



Linda A. Curran, BCPC, LPC, CAADC, CCDP

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Materials Provided By

Instructor

Linda A. Curran, BCPC, LPC, CAADC, CCDP

Sought-after national trainer, best-selling author, and film producer, Linda has trained thousands of mental health clinicians across the country on trauma treatment. She is President of Integrative Trauma Treatment, LLC, in Wilmington, Delaware. With advanced degrees in both clinical psychology and public health, Linda is a Board Certified, Licensed Professional Counselor; Certified Addiction Counselor Diplomate; Certified Co-Occurring Professional Diplomate; Certified Gestalt Therapist; Certified Neurofeedback Practitioner; Certified Hypnotherapist; and Level II EMDR practitioner.

International speaker on the treatment of trauma, author of both Trauma Competency: A Clinician's Guide and 101 Trauma-Informed Interventions, Linda has developed, produced, and presents multi-media workshops on all aspects of psychological trauma.

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Course Objectives

Upon completion of this course, participants will be able to:

1. Evaluate the biological nature of trauma and how trauma can create physical and psychological symptoms.
2. Examine Porges' Polyvagal Theory as it relates to clinical treatment of traumatized clients.
3. Differentiate between sympathetic (activated) freeze responses and the parasympathetic (deactivated) dorsal vagal immobilization response.
4. Identify distinguishing factors of the following types of traumatic stress: normal, prolonged, complex and developmental.
5. Determine the clinical implications of traumatic stress symptomology, including hyperarousal, affect dysregulation, dissociation, body memories, and flashbacks.
6. Select three somatic techniques to reduce symptoms of body memories, "flashbacks," and dissociation.
7. Summarize the landmark Adverse Childhood Experiences Study.
8. Analyze the relationship between developmental trauma and the inability to regulate both affect and physiological arousal.
9. Evaluate the relationship between developmental trauma and "health-risk behaviors."
10. Evaluate the relationship between Adverse Childhood Experiences and adult attachment difficulties.
11. Evaluate the clinical presentation of various attachment styles through clinical assessment.
12. Select clinical interventions based on the client's attachment style.
13. Differentiate between PTSD, CPTSD and Borderline Personality Disorder to improve clinical assessment and treatment of client trauma history.
14. Apply Herman's tri-phasic model of trauma treatment to current treatment methodology.
15. Choose strategies to aid clients in acquiring the requisite skills for processing trauma via EMDR.
16. Utilize stabilization tools, including mindfulness practices, energy psychology, and guided imagery to modulate affect.
17. Facilitate client-driven imagery for safety and containment during trauma processing.
18. Utilize imagery in both stage one and stage two of treatment.
19. Practice imaginal resourcing skills in preparation for trauma processing.
20. Evaluate Shapiro's Adaptive Information Processing model as it relates to clinical treatment.
21. Identify three types of alternating bilateral stimulation as a mechanism of action for EMDR RDI and EMDR.
22. Analyze the original eight phases of EMDR's standard protocol (Shapiro) as it relates to clinical treatment.
23. Evaluate Parnell's four essential elements of EMDR sessions and how they relate to client treatment.
24. Summarize the clinical applications of Parnell's modified EMDR protocol for working with complex and developmental trauma.
25. Practice the EMDR protocol, using all necessary therapeutic skills, including—but not limited to—attunement, co-regulation of client nervous system, i.e., keeping arousal levels regulated for integration of traumatic memories/material.
26. Discuss one absolute contraindication and three precautions for utilizing EMDR.

27. Describe two EMDR protocols for working with addictions and compulsions.
28. Summarize Miller's Feeling-State Therapy Addiction Protocol.
29. Appraise Popky's urge reduction protocol, Desensitization of Triggers and Urge Reprocessing (DeTUR).
30. Practice the EMDR protocol in session: Using Curran's written script (2014), which includes Parnell's modifications for complex trauma (2007).

Course Materials

Participants will receive:

- Comprehensive course manual (digital)
- Modified EMDR script (6 copies in manual)
- Resourcing imagery scripts
- Quick Assessment for EMDR Readiness
- Debrief/Integration sheets
- Certificate of completion (42 CE hours)

Technical Requirements

- Reliable internet connection
- Computer with camera and microphone (required for participation)
- Zoom platform access
- Private, quiet space—especially for Days 4, 6, and
-

Certification Information

This training meets all education hour requirements for:

- Evergreen Certified EMDR Clinician (EMDR-C)
- Nearly all requirements for Certified Clinical Trauma Professional Level II (CCTP-Level II)
- Questions regarding certification: Contact Evergreen Certifications:
www.evergreencertifications.com

Day One: Neuroscience of Trauma

Wednesday, June 3 | 9:00 AM – 4:00 PM (with breaks) | 6 CE Hours

Learning Objectives

Objectives 1–5

- Evaluate the biological nature of trauma and how trauma can create physical and psychological symptoms.
- Examine Porges' Polyvagal Theory as it relates to clinical treatment of traumatized clients.
- Differentiate between sympathetic (activated) freeze responses and the parasympathetic (deactivated) dorsal vagal immobilization response.
- Identify distinguishing factors of the following types of traumatic stress: normal, prolonged, complex and developmental.
- Determine the clinical implications of traumatic stress symptomology, including hyperarousal, affect dysregulation, dissociation, body memories, and flashbacks.

Content Outline

Neuroscience's Current Trauma Paradigm

- Working definition of trauma
- Biological nature of trauma
 - Flight, fight, freeze response (sympathetic response)
 - Collapse/dissociate (parasympathetic response)
- Triune Brain, the Autonomic Nervous System and the Stress Response
- Stress: Eustress, manageable, normal vs. Traumatic Stress: prolonged, complex, developmental

The Polyvagal Theory

- Polyvagal Theory as it relates to trauma
- Research limitations on differences in theory and in the associated neurophysiological model

Trauma Symptoms & Treatment Issues

- Specific trauma symptoms
- Primary treatment issues in trauma therapy

Trauma's Somatic and Sensorimotor Sequelae

- Hyperarousal
- Hypoarousal
- Dissociation, body memories, and "flashbacks"
- Affect dysregulation

Between Sessions

- Read manual pp. 9–17
- Review Home Group roster; identify potential practice partners
- *Seminar Slides covered: pp. 129–139*

Day Two: ACE Study & Attachment

Wednesday, June 10 | 9:00 AM – 4:00 PM (with breaks) | 6 CE Hours

Learning Objectives

Objectives 6–12

- Select three somatic techniques to reduce symptoms of body memories, "flashbacks," and dissociation.
- Summarize the landmark Adverse Childhood Experiences Study.
- Analyze the relationship between developmental trauma and the inability to regulate both affect and physiological arousal.
- Evaluate the relationship between developmental trauma and "health-risk behaviors."
- Evaluate the relationship between Adverse Childhood Experiences and adult attachment difficulties.
- Evaluate the clinical presentation of various attachment styles through clinical assessment.
- Select clinical interventions based on the client's attachment style.

Content Outline

Trauma and Attachment

- The Adverse Childhood Experiences Study (ACE Study)
 - Study methodology and key findings
 - The ten categories of adverse childhood experiences
 - Dose-response relationship: ACE scores and health outcomes
 - Health-risk behaviors as adaptive coping

Attachment Essentials

- Baby/momma trauma
- Secure attachment
- Insecure Attachment Styles: Assessment and Primary Treatment Issues
 - Avoidant
 - Preoccupied
 - Disorganized type
- Clinical interventions based on attachment style

Between Sessions

- Read manual pp. 19–25
- Confirm dyad partner from Home Group for Day 4 resourcing practice
- *Seminar Slides covered: pp. 139–144*

Day Three: Stage One – Safety, Stabilization & Trauma Tools

Wednesday, June 17 | 9:00 AM – 4:00 PM (with breaks) | 6 CE Hours

Learning Objectives

Objectives 13–18

- Differentiate between PTSD, CPTSD and Borderline Personality Disorder to improve clinical assessment and treatment of client trauma history.
- Apply Herman's tri-phasic model of trauma treatment to current treatment methodology.
- Choose strategies to aid clients in acquiring the requisite skills for processing trauma via EMDR.
- Utilize stabilization tools, including mindfulness practices, energy psychology, and guided imagery to modulate affect.
- Facilitate client-driven imagery for safety and containment during trauma processing.
- Utilize imagery in both stage one and stage two of treatment.

Content Outline

Assessment and Diagnosis of Trauma Disorders

- **Current Trauma Diagnoses:**
 - Acute Stress Disorder
 - PTSD and subtypes: Dissociative and Preschool
 - Borderline Personality Disorder (BPD)
- **Proposed Trauma Diagnoses:**
 - Developmental Trauma Disorder (DTD)
 - Complex PTSD (ICD-11)
 - Dissociation
 - Definition: Theory of Structural Dissociation
 - Assessment/Instruments, In-session treatment tools

Introduction to EMDR: The Stage Model of Trauma Treatment

- Tri-Phasic model of trauma treatment
- Overview of the Stage Model of Treatment

Stage One: Stabilization and Safety

- Assessment, Rapport, Psychoeducation
- Prerequisites to processing memories
- Developing the "Skills to Stay Stable"
- **Trauma Tools for Stabilization:**
 - Recognizing and regulating client (and clinician's) physiology (co-regulation)
 - Recognizing and regulating emotion and affect (self-regulation)
 - Recognizing and interrupting dissociative episodes and "flashbacks"
 - Grounding clients in their bodies—in the here and now
- **Mindfulness/Bodyfulness:**
 - Somatic and sensorimotor interventions
 - EFT (meridian tapping)
 - Reducing or increasing physiological arousal
 - Recognizing the necessity of up & down regulating arousal levels
 - Containment and self-soothing
 - Multisensory Guided Imagery
 - Research and limitations of research

Between Sessions

- Read manual pp. 18–25 (Resourcing Exercise: Development and Installation of Imaginal Resources)
- Confirm dyad partner for Day 4
- Review resourcing imagery scripts: Container, Comfortable Place, Protector, Nurturer, etc.
- *Seminar Slides covered: pp. 144+*

Day Four: Resource Development & Installation

Wednesday, June 24 | 9:00 AM – 4:00 PM (with breaks) | 6 CE Hours

Learning Objectives

Objective 19

- Practice imaginal resourcing skills in preparation for trauma processing.

Content Outline

Morning: Demonstration

- Live demonstration: Development and Installation of Imaginal Resources
- Discussion and Q&A

Afternoon: Experiential Practice in Dyads

Participants practice in breakout rooms with their Home Group dyad partner under supervision.

- Each participant practices as both client and clinician
- Resourcing imagery practiced:
 - Containment Imagery
 - Comfortable Place Imagery
 - Protection Imagery
 - Nurture Imagery
 - Triumph Imagery
- Debrief/Integration sheets provided for structure
- Group Q&A to close

Between Sessions

Practice resourcing with 1–2 partners from your *Home Group* during the week.

- Schedule practice sessions with Home Group partner/s
- Use Debrief/Integration sheet for each practice session
- Note questions/challenges to bring to Day 5

Day Five: Stage Two & EMDR Fundamentals

Wednesday, July 1 | 9:00 AM – 4:00 PM (with breaks) | 6 CE Hours

Learning Objectives

Objectives 20–29

- Evaluate Shapiro's Adaptive Information Processing model as it relates to clinical treatment.
- Identify three types of alternating bilateral stimulation as a mechanism of action for EMDR RDI and EMDR.
- Analyze the original eight phases of EMDR's standard protocol (Shapiro) as it relates to clinical treatment.
- Evaluate Parnell's four essential elements of EMDR sessions and how they relate to client treatment.
- Summarize the clinical applications of Parnell's modified EMDR protocol for working with complex and developmental trauma.
- Discuss one absolute contraindication and three precautions for utilizing EMDR.
- Describe two EMDR protocols for working with addictions and compulsions.
- Summarize Miller's Feeling-State Therapy Addiction Protocol.
- Appraise Popky's urge reduction protocol, Desensitization of Triggers and Urge Reprocessing (DeTUR).

Content Outline

Stage Two: Working Through Traumatic Memories

- Single incident vs. complex trauma: Completely separate approaches
- Overview of several trauma processing modalities:
 - Sensorimotor Psychotherapy (SP)
 - Somatic Experiencing (SE)
 - EMDR
- Contraindications and precautions for reprocessing trauma

EMDR: The Development, Research, Fundamentals & Modifications

- Current research and limitations of the research
- Shapiro's Adaptive Information Processing
- Shapiro's EMDR 8-Phase Protocol
- Parnell's Modified Protocol for Complex Trauma
- Steps to EMDR
- EMDR modified script for sessions
- Quick Assessment for EMDR readiness

Alternating Bilateral Stimulation

- Types/options: Visual, auditory & tactile

Specialized Applications

- Considerations and further resources for EMDR with children
- Considerations and available protocols for working with addictions/compulsions:
 - Miller's Feeling-State Therapy Addiction Protocol
 - Popky's DeTUR (Desensitization of Triggers and Urge Reprocessing)
- Next steps for continued practice and training

Demonstration

- Live EMDR session demonstration
- Discussion and Q&A

Preparation for Intensive (Days 6–7)

July 1 → July 9 = 8 days. Use this time to prepare.

♦ Reread and be thoroughly familiar with the following:

- ❖ Manual pp. 28–37: Contraindications/Precautions, EMDR Readiness, Cognitive Interweaves
- ❖ Modified EMDR Script pp. 41–74 (6 copies in manual)—you will be reading from it during practice
- ❖ Future Template Script p. 75
- ❖ Key Definitions pp. 76–79

◆ Confirm triad partners from Home Group for Day 6

- ❖ Confirm dyad partner from Home Group for Day 7 (NOT your resourcing partner from Day 4)
- ❖ Identify a personal memory (SUD 3–5) for processing practice
- ❖ Ensure quiet, private space for both intensive days

Day Six: Intensive – Triad EMDR Sessions

Thursday, July 9 | 9:00 AM – 4:00 PM (with breaks) | 6 CE Hours

Learning Objectives

Objectives 25, 30

- Practice the EMDR protocol, using all necessary therapeutic skills, including—but not limited to—attunement, co-regulation of client nervous system, i.e., keeping arousal levels regulated for integration of traumatic memories/material.
- Practice the EMDR protocol in session: Using Curran's written script (2014), which includes Parnell's modifications for complex trauma (2007).

Structure

Participants work in triads in breakout rooms under supervision.

Format: Three Full EMDR Sessions

- Each session: 60 minutes
- Each session followed by integration time with triad (using Debrief/Integration sheet)
- Structure: Two participants act together as co-therapists, one participant is client
- Rotation ensures each participant serves as client once
- Co-therapists read from Modified EMDR Script together

Supervision Structure

- Instructor and Assistant will float between breakout rooms
- Debrief/Integration sheets provide structure for processing
- Group Q&A between rounds as needed

Between Days 6 and 7

- Reading/self-care/personal work
- Note any questions for Day 7

Day Seven: Intensive – Paired Sessions & Closing

Friday, July 10 | 9:00 AM – 4:00 PM (with breaks) | 6 CE Hours

Learning Objectives

Objectives 19, 25, 30 (Continued Practice)

- Practice imaginal resourcing skills in preparation for trauma processing.
- Practice the EMDR protocol, using all necessary therapeutic skills.
- Practice the EMDR protocol in session using Curran's modified script.

Structure

Participants work in pairs in breakout rooms under supervision

Format: Four 50-Minute Sessions

- Each session: 50 minutes
- Each session followed by integration time (using Debrief/Integration sheet)
- Each participant serves as both client and therapist multiple times

Closing

- Group Q&A
- Group discussion
- Closing Circle
- Next steps for continued practice and training
- Information on CE's and certification

Objectives by Day

Day	Objectives Covered
Day 1	Objectives 1–5 (5 objectives)
Day 2	Objectives 6–12 (7 objectives)
Day 3	Objectives 13–18 (6 objectives)
Day 4	Objective 19 (1 objective – practice)
Day 5	Objectives 20–29 (10 objectives)
Day 6	Objectives 25, 30 (2 objectives – practice)
Day 7	Objectives 19, 25, 30 (3 objectives – practice)

Pre Training Email

Greetings fellow clinicians!

Welcome to the 7-Day EMDR Clinical Mastery Certification Bootcamp!

I wanted to briefly introduce myself prior to our meeting. My name is Linda Curran. I am a trauma therapist, trainer and consultant. I've been working for 15 years as a trainer and have found it to be helpful to participants (and myself) if I provide some information prior to the training. I will expect that you have read the following prior to and/or in between sessions of the training:

1. Quick and Dirty: EMDR's Development, Research & Current Modifications for Developmental & Complex Trauma (where EMDR is today)
2. Trauma 101: A Prerequisite for the Use of Any and All Trauma Technique
3. Virtual EMDR Therapy: A Clinician's Reference
4. Chapter 2: Dissociation and Complex Trauma: Comprehensive Assessment and Strategies for Modifying Treatment *The Most Important Chapter (everything in red)*
5. Window of Tolerance
6. Assessing for Complex Trauma and Dissociation: A Practical Clinical Resource for Trauma Clinicians
7. Stabilization & Readiness Assessment
8. Excerpt from Chapter 3: Enhancing Resilience: Integrating Multisensory Guided Imagery and ABLS for Resource Development

Additionally, I'd like for you to consider the following:

You will be asked to introduce yourself on the first day, so think about whether you are an EMDR believer, skeptic, or on the fence.

I will be asking for volunteers during the training and you all will be practicing guided imagery and EMDR with each other. So, before the fear of strangers sets in, it is important for you to know that you DO NOT have to share your story with anyone in order to do EMDR. You DO NOT have to talk about the memory in order to process it.

I look forward to meeting you all. See you soon!

My Best,

Linda

Homework

Day 1 Between Sessions

- Read manual pp. 9–17
- Review Home Group roster; identify potential practice partners
- *Seminar Slides covered: pp. 129–132*

Day 2 Between Sessions

- Read manual pp. 19–25
- Confirm dyad partner from Home Group for Day 4 resourcing practice
- *Seminar Slides covered: pp. 139–144*

Day 3 Between Sessions Exercise

- Read manual pp. 18–25 (Resourcing Exercise: Development and Installation of Imaginal Resources)
- Read Chapter 3: Enhancing Resilience: Integrating Multisensory Guided Imagery and ABLS for Resource Development
- Confirm dyad partner for Day 4
- Review resourcing imagery scripts: Container, Comfortable Place, Protector, Nurturer, etc.
- *Seminar Slides covered: pp. 144+*

Day 4 Between Sessions Exercise

Practice resourcing with 1–2 partners from your *Home Group* during the week.

- Schedule practice sessions with Home Group partner/s
- Use Debrief/Integration sheet for each practice session
- Note questions/challenges to bring to Day 5

Day 5 Between Sessions Exercise

Preparation for Intensive (Days 6–7)

July 1 → July 9 = 8 days. Use this time to prepare.

♦ Reread and be thoroughly familiar with the following:

- ❖ Manual: Contraindications/Precautions, EMDR Readiness, Cognitive Interweaves
- ❖ Modified EMDR Script pp. 41–74 (6 copies in manual)—you will be reading from it during practice
- ❖ Future Template Script p. 75
- ❖ Key Definitions pp. 76–79
- ♦ Confirm triad partners from Home Group for Day 6
- ♦ Confirm dyad partner from Home Group for Day 7 (NOT your resourcing partner from Day 4)
- ♦ Identify several personal memories for processing practice
- ♦ Ensure quiet, private space for both intensive days

Trauma and the ACE Study

In addition to both temperament and attachment patterns, traumatic or adverse experiences in childhood seriously affect the trajectory of development. It is no surprise that trauma-early and often-is damaging to the developing child, but rather recently the research has demonstrated that trauma's impact does not stop there.

In a large scale study designed to evaluate the relationship between childhood maltreatment and later physical health and well-being, researchers confirmed **that children who have experienced traumatic events are at increased risk for a great number medical, psychological, and relational problems not only in childhood, but throughout their entire lifespan.** These traumatic events in childhood have been given the designation, Adverse Childhood Experiences (ACE). Below are the definitions that were used in the ACE Study to investigate the effects of these experiences.

Ten Categories of Adverse Childhood Experiences

Note: each category occurred in the participant's first 18 years of life.

1. **Emotional Abuse :** Often or very often a parent or other adult in the household swore at you, insulted you, or put you down and sometimes, often or very often acted in a way that made you think that you might be physically hurt.
2. **Physical Abuse** Sometimes, often, or very often pushed, grabbed, slapped, or had something thrown at you or ever hit you so hard that you had marks or were injured.
3. **Sexual Abuse** An adult or person at least 5 years older ever touched or fondled you in a sexual way, or had you touch their body in a sexual way, or attempted oral, anal, or vaginal intercourse with you or actually had oral, anal, or vaginal intercourse with you.
4. **Emotional Neglect** Respondents were asked whether their family made them feel special, loved, and if their family was a source of strength, support, and protection. Emotional neglect was defined using scale scores that represent moderate to extreme exposure on the Emotional Neglect sub-scale of the Childhood Trauma Questionnaire (CTQ) short form.
5. **Physical Neglect** Respondents were asked whether there was enough to eat, if their parents drinking interfered with their care, if they ever wore dirty clothes, and if there was someone to take them to the doctor. Physical neglect was defined using scale scores that represent moderate to extreme exposure on the Physical Neglect sub-scale of the Childhood Trauma Questionnaire (CTQ) short form constituted physical neglect.
6. **Mother Treated Violently** Your mother or stepmother was sometimes, often, or very often pushed, grabbed, slapped, or had something thrown at her and/or sometimes often, or very often kicked, bitten, hit with a fist, or hit with something hard, or ever repeatedly hit over at least a few minutes or ever threatened or hurt by a knife or gun.
7. **Household Substance Abuse** Lived with anyone who was a problem drinker or alcoholic or lived with anyone who used street drugs
8. **Household Mental Illness** A household member was depressed or mentally ill or a household member attempted suicide.
9. **Household member imprisoned** Lived with anyone who imprisoned
10. **Parental Separation or Divorce** Parents were ever separated or divorced.

The Adverse Childhood Experiences (ACE) Study

What is it?

A collaborative venture between the Centers for Disease Control and Prevention and Kaiser Permanente with over 17,000 Health Maintenance Organization (HMO) members participating, it was one of the largest investigations ever conducted.

How did they get the data?

Each participant underwent a comprehensive physical examination and completed two questionnaires, *Family Health History Questionnaire** and *Health Appraisal Questionnaire*,** that provided information on childhood maltreatment, household dysfunction, and other socio-behavioral factors.

What were the results?

“Particular experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States.”

What was the conclusion?

“There is a strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults.” (Centers for Disease Control and Prevention’s website, www.cdc.gov)

Below are sample questions taken from the questionnaires used in the ACE Study. (They are not copyrighted and there are no fees for their use. To obtain copies of one or both, visit: <http://www.cdc.gov/ace/questionnaires.htm>). The questions are included here for two reasons: first, to elucidate how the information was obtained for the study, and second, to demonstrate not only the similarity to between the health history questions and attachment interview questions, but the overlap between them.

Family Health History Questionnaire *Sample Questions Response categories

Verbatim Question

Were your parents ever divorced or separated?	1=yes 2=no
Did you ever live with a stepfather?	1=yes 2=no
Did you ever live with a stepmother?	1=yes 2=no
Were you a foster child?	1=yes 2=no
Did you ever run away from home for more than one day?	1=yes 2=no
Did your brothers or sisters run away from home for more than one day?	1=yes 2=no
Was anyone in your household depressed or mentally ill?	1=yes 2=no
Did anyone in your household attempt to commit suicide?	1=yes 2=no
Did anyone in your household go to prison?	1=yes 2=no
Did anyone in your household ever commit a serious crime?	1=yes 2=no

Health Appraisal Questionnaire *Sample Questions

Have you ever been treated for or told you had:

Any venereal disease	1=yes 2=no
Diabetes	1=yes 2=no
To take medicine for diabetes	1=yes 2=no
Thyroid disease	1=yes 2=no
Cancer	1=yes 2=no

ACE Study Major Findings, Results and Conclusions

- More than 50% of participants reported at least one, and 25% reported ≥ 2 categories of adverse childhood exposures. A graded relationship was found between the number of categories of childhood exposure and each of the adult health risk behaviors and diseases that were studied.

- The categories of adverse childhood experiences were strongly interrelated and persons with multiple categories of childhood exposure were likely to have multiple health risk factors later in life.
- The number of categories of adverse childhood exposures showed a graded relationship to the presence of adult diseases including:
 - ischemic heart disease
 - cancer
 - chronic lung disease
 - skeletal fractures
 - liver disease

Participants who had experienced **four or more categories of childhood exposure**, (compared to those who had experienced none) had a:

4- to 12-fold increased health risks for:

- alcoholism
- suicide attempt
- Drug abuse
- Depression

2- to 4-fold increase in:

- smoking
- poor self-rated health
- >50 sexual intercourse partners
- sexually transmitted disease

1.4- to 1.6-fold increase in:

- Physical inactivity
- Severe obesity

What's Your ACE Score?

There are 10 types of childhood trauma measured in the ACE Study. Five are personal-physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect. Five are related to other family members: a parent who's an alcoholic, a mother who's a victim of domestic violence, a family member in jail, a family member diagnosed with a mental illness, and the disappearance of a parent through divorce, death or abandonment. Each type of trauma counts as one. So a person who's been physically abused, with one alcoholic parent, and a mother who was beaten up has an ACE score of three.*

*Note: There are, of course, many other types of childhood trauma — watching a sibling being abused, losing a caregiver (grandmother, mother, grandfather, etc.), homelessness, surviving and recovering from a severe accident, etc. The ACE Study included only those 10 childhood traumas because those were mentioned as most common by a group of about 300 Kaiser members; those traumas were also well studied individually in the research literature. The ACE score is meant as a guideline: If you experienced other types of toxic stress over months or years, then those would likely increase your risk of health consequences. Now that you've got your ACE score, what does it mean? First....a tiny bit of background to help you figure this out.....

The CDC's Adverse Childhood Experiences Study (ACE Study) uncovered a stunning link between childhood trauma and the chronic diseases people develop as adults, as well as social and emotional problems. This includes heart disease, lung cancer, diabetes and many autoimmune diseases, as well as depression, violence, being a victim of violence, and suicide. The first research results were published in 1998, followed by 57 other publications through 2011. It showed that:

- childhood trauma was very common, even in employed white middle-class, college- educated people with great health insurance;
- there was a direct link between childhood trauma and adult onset of chronic disease, as well as depression, suicide, being violent and a victim of violence;
- more types of trauma increased the risk of health, social and emotional problems.
- people usually experience more than one type of trauma – rarely is it only sex abuse or only verbal abuse.

A whopping two thirds of the 17,000 people in the ACE Study had an ACE score of at least one – 87 percent of those had more than one. Eighteen states have done their own ACE surveys; their results are similar to the CDC's ACE Study.

The study's researchers came up with an ACE score to explain a person's risk for chronic disease. Think of it as a cholesterol score for childhood toxic stress. You get one point for each type of trauma.

The higher your ACE score, the higher your risk of health and social problems. (Of course, other types of trauma exist that could contribute to an ACE score, so it is conceivable that people could have ACE scores higher than 10; however, the **ACE**

Study measured only 10 types.)

As your ACE score increases, so does the risk of disease, social and emotional problems. With an ACE score of 4 or more, things start getting serious. The likelihood of chronic pulmonary lung disease increases 390 percent; hepatitis, 240 percent; depression 460 percent; suicide, 1,220 percent. (By the way, lest you think that the ACE Study was yet another involving inner-city poor people of color, take note: The study's participants were 17,000 mostly white, middle and upper-middle class college-educated San Diegans with good jobs and great health care – they all belonged to the Kaiser Permanente health maintenance organization.)

Source: www.AcesTooHigh.com
www.acestudy.org

What's Your ACE Score?		
Prior to your 18th birthday:		IF Yes, enter 1
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?	
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?	
3	Did an adult or person 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?	
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?	
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?	
6	Was a biological parent ever lost to you through divorce, abandonment, or other reason ?	
7	Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?	
8	Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?	
9	Was a household member depressed or mentally ill, or did a household member attempt suicide?	
10	Did a household member go to prison?	
Now add up your "Yes" answers: This is your ACE Score		

Attachment Styles (Excerpted from Clinician Playbook)

“Attachment styles are survival-based adaptations”

Thus, just as animals of many species, including man, are disposed to respond with fear to sudden movement or a marked change in level of sound or light because to do so has a survival value, so are many species, including man, disposed to respond to separation from a potentially caregiving figure and for the same reasons. ~John Bowlby

Strange Situation is an experimental procedure developed by Mary Ainsworth to observe the variety of attachment styles exhibited between mothers and infants. Conducted with children between the ages of nine-months-old to about five-years-old, it is set in a playroom specifically outfitted for this purpose. Neither the mother nor the child has been in the setting before, so it literally presents a strange situation. The procedure consists of eight episodes. The first and second have the mother and baby come into the playroom, get comfortable, and begin to play. The third episode starts when a stranger comes into the room. After one minute, the stranger begins to talk to the mother and, at around the three minute mark, the stranger attempts to play with the baby. In the fourth episode, the mother hears a signal from the researchers and gets up and leaves the room. After three minutes of separation, the mother calls out to the baby as she comes back into the room, and consoles the baby. After the baby has calmed down, the fifth episode has the mother leave again, leaving the baby alone. The sixth episode begins after another three minutes of separation, but this time instead of the mother coming in, the stranger comes in. In the seventh episode, the mother comes back, consoles the child, and they begin to play again. The attachment styles below were created based on the babies' reactions to the *Strange Situation*.

- **Secure**
- **Insecure**
 - **Avoidant/dismissive**
 - **Anxious/preoccupied**
 - **Avoidant/fearful** sometimes labeled
 - **Disorganized*** (which was further developed by Mary Main, a student of Ainsworth)

Secure Attachment: Signal cry consistently met by attuned caretaker (Adult Attitude toward attachment: *Secure/Autonomous*)

Securely attached infants in the *Strange Situation* become distressed when the mother leaves the room; when the mother returns, the baby runs to her, is easily soothed, and begins to play again. These children feel confident that their caregiver will be available to meet their needs. Securely attached adults tend to be balanced in their relationships and independence. These adults tend to describe varied childhood experiences, with not all being good or bad.

Securely attached children perceive their caregiver as a secure base from which they can endeavor out on their own to explore the world, knowing that they can return to their attachment and will be welcomed back. Similarly, securely attached adults are able to experience close connection with their partner, as well as appreciate that they and their partner will sometimes need space. Securely attached adults offer support when their partner feels distressed and are able to ask for and accept comfort when distressed. Generally, secure relationships tend to be egalitarian, open, and honest, with both people autonomous, independent, satisfied, and loving toward one another.

Securely attached people agree with the following statements:

- "It is relatively easy for me to become emotionally close to others."
- "I am comfortable depending on others and having others depend on me."
- "I don't worry about being alone or others not accepting me."

Securely attached people tend to have positive views of themselves, their attachments, and their relationships with others. They generally report greater satisfaction in their relationships than people with other attachment styles. Securely attached people feel comfortable both with intimacy and with independence.

Shorthand: Feels good/safe with self and others.

Insecure Avoidant Attachment: Signal cry consistently unmet by caretaker.

(Adult Attitude toward attachment: *Dismissive*)

In the *Strange Situation* scenario, infants with avoidant attachment present **as though** nothing really bothers them; they don't cry when their mother goes away and they ignore her when she comes back. However this does not mean that they **are** unaffected, in fact, when measured, their physiological states mimic that of every other stressed baby, which is hyperarousal. They have learned that displaying their distress does not lead to consolation from their particular caregiver. Avoidantly-attached adults were unable to integrate experiential memories as children and therefore have difficulty recalling specific experiences. Instead, their memories tend to be vague and non-specific. They tend to deny any early attachment relationships or consider them of little importance. Individuals with this avoidant-dismissive attachment style tend to seek isolation. They detach from themselves and others with relative ease. These individuals establish and maintain emotional distance from their partner and have the ability to completely shut down emotionally, regardless of the relational circumstances.

Adults with a dismissive style of avoidant attachment tend to agree with these statements:

- "I am comfortable without close emotional relationships."
- "It is important to me to feel independent and self-sufficient."
- "I prefer not to depend on others or have others depend on me."

People with this attachment style desire a high level of independence, which often appears as an attempt to avoid attachment altogether. They view themselves as self-sufficient and invulnerable to feelings associated with being closely attached to others. They often deny needing close relationships and may view close relationships as relatively unimportant. Not surprisingly, they seek less intimacy with attachments, whom they often view less positively than they view themselves. They tend to suppress and hide their feelings, and they tend to deal with rejection by distancing themselves from the sources of rejection (e.g. their attachments or relationships).

Shorthand: Does not feel good/safe with others.

Insecure, Anxious/Ambivalent: Signal cry inconsistently met by caretaker (Adult Attitude toward attachment: *Preoccupied*)

In anxious or ambivalent attachment, the infants in *Strange Situation* continuously draw attention to themselves by crying, yelling, clinging, or screaming; they seem to have concluded that unless they make a spectacle, nobody will pay attention. They become exceedingly upset when their mother is absent but derive little comfort from her return and are often inconsolable. Even though they don't seem to enjoy her company, they stay passively or angrily focused on her, even in situations where most children would rather play.

Like avoidantly attached adults, anxiously attached adults have also failed to integrate and assess the meaning of experiential memories. These adults tend to display confusion about past experiences and ruminate over painful experiences that lack resolution. Current relationships with attachment figures are marked by active anger or passivity. Rather than love, these clients experience the intense, painful longing of emotional need. Anxiously attached individuals tend to maintain their signal-cry or need for attention even when their needs are being met. This is often done out of fear that, if they turn off their signal cry, attention will no longer be paid. Due to the inconsistency of the caregiver, these individuals tend to have a difficult time trusting that their needs will continue to be met.

Adults with anxious-ambivalent attachment type tend to agree with the following statements:

- "I want to be completely emotionally intimate with others, but I often find that others are reluctant to get as close as I would like."
- "I am uncomfortable being without close relationships, but I sometimes worry that others don't value me as much as I value them."

People with this style of attachment seek high levels of intimacy, approval, and responsiveness from their attachment figure. Compared with securely attached people, people who are anxious or preoccupied with attachment tend to have negative views about themselves. They may feel a sense of anxiousness that only recedes when in contact with the attachment figure and need consistent reassurance that they are loved and worthy. They often doubt their worth as a person and blame themselves for the attachment figure's lack of responsiveness.

Shorthand: Does not feel good/safe with self.

Disorganized (fearful-avoidant/unresolved/can't classify): Signal cry inconsistently met by frightened and/or frightening caretaker (Adult Attitude toward attachment: *Disoriented/Disorganized*)

A modest percentage of children (15% in studies conducted by Mary Main) appear unable to figure out how to engage with their caregivers - seemingly because the caregivers themselves are a source of distress or terror to the children. Children in this situation have no one to turn to, and they are faced with an unsolvable dilemma: their mothers are simultaneously necessary for survival and a source of fear. They "can neither approach (the secure and ambivalent 'strategies'), shift [their] attention (the avoidant 'strategy'), nor flee." In the attachment laboratory, these children look toward their parents when they enter the room and then quickly turn away. Unable to choose between seeking closeness and avoiding the parent, they may rock, appear to go into a trance, freeze with their arms raised, or get up to greet their parent and then fall to the ground. *On the Origins of Disorganized Attachment and Internal Working Models: Paper II. An Empirical Microanalysis of 4-Month Mother-Infant Interaction*, Beatrice Beebe wrote:

Lowered maternal contingent coordination, and failures of maternal affective correspondence, constituted maternal emotional withdrawal from distressed infants. This maternal withdrawal compromises infant interactive agency and emotional coherence. We characterize of the nature of emerging internal working models of future disorganized infants as follows: Future disorganized infants represent states of not being sensed and known by their mothers, particularly in moments of distress; they represent confusion about both their own and their mothers' basic emotional organization, and about their mothers' response to their distress. This internal working model sets a trajectory in development which may disturb the fundamental integration of the person.

People with this type of attachment tend to agree with the following statements: "I am somewhat uncomfortable getting close to others. I want emotionally close relationships, but I find it difficult to completely trust others, or to depend on them. I sometimes worry that I will be hurt if I allow myself to become too close to other people." They tend to feel uncomfortable with emotional closeness, and the mixed feelings are combined with sometimes unconscious, negative views about themselves and their attachments. They commonly view themselves as unworthy of responsiveness from their attachments, and they don't trust the intentions of their attachments.

Shorthand: Does not feel good/safe with self or others.

Adult Attachment Interview (AAI) (Mary Main) For the full Questionnaire, go to:

http://www.psychology.sunysb.edu/attachment/measures/measures_index.html
http://www.psychology.sunysb.edu/attachment/measures/content/aai_interview.pdf

Resourcing Exercise Development and Installation of Imaginal Resources

(Activating multi-sensory imagery and adding short sets of tactile alternating bilateral stimulation (abts) to strengthen the resource)

**Please be very familiar with the following details for
the Experiential Resourcing Exercise~
Development & Installation of Imaginal Resources**

Definition and Purpose: Imaginal resourcing is a therapeutic technique used to help clients develop internal resources and coping skills by creating positive, safe, and empowering mental images. Here is an overview of EMDR and imaginal resourcing, along with dialogue for implementation explains how to integrate them into therapy for more effective treatment outcomes.

A therapeutic technique that helps clients create positive, safe, and empowering mental images Builds internal resources and coping skills Can be used as a stand-alone intervention or integrated with other therapies, such as EMDR

The technique involves three steps:

1. **Resource Identification:** The therapist works with the client to identify a positive quality, skill, or source of support that the client wishes to strengthen. This could be anything that helps the client feel safe, secure, or confident.
2. **Resource Development:** Through guided imagery and discussion, the therapist helps the client explore this resource, enhancing their connection to it and helping them understand how it can be useful in managing distress.
3. **Resource Installation:** Using bilateral stimulation (eye movements, taps, or tones), the therapist assists the client in strengthening and integrating this resource into their memory network. This helps the client access and utilize this resource during challenging times, such as during trauma processing in EMDR therapy.

Is there a difference between EMDR:RDI Resource Development and Installation protocol developed by Korn & Leeds (2002) and Parnell's Resource Tapping™? According Deborah Korn and Andrew Leeds paper, Preliminary evidence of efficacy for EMDR resource development and installation in the stabilization phase of treatment of complex post traumatic stress disorder (2002):.

“RDI refers to a set of EMDR-related protocols which focus exclusively on strengthening connections to resources in functional (positive) “memory networks” (Leeds & Shapiro, 2000; Shapiro, 1995) while deliberately not stimulating dysfunctional (traumatic) memory networks. The addition of bilateral stimulation differentiates RDI from earlier hypnotic ego-strengthening methods in the hypnotherapeutic tradition. Again, the inclusion of the bilateral stimulation in the protocol appears to lead to spontaneous, rapid increases in affective intensity within an initially selected memory network and to rich, emotionally vivid associations to other functional (positive) memory networks. These increases in intensity of positive emotions and new functional associations bring additional ego-strengthening material into consciousness. Patient reports of these changes during RDI lead to other RDI procedural steps that may further reinforce the patient's ability to access affective, cognitive, and behavioral coping skills linked to these functional memory networks when the patient is later confronted by stress-related stimuli.”*

Citation: Korn DL, Leeds AM. Preliminary evidence of efficacy for EMDR resource development and installation in the stabilization phase of treatment of complex posttraumatic stress disorder. *J Clin Psychol.* 2002;58(12):1465-1487. doi:10.1002/jclp.10099.

Since the early 2000's, clinicians began to realize that the standard protocol was not maximally effective, ineffective, and at times, retraumatizing for certain population—including clients with histories of developmental trauma and/or complex trauma, i.e. months to years of repeated traumatization in adulthood.

Ricky Greenwald cautions,

“...many therapists will religiously teach their clients Safe Place as a preliminary to doing EMDR, without necessarily understanding that Safe Place is only intended as one example of a class of interventions that can help clients to learn to self-soothe and build affect tolerance. ...The real point, of course, is not to teach Safe Place but to accomplish the task of helping clients to be in a position to tolerate, and benefit from, EMDR” (Greenwald, 2006*).

In her book, *Tapping In* (Parnell, 2008*), Laurel Parnell writes,

“In the early days of EMDR we discovered that bilateral stimulation could also be used in a focused way to activate and strengthen certain resources within our clients. The first resource to be tapped in was the safe place. Guiding people to a safe place where they feel safe and comfortable had been used for many years by psychotherapists to reduce anxiety. We found that directing clients to focus on a safe place and then adding short sets of bilateral stimulation worked even better than imagery alone to calm them and provide them with a sense of control over their distress. This practice, called ‘installing a safe place’ helped traumatized people feel safer and was used by therapists prior to beginning emdr sessions.”

Resourcing has proven successful in many clients (if a client is unable to use this resourcing method, it is not advised to use the emdr protocol for reprocessing trauma). Clinicians can facilitate the development and installation of many different kinds of resources to help strengthen egos and stabilize clients, especially those who have histories of abuse and/or neglect in their childhood. Although resource installation has become a mainstay prior to an EMDR reprocessing session, Parnell and others have begun using this technique as a stand-alone procedure. “By focusing attention on our resources and adding short sets of simple bilateral tapping, we can strengthen these resources, making them more present and accessible to us” (Parnell, 2008).

In contrast to emdr for trauma processing, resourcing work is kept focused exclusively on the development of positive, healing resources followed by a short set of bilateral stimulation.

In the resourcing process, the client is directed in a multi-sensory guided imagery exercise, which includes deliberate enhancement and awareness of his/her sensory, somatic and affective experience of the resource being installed. Clinician should ask questions explicitly. For example, when developing a safe/comfortable place, Clinician asks, what do you see now? What about when you look all around? Are there any sounds? Smells? What is the temperature? What makes this place so comfortable? What do you like about it? When you look around again, experiencing the sights, sounds, smells, how do you feel like? Where do you feel that in your body? When the resource is located and being vividly experienced by the client, the clinician asks the client for a word or phrase that captures his/her feeling state e.g. relax, calm, strong and solid, the beach, chill... anything. Really.

The clinician then directs the client to “breathe into that” while applying alternating bilateral tactile stimulation (abts) for a short duration, i.e. the clinician turns on the Theratapper for approximately ten seconds or two full breaths. (It is important to keep the abts short, while continuously monitoring the client’s affect, as positive resources can easily turn negative or become contaminated with negative associations. Even when keeping the sets short it can happen, so continuous monitoring and checking in with the client is essential.)

Theory behind resource installation: The abts is applied to strengthen the associations between the client's anchor word, sights, sounds, smells, tactile sensations and his/her visceral response and the feeling state. ("The general idea is an old one, that any two cells or systems of cells that are repeatedly active at the same time will tend to become 'associated', so that activity in one facilitates activity in the other... The theory is commonly evoked to explain some types of associative learning in which simultaneous activation of cells leads to pronounced increases in synaptic strength. Such learning is known as Hebbian learning-often summarized as "cells that fire together, wire together." {Hebb, 1949}) 24

This is Not a Script; it's a Reference

Imaginal Container Have the client bring up an image of a container-one that is big enough to hold each and every disturbing thing-but, discourage the client from focusing on any particular thing or image. Encourage the client to make the container as real as possible, noticing its heavy, secure lid. Explain to the client that s/he may put in or take out whatever s/he wants any time that s/he wants. Explain to the client that this container should be labeled with something to the effect that it should only be only when it would be in the service his/her healing. Instruct the client that at no time should any part of him/herself be placed in the container. (For ego states work and Internal Family Systems work, the reader is referred to Forgash and Copely, 2007* and Schwartz, 1995*) The client should imagine placing all the distressing or disturbing material into the container and sealing it tightly. As the name suggests, when containers are installed, the client should feel as though s/he has the ability to contain his/her own affect. It should also produce feelings of agency and control over the traumatic material.

Comfortable Place Remember the Client already has the resource. Clinicians are just helping to evoke it; elaborate on it, and reinforce it. By getting the client to pay attention to his/her sensory experience (all or most of his/her senses should be activated); his/her body sensations; and his/her emotions while experiencing the resource. The client should (cognitively) label his/her experience. The clinician then adds abts (ten seconds or two full breaths is fine) to strengthen those connections.

- ◆ Have client close his eyes or find a spot on which to focus.
- ◆ Have client pay attention to his/her breath, finding a quiet place within herself.
- ◆ Invite client to breathe deeply, attempting to make the exhalation longer than the inhalation, relaxing and releasing with each breath.
- ◆ Have the client bring to mind the resource of **Safe/Comfortable Place**. Imagining it as fully as possible. Have him/her notice what s/he is seeing, hearing, smelling, touching. Ask what sensations are felt on the skin. What does s/he taste? What does s/he feel in his/her body when in this place? Give the client all the time s/he may need.
- ◆ Ask the client to report when s/he feels like s/he is really there.
- ◆ If it is positive, apply a short set of abts (ten seconds or two breaths is fine).
- ◆ Turn off Theratapper and have client check in again. Ask what the client is noticing? If the resource is strengthening and remains positive continue to add abts (Remember, it is important that the resource feel completely positive.)
- ◆ Clinician should be willing and encouraging even if several resources turn negative. Treat it all as a tentative experiment, where there can be no failure, "Okay, maybe that one isn't altogether positive, so let's develop a different one- one that is all positive". If a distressing thought, feeling or memory arises, have the client imagine

placing it in a container. The container can be anything that can safely hold the material that has come up. In his book, *Psychotherapeutic Interventions for Emotion Regulation: EMDR and Bilateral Stimulation for Affect Management* (Omaha, 2004), John Omaha recommends creating an imaginal container which would serve to limit pressures and feelings preventing client overwhelm. It can be used to contain distress, emotions and problems in and out of session. It can also hold material that emerges during emdr sessions that are not directly related to the target and are affecting the client's ability to process. The container can also be used in closing down incomplete sessions to hold unresolved aspects of traumatic material.

Nurturing Figures Nurturing figures can be anyone-real or imaginary figures from the present or past, inner guides, or animals. Instruct clients to look for those people who were loving, safe, nurturing figures. Perhaps people from his/her past or current life that are, or have been important sources of comfort and care. Alternatively, these figures can be from movies, TV, books or historical figures. Could be anybody, really. Anybody by whom the client feels-or could feel-nurture. It could be Glinda, the good witch, a guardian angel, fairy godmother, Mary, Jesus, a Native American elder, Buddha, goddesses like Kwan Yin or Tara, or Mother Teresa. Anybody, really. Animals can also serve as nurturing figures childhood or present-day pets, a power animal or mythological creature. Any animal, really. The clinician may suggest that the client use his/her adult self as a nurturer. That aspect of the client may be contacted by having him/her recall times when s/he cared for another. Perhaps s/he remembers holding a child or petting an animal. When developing the nurturing figure resource, it is important to imagine the figure in its nurturing aspect. This can include memories or images of the figure being nurturing. For example, you might think of a time when your Mom-mom held you in her arms and sang to you. This image represents the quality of nurture to be strengthened and made available for later use. Your Mom-mom may also serve as a protective figure, but in that case the conjured image would be of her acting in a protective vs. nurturing way. The client should feel the quality of nurture from the figure.

Protector Figures Protector figures can be anyone. Could be a real person-someone from childhood or present life. It is important that when you think of your protectors that you believe that they would defend you against harm. Someone who has had-or will have your back if you were to be threatened. Memories of positive experiences with real-life protector figures can be used. Like nurturing figures, protector figures can include anybody. Really. Parents, grandparents, friends, partners, cats, and rats and elephants, action heroes, superheroes or mythic figures. The clinician may even suggest that the client use his/ her own protective adult self. Again when developing the protective figure, it is important to imagine the figure in its protective aspect, i.e. when they are keeping you or someone else from harm. The client should feel the quality of protection from the figure.

Triumphant Moment Resource

Purpose: The Triumphant Self reconnects clients with moments of personal victory and resilience. This resource reminds them of their ability to face challenges and persevere, no matter the scale of the accomplishment. Whether the triumph is completing a race, resolving a conflict, or overcoming a personal fear, it fosters a sense of pride and strength.

Therapist Script with Client Example

Step 1: Introduce the Resource

Therapist: "Let's explore a moment in your life when you accomplished something that felt challenging. It could be a big achievement or a small victory—whatever feels significant to you. What comes to mind?"

Client: "Finishing my first half marathon."

Therapist: "That's a great example! Picture yourself in that moment of triumph. What do you see?"

Step 2: Visual Details

Therapist: "Let's focus on that image. What do you notice around you? Are there colors, shapes, or specific details that stand out?"

Client: "I see myself crossing the finish line with my hands in the air. There's a big banner over the street, and the crowd is cheering."

Therapist: "That's a vivid image. Focus on those details as we tap that in."

(Therapist provides ABLS, such as thigh tapping or foot tapping, to anchor the visualization.)

Step 3: Auditory Details

Therapist: "Can you hear anything in this moment? Maybe the cheers of the crowd, your own breath, or the sound of your feet on the pavement?"

Client: "I hear clapping and people cheering my name."

Therapist: "Let's tap that in while you focus on those sounds."

(Therapist provides ABLS to reinforce auditory elements.)

Step 4: Emotional and Physical Connection

Therapist: "What makes this accomplishment so meaningful to you?"

Client: "I never thought I could run that far. I trained for months and didn't give up."

Therapist: "That determination and persistence are powerful. Let's deepen that connection with some tapping."

(Therapist provides ABLS to anchor the emotional significance of this memory.)

Therapist: "As you connect with this moment, what emotions come up? Where do you feel those emotions in your body?"

Client: "Pride and joy. I feel it in my chest—it's like I'm standing taller."

Therapist: "Let's anchor that pride and strength with another set of tapping."

(Therapist provides ABLS to solidify the emotional and somatic experience.)

Step 5: Anchoring with Gestures

Therapist: "What gesture or posture represents this feeling of triumph? For example, raising your arms as you did at the finish line."

Client: "Raising my arms in the air—it feels powerful."

Therapist: "Perfect. Let's pair that gesture with foot tapping to reinforce your connection to your Triumphant Self. Focus on the feeling of pride and power as we do this together."

(Therapist guides foot tapping while the client holds the gesture of raised arms.)

Therapist: "You can use this gesture and tapping anytime you want to reconnect with your Triumphant Self. What name or title would you like to give this resource?"

Client: "My Runner Self."

Key Elements of the Triumphant Self

1. Focus on a Real Accomplishment

Help the client identify a specific moment of triumph, regardless of scale.

Highlight the effort, challenges, and victory associated with the accomplishment.

2. Sensory Exploration with ABLS

Visual: "What does the moment of triumph look like?" (Provide ABLs after visualizing.)

Auditory: "What sounds are present in this moment?" (Provide ABLs after auditory details.) etc.

Emotional and Physical: "What emotions come up, and where are they felt in your body?" (Provide ABLs after exploring these sensations.)

3. Anchoring Gestures with ABLs

Encourage a gesture that represents triumph (e.g., raising arms, standing tall).

Use foot tapping if gestures limit hand-based tapping or TheraTapper use.

4. Naming the Resource

Encourage the client to choose a meaningful name for the resource (e.g., "My Runner Self," "Victory Pose," "The Champion").

Why It Matters: The Triumphant Self resource is a powerful reminder of the client's resilience and capability. By reconnecting with these moments of success, clients can draw on their internal strength to face current and future challenges with confidence. Through ABLs, the resource is anchored in both the body and mind, making it readily accessible during difficult times.

Remember, these resources should always align with the individual's experiences and context. It's crucial to use the client's own words and descriptions to ensure they resonate with the resources and can effectively draw upon them during therapy.

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Experiential Exercise

Development & Installation of Imaginal Resources

- Presenter will do a demonstration with a volunteer
- Participants then break up into pairs for experiential exercise. 60 minutes total: each person will have opportunity to be both client and clinician.

Directions:

1. Choose a partner.
2. Take your chairs and manual and move as far away from the next pair as possible. (Avoid the door area or noisy places)
3. Choose role for first round~client or clinician.
4. Each round will last 30 minutes.
5. First round: Clinician instructs client in guided imagery with tapping, (a.k.a., EMDR:RDI). *First, Container, Comfortable Place, Protector Figure, Nurturing Figure and Triumphant Moment*
6. Stop.
7. Q & A, if necessary
8. Switch roles.
9. Clinician instructs client in guided imagery with tapping, (a.k.a., EMDR:RDI). *First, Container, Comfortable Place, Protector Figure, Nurturing Figure and Triumphant Moment*
10. Stop.
11. Process comments and Q & A.

Historical Context of EMDR's Construction

EMDR wasn't created out of thin air. Francine Shapiro developed it in the late 1980s by integrating techniques from existing psychotherapeutic approaches, including exposure therapy, cognitive therapy, Neuro-Linguistic Programming (NLP), and psychodynamic therapy.

This history underscores that EMDR's tools are built on well-established practices. They aren't just effective—they're adaptable, giving clinicians the freedom to use them flexibly and safely.

- **Influence of Exposure Therapy** (Systematic Desensitization (Not Flooding)) Joseph Wolpe's systematic desensitization (1958) paired gradual exposure to fears with relaxation techniques to reduce anxiety. It was a breakthrough for its time, but Shapiro made it better. She kept the gradual exposure but replaced relaxation with alternating bilateral stimulation (ABLS).

Why ABLS instead of relaxation? Progressive muscle relaxation (PMR), commonly used in systematic desensitization, helps create a temporary state shift, calming the nervous system. But that's where it stops—it doesn't process the underlying trauma. ABLS, on the other hand, not only calms the nervous system but also facilitates information processing.

Shapiro initially believed eye movements mimicked REM sleep, helping the brain "digest" trauma. While that hypothesis didn't hold up, research supports ABLS as effective for reducing distress and integrating traumatic memories (Lee & Cuijpers, 2013). By swapping relaxation for ABLS, Shapiro turned desensitization into a more dynamic, trauma-processing tool.

- **Some Heavy Lifting from Neuro-Linguistic Programming (NLP)** Shapiro's background in NLP heavily influenced EMDR's core techniques. NLP, developed by Richard Bandler and John Grinder in the 1970s, focused on creating rapid emotional and cognitive shifts through methods like anchoring, submodality adjustments, and dissociation (Bandler & Grinder, 1979). Shapiro adapted and reframed these strategies for trauma therapy.

- **Anchoring** → Resource Development and Installation (RDI) In NLP, anchoring links a positive emotional state to a specific trigger (e.g., a touch or sound). Shapiro took this concept and added ABLS, turning it into Resource Development and Installation (RDI). With RDI, ABLS strengthens internal resources like calmness or confidence, making them more accessible when clients face challenges.
- **Submodality Adjustments** → Desensitization with ABLS NLP uses submodality adjustments—altering the sensory qualities of a memory (e.g., making it smaller or farther away)—to weaken its emotional impact. EMDR achieves a similar outcome with ABLS, which naturally reduces the intensity of distressing memories without requiring clients to consciously manipulate their mental imagery.
- **Safe Distancing** → Visual-Kinesthetic Dissociation (VKD) NLP's "movie theater technique" asks clients to imagine watching a memory on a screen to create emotional distance. Shapiro adopted this distancing but paired it with ABLS, which allows clients to stay detached while actively reprocessing traumatic material.

- **Massive Contribution from Cognitive Therapy** Cognitive therapy, developed by Aaron Beck in the 1960s, focuses on identifying and changing distorted thinking patterns that fuel distress. Shapiro integrated several key elements into EMDR:

- **Identifying Negative Beliefs:** Like cognitive therapy targets automatic thoughts, EMDR identifies trauma-related beliefs (e.g., “I am powerless”).
- **Cognitive Restructuring:** EMDR uses ABLS to reprocess these beliefs, transforming them into adaptive alternatives (e.g., “I am strong and capable”).
- **Cognitive Interweave:** When clients get stuck, EMDR’s interweave introduces helpful perspectives, similar to cognitive therapy’s guided questioning.
- **Behavioral Integration:** Cognitive therapy reinforces new beliefs through experiments. EMDR achieves this with “future templates,” where clients visualize and rehearse healthier responses to future situations.

• **Finally and Obviously, Psychodynamic Therapy** Psychodynamic therapy emphasizes the role of unconscious processes and relational dynamics in shaping emotional distress. Shapiro incorporated these principles into EMDR to address how unresolved trauma affects present beliefs, emotions, and relationships.

- **Uncovering Deep-Seated Traumas:** EMDR facilitates access to unconscious material, helping clients address the root causes of symptoms.
- **Addressing Relational Patterns:** EMDR explores how past relationships influence present-day behaviors and beliefs, allowing clients to break harmful cycles.
- **Holistic Healing:** By combining psychodynamic insights with ABLS, EMDR integrates emotional, cognitive, and relational healing, creating a comprehensive trauma resolution process.

Conclusion

EMDR isn’t a standalone invention—it’s a remix of proven techniques. Shapiro took the best of systematic desensitization, NLP, cognitive therapy, and psychodynamic therapy, then layered in ABLS to create a trauma processing modality that’s both effective and adaptable. Understanding this history shows that EMDR’s tools aren’t rigid—they’re modular. Clinicians can break them down, adapt them, and use what works best for each client without compromising effectiveness or safety.

Quick and Dirty: EMDR's Development, Research & Current Modifications for Developmental & Complex Trauma

The myth*:

In 1987, graduate student Francine Shapiro was walking in the park when she made a personal discovery; she observed that involuntary randomized eye movements seemed to diminished her own disturbing thoughts (Colwell, 2000). From that initial experience, Shapiro brought those eye movements under voluntary control and integrated them with “other treatment elements” and created a new psychotherapy that she called **Eye Movement Desensitization (EMD)** (EMDR 2004). To investigate this new psychotherapy further, she conducted a controlled study with twenty-three (23) participants with traumatic memories and Post-Traumatic Stress Disorder (PTSD) symptoms. In the study, the participants were first asked to rate their feelings of distress and/or discomfort regarding a particular traumatic memory using the **Subjective Units of Disturbance (SUDs)** scale, which is a 0-10 rating system. Participants were also asked to think of a **Positive Self-Statement (PSS)** that they would like to attach to the memory, erasing and replacing the negative one currently associated with the memory. Participants when evaluated their confidence in the veracity of the PSS (now called Validity of Cognition) on a Likert scale from 1-7, where 1 was completely false, and 7 was completely true.

On average, before treatment the participants reported a SUDs score of seven and reported the validity of the PSS as four. After only one EMD session, participants on average rated the memory as less than one on the SUDs scale, and the positive self-thought was receiving ratings above six. These results remained unchanged three months later (Lipke & Botkin, 1992), leading Shapiro to assert “a single session of the procedure was sufficient to desensitize participants” (EMDR, 2004).

By 1991, Shapiro changed the name of the therapy to **Eye Movement Desensitization and Reprocessing (EMDR)** to reflect how the therapy not only desensitizes traumatic material, but also changes negative self-thoughts. Shapiro refers to this shift as the Adaptive Information Processing (AIP) Theory (EMDR Institute, 2004).

EMDR, the Eight-Phase Process:

First, the therapist determines whether the client is appropriate for EMDR. (THIS ASSESSMENT IS THE MOST CRITICAL STEP).

In **phase two**, the therapist ensures that the client has the skills to stay stable during and after revisit his/her traumatic experience. Along with building the therapeutic alliance, the development of safety and stability, (via skills building, i.e., emotion regulation, distress tolerance, mindfulness, etc.) is generally the bulk of trauma treatment. (Most Clients DO NOT come to us with single incident trauma, therefore Phases one and two of Shapiro's 8 Phase model may take a week or it may take several years{LAC}).

Phase three begins the actual modality of trauma processing: “accessing” the traumatic memory and rating the distress or disturbance associated with the memory. (Choose which memory to work on: **first** or **worst**) As in the initial study, clients evaluate the disturbance caused by the memory, and rate the validity of the new positive self-statement.

Phase four is the desensitization phase, in which the client recalls the memory and its associated imagery, while the therapist provides bilateral stimulation. This can be done by: 1. Instructing the client to shift his/her eyes side to side-visually crossing the midline; 2. Instructing the client to follow a moving light or the clinician's waving finger; 3. Rhythmic hand taps; or 4. Alternating musical tones. (We will be using tactile stimulation via the **Theratapper**)

In *phase five* short sets of alternating bilateral stimulation are provided, as the client associates his/her new adaptive cognition with the traumatic memory. Followed by *phase six*, where the client scans his/her body to assess for any remaining tension. The client scans his body to assess and release remaining tension in *phase six*. At this point the actual EMDR modality ends as *phase seven* is closure of the session and reviewing what has been done in the session. *Phase eight* occurs at the following session, when the client once again is instructed to access and re-rate distress currently caused by the memory and the validity of his positive self-statement (Soderlund, 2000).

Similar to both exposure treatments—systematic desensitization and flooding therapies—, EMDR is a kinder, gentler (some would say *exposure*) method, in that it does not require days, or even weeks, of continued activation of the stress response for desensitization to occur. In fact, it requires fewer sessions and no homework is required. Shapiro's theory, the AIP (Adaptive Information Processing) model posits that ["EMDR activates] an information processing mechanism that is inherent within all of us" (Soderlund, 2000). Shapiro asserts that traumatic experiences are often left "*undigested*", i.e not adaptively processed, and that EMDR can help clients identify these unprocessed memories and reactivate the mechanism. The EMDR Institute website explains that the therapy seeks to link traumatic memories and adaptive information that the clients already knows but that has not been connected to the traumatic material.

EMDR's popularity is growing, however, its efficacy is still in dispute due in part to the small size of Shapiro's 1989 study, to the ever-evolving guidelines she and the EMDR Institute impose regarding educational requirements and practice. Initially, Shapiro claimed that the eye movements were an essential part of the therapy, saying, "[T]he primary component of the EMD procedure is the generation of rhythmic, multi-saccadic eye movements while the client concentrates on the memory to be desensitized" (Erwin, 2004). In the late 1980s and early 1990s, EMDR practitioners who were working with blind clients had success using musical tones and hand-tapping. Today, evidence suggests that EMDR can be practiced with bilateral stimulation using auditory, tactile, or visual stimuli (EMDR Institute, 2004).

Early on, Shapiro believed that her dissertation explained EMDR thoroughly enough to enable clinicians to begin to use the technique (Erwin, 2004). As time went on, she thought that therapists could benefit from additional training so she created a one- day workshop for clinicians, which eventually evolved into a lengthy certification process. Initially—and problematically—, clinicians being trained through the EMDR Institute were not allowed to share the technique with other practitioners, which created a "walled-garden" of knowledge that has been criticized by both clinicians and scientists.

Despite the polarizing opinions on EMDR, research continues to be done with particularly positive outcomes in civilian and military populations. Although EMDR's exact mechanism of action remains unknown, given the empirical data, EMDR is "strongly recommended" for treatment of PTSD by the Department of Veterans Affairs/Department of Defense (EMDR Institute, 2004). In an exclusive interview By John Soderlund with Francine Shapiro on why EMDR is a prototypically integrative approach:

"It doesn't matter whether it's eye movements or hand tapping that's being used. It's still the attentional shift. The orienting response has been suggested by a number of researchers as contributing to this. And so at this time, as with any form of therapy, it's impossible to define the neurobiological causes for the effect, but there have been studies by van der Kolk that show neurological differences pre and post EMDR treatment. So, after the EMDR treatment you have different brain structure activation."

Evidence suggests that modified EMDR can be helpful with patients who have a history of complex trauma (Twombly, 2000). In 2000, Joanne Twombly's study showed that EMDR adaptations helped "facilitate learning, intervene in [Dissociative Identity] Disorder, decrease some negative transferences and provide a protective format for processing traumatic material." (Twombly, 2000) In a study focusing on the use of EMDR with Dissociative Identity Disorder, Lazarove and Fine recommend modifying EMDR. The changes to the original protocol are minor, and including the addition of the creation of a visualized safe place that can be utilized by the client during sessions, as well as de-emphasizing the post-treatment body scan. The researchers suggested that "[Modified] EMDR complements existing strategies for treating DID by offering an alternative method for managing the processing of trauma." (Lazarove & Fine, 1996)

In this training, we will be using a script that has been modified for complex trauma, however, it is important for clinicians to be familiar with the original protocol, script, and justification for each clinical modification.

Informed Consent for EMDR

What It Is

Eye Movement Desensitization and Reprocessing (EMDR) is a structured psychotherapy modality designed to help individuals process distressing memories and reduce their emotional impact. EMDR is supported by extensive research and is an effective treatment for trauma and other distress-related conditions.

What to Expect

- EMDR focuses on processing specific memories, reducing their emotional intensity, fostering adaptive beliefs, creating narrative and integrating experience.
- Sessions typically last 60 to 90 minutes.
- The process involves alternating bilateral stimulation, often using eye movements, self tapping or TheraTapper or other methods, while focusing on a targeted memory.
- You may experience strong emotions or physical sensations during and after sessions. These are a normal part of the processing experience.
- Additional thoughts, memories, or dreams may arise between sessions as your brain continues to process.

Key Considerations

1. **Stabilization and Readiness:** Before starting memory processing, we will ensure you have the necessary skills and resources to stay emotionally stable. Imaginal resources, such as a comfortable place or protective figure, will be introduced and practiced to support you.
2. **Trauma Processing and Pacing:** Processing a single memory may take multiple sessions, especially if related memories surface that also need to be addressed. The therapy will proceed at a pace that feels manageable for you.
3. **Crisis Plan:** If you already have an existing crisis plan, it will be reviewed prior to beginning trauma processing. EMDR therapy itself is not expected to lead to crisis, as it is conducted with your stability and readiness in mind.
4. **Pregnancy:** Unless circumstances warrant, pregnant individuals are advised to delay trauma processing due to the potential emotional intensity involved.
5. **Legal Considerations:** If you are involved in legal proceedings, please be aware that EMDR can potentially influence memory recall, and its effects on memory accuracy are not guaranteed. Discuss this with your therapist if this applies to you.

Possible Reactions

- While EMDR is generally safe and effective, you may experience temporary increases in emotional or physical sensations as memories are processed.
- Some clients report temporary fatigue or vivid dreams as part of the natural integration process.

Your Rights

- You have the right to ask questions about EMDR at any time.
- You may withdraw consent and discontinue EMDR at any point.
- Follow-up sessions will be scheduled to review progress and ensure continued stability.

Acknowledgment and Consent

I have read and understood the above information about EMDR therapy. I have had the opportunity to ask questions and discuss any concerns. I understand the potential benefits, risks, and limitations of EMDR therapy and consent to participate.

Client Name (Printed): _____

Client Signature: _____ **Date:** ____/____/____

Relative Contraindications for Reprocessing Trauma Memories (Using Any Version of EMDR Protocol)

This method of traumatic reprocessing should be used by skilled clinicians with:

- Knowledge and thorough understanding of current trauma theory; the physiology of trauma and the neuroscience behind it.
- Adequate assessment skills for determining appropriateness of candidates. (See: Quick Assessment EMDR for Readiness (Parnell, 2007))
- Adequate supervision/consultation.
- Clinical skills to handle abreaction; flooding, dissociation and “flashbacks” related to traumatic material.
- The knowledge of his/her own expertise and to work within the scope of those abilities.
-

While there are several relative contraindications that require careful consideration and preparatory work before proceeding, there are few ABLSolute contraindications. However, certain situations are generally considered as potentially unsuitable for initiating EMDR therapy without significant modifications or precautions:

- **Active Psychosis:** EMDR is not typically recommended for individuals experiencing active psychotic symptoms such as hallucinations or delusions until these symptoms are stabilized, as the therapy could potentially exacerbate these conditions.
- **Severe Dissociative Disorders:** For those with conditions like Dissociative Identity Disorder (DID), the integration of dissociated or fragmented aspects of the personality might be necessary before EMDR can be safely used.
- **Current Severe Substance Abuse:** Clients actively abusing substances may lack the necessary stability and ability to tolerate the emotional and psychological stress that can arise during EMDR processing. EMDR could increase emotional distress temporarily, which they might try to manage through increased substance use.
- **Unstable Medical Conditions:** Clients with serious medical conditions that could be worsened by intense emotional stress (e.g., recent heart attack) might need to stabilize these conditions before undergoing EMDR therapy.
- **Pregnancy:** As a precaution, some practitioners advise against starting EMDR therapy during pregnancy due to the emotional intensity of the process, which could potentially cause increased stress, therefore increased stress hormones (adrenaline and cortisol) that cross the placenta.

While the above situations may represent ABLSolute contraindications in certain contexts, they often require nuanced clinical judgment. Many contraindications can be addressed through preparatory work within EMDR therapy itself or through other supportive interventions. The decision to proceed with EMDR should always be made on a case-by-case basis, assessing the individual’s overall clinical picture and the potential benefits and risks of the therapy.

The Original 8 Phase EMDR Protocol

(Shapiro, 1995, 2001, 2002, 2005)

Phase 1: Client History and Treatment Planning:

A complete biopsychosocial history, including current and past medical status, family and childhood history-including neglect, abuse and traumatic events (big “T” and little “t” trauma), and any/all current symptoms. The clinician usually shares his/her impression with the client, and then proceeds to co-create a plan for treatment.

Phase 2: Preparation

If client and clinician agree that EMDR will be used in therapy, then clinician must prepare the client for the work ahead.

1. Some degree of rapport and trust must be established between the client and clinician.
2. The process should be explained fully; client should have a basic understanding of EMDR; effects and side effects; and some idea of the actual process-session length etc.
3. The client’s concerns and fears are addressed; safety procedures are discussed and set in place.
4. The therapist resources client with self-soothing, affect regulation and arousal reduction techniques.
5. If applicable, the client chooses type of alternating bilateral stimulation-auditory, tactile or eye movement.

Phase 3: Assessment

The assessment phase begins the essence of the EMDR process. The client chooses the traumatic experience (Target) for the session. He/she is asked to evoke the image that represents the worst part of the traumatic experience. The client links words to the image (or experience) that expresses a global negative cognition (NC) about him/herself in the present time. After that, the client is asked what he/she would like to believe about him/herself in place of the negative cognition. (PC) Using a seven-point VOC scale, (0=false-7=completely true) the client assesses the validity of the positive cognition (VOC) relative to the target experience. The client describes the emotions associated with the target event and rates the disturbance on a (0-10) Subjective Units of Distress Scale (SUDS). Finally, the client describes the related body sensations.

Phase 4: Desensitization

The desensitization process begins with the client holding in focus the traumatic image; his/ her negative cognitions about the self/world; emotions and body sensations associated with the traumatic incident. A set (or round) of Alternating Bilateral Stimulation is introduced. It may take the form of hand movements or moving lights in the client’s field of vision; alternating tones to the ears; or alternating taps on the hands. These sets of Alternating Bilateral Stimulation may last from thirty seconds to several minutes, depending on the client’s response. At the completion of each set, the client is asked to clear his/her mind and to allow whatever comes in awareness. After giving a short description of what has come up, another set (or round) of Alternating Bilateral Stimulation is introduced. Over many sets of bilateral stimulation, the therapist guides the client thorough the processing of whatever comes to mind.

Phase 5: Installation of Positive Cognition

When the processing of the traumatic material is complete, as measured by the amount of residual disturbance of the incident (SUDS=0), the PC is then revisited and re-scaled (0-7 on the VOC scale) as to validity in the presence of the original incident. Sets (or rounds) of Alternating Bilateral Stimulation are again applied until the PC is experienced as being totally valid (VOC=7).

Phase 6: Body Scan

The client is asked to once again evoke the original incident and mentally scan his/her body. If sensations or lack of sensations are reported, short sets (or rounds) of Alternating Bilateral Stimulation are then applied until the sensation subsides or a positive feeling is experienced.

Phase 7: Closure

It is very common for clients to continue processing traumatic material for days or even weeks after a session, some insights, vivid dreams, strong feelings, intrusive thoughts, or recollections past experiences. These experiences may feel unfamiliar, disorganizing and or confusing; however, clients should be prepared for them and reassured that they are just part of the healing process. Clients should be instructed to write them down and bring them back to session. If the client becomes overwhelmed or flooded, he/she should be instructed to call the therapist and therapists should be prepared to return calls in a timely