel numb or emotionally shut down.	0	1	2	3	4
C3. I feel like a failure.	0	1	2	3	4
C4. I feel worthless.	0	1	2	3	4
C5. I feel distant or cut off from people.	0	1	2	3	4
C6. I find it hard to stay emotionally close to people.	0	1	2	3	4
In the past month, have the above problems in emotions, in beliefs about yourself and in relationships:					
C7. Created concern or distress about your relationships or social life?	0	1	2	3	4
C8. Affected your work or ability to work?	0	1	2	3	4
C9. Affected any other important parts of your life such as parenting, or school or college work, or other important activities?	0	1	2	3	4

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Scoring PTSD	Pre-	≥2?	Post-	≥2?	Scoring CPTSD	Pre-	≥2?	Post-	≥2?
P1 Re-experiencing in here & now	/4	y/n	/4	y/n	C1 Affect dysregulation	/4	y/n	/4	y/n
P2 Re-experiencing in here & now	/4	y/n	/4	y/n	C2 Affect dysregulation	/4	y/n	/4	y/n
P3 Avoidance	/4	y/n	/4	y/n	C3 Negative self-concept	/4	y/n	/4	y/n
P4 Avoidance	/4	y/n	/4	y/n	C4 Negative self-concept	/4	y/n	/4	y/n
P5 Sense of Current Threat	/4	y/n	/4	y/n	C5 Relational disturbance	/4	y/n	/4	y/n
P6 Sense of Current Threat	/4	y/n	/4	y/n	C6 Relational disturbance	/4	y/n	/4	y/n
P7 Functional Impairment	/4	y/n	/4	y/n	C7 Functional Impairment due to Disturbance in Self-Org	/4	y/n	/4	y/n
P8 Functional Impairment	/4	y/n	/4	y/n	C8 Functional Impairment due to Disturbance in Self-Org	/4	y/n	/4	y/n
P9 Functional Impairment	/4	y/n	/4	y/n	C9 Functional Impairment due to Disturbance in Self-Org	/4	y/n	/4	y/n
PTSD pre?	**y/n**	**PTSD post?**		**y/n**	**DSO pre?**	**y/n**	**DSO post?**		**y/n**

How to score the ITQ:

A 'yes' for at least one of the red, green and blue categories, AND a 'yes' for at least one of the orange categories, indicates the presence of either PTSD or Disturbances in Self-Organisation (DSO).

A 'yes' for PTSD but a 'no' for DSO indicates PTSD.

A 'yes' for PTSD and DSO indicates complex PTSD.

A 'no' for PTSD and a 'yes' for DSO is a nil result.

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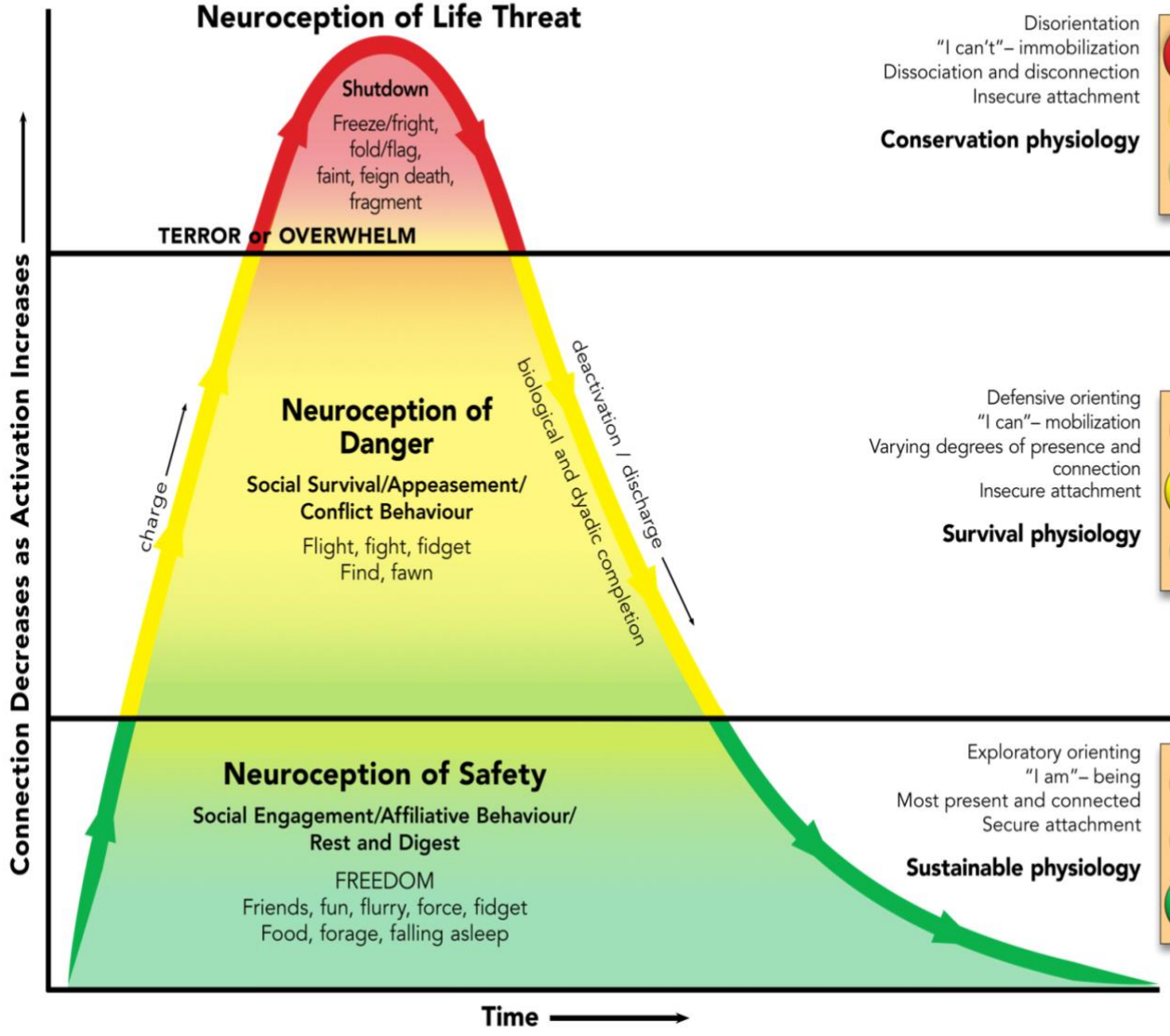
Polyvagal Chart

The Polyvagal Defense Hierarchy



Disorientation
"I can't"– immobilization
Dissociation and disconnection
Insecure attachment

Conservation physiology

Parasympathetic Nervous System:

Brake System: Dorsal Vagal Complex (high tone)

When the other strategies are not possible or successful, an organism may enter a state of energy conservation involving either tonic (rigid) or collapsed (floppy) immobility. Defeat, hopelessness, learned helplessness, shame, shutdown, numbing, depressed life energy, derealization, depersonalization, personality splitting, dissociation, altered states of consciousness, or loss of consciousness can be experienced. Blended states occur at this point in the hierarchy as well, where the gas and the brakes can be on at the same time (high tone DVC + SNS : freeze).

Defensive orienting
"I can"– mobilization
Varying degrees of presence and connection
Insecure attachment

Survival physiology

Sympathetic Nervous System:

Gas Pedal: Sympathetic Activation

With the neuroception of danger, a hierarchy of responses begins to mobilize, beginning with a transitory activation then depression of social engagement behaviours. Blended states of find and fawn (SNS+VVC) are followed by defensive fight or flight actions (SNS) when social strategies are not possible or effective. Fidget here refers to stress and calming signals, thwarted attempts at mounting a survival response, and behaviours that are self-stimulating, self-soothing, or self-medicating.

- **Find:** "Tend and befriend" (SEEKING), looking to the herd, pack, or attachment figures for comfort, soothing, or protection (attachment cry, proximity seeking, reaching out, clinging, herd cohesion and bunching, protesting separation)
- **Fawn:** Appeasement behaviours to defuse conflict and tension, and to decrease likelihood of pain, harm, or rejection (reasoning, negotiating, complying, placating, peace keeping, caretaking, codependency, Stockholm syndrome)
- **Flee:** Avoiding, ignoring, moving away, away-from marching, running away, stampede
- **Fight:** Resisting, posturing, intimidation, aggression, defending, protecting

Exploratory orienting
"I am"– being
Most present and connected
Secure attachment

Sustainable physiology

Parasympathetic Nervous System:

Brake System: Ventral Vagal Complex (social engagement) or Dorsal Vagal Complex (low tone, rest and digest)

Safety is restorative, pleasurable, and supports rest and repair (emotional, physical, and relational). It sets the conditions for eating, digestion, sleeping, nursing, meditation, prayer, reading (low tone DVC) and healthy social interactions (VVC). When feeling safe, SNS arousal is tempered by the ventral brake to enjoy activities like play, sports, sex, learning, exploration (SEEKING), and creative pursuits (shaded area depicting blended states of VVC + SNS). Unpleasant effortful activity can occur as well, as can fidget behaviours (out of boredom, excitement, and anticipation). Effortful movement requiring limited metabolic resources can also be managed through the VVC without recruiting the SNS.

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Adapted from Porges (2011, 2017), Panksepp (1998), Levine (1997, 2010), Walker (2013), Hoskinson Consulting (n.d.), Draaisma (2018), Rees (2017), Schauer & Elbert (2010), Koslowska et al. (2015), and Payne & Crane-Godreau (2015), Riordan, Blakeslee & Levine (2019).

23. Some Reading Suggestions

- EMDR Therapy: Third Edition – Francine Shapiro
- A Therapist's Guide to EMDR – Laurel Parnell
- Attachment-Focused EMDR: Healing Relational Trauma – Laurel Parnell
- EMDR Toolbox – Jim Knipe
- EMDR Made Simple – Jamie Marich
- EMDR & the Relational Imperative – Mark Dworkin
- Integrative Team Treatment for Attachment Trauma in Children: Family Therapy and EMDR - Debra Wesselmann, Cathy Schweitzer and Stefanie Armstrong
- Healing the Fragmented Selves of Trauma Survivors – Janina Fisher
- The Body Keeps the Score – Bessel van der Kolk
- The Master and his Emissary - Iain McGilchrist
- Why Love Matters - Sue Gerhardt
- Trauma and Recovery - Judith Lewis Herman
- Internal Family Systems Therapy – Richard Schwartz
- Healing without Freud or Prozac - David Servan-Schreiber
- Love and War in Intimate Relationships – Solomon and Tatkin
- Attachment in Psychotherapy – David Wallin

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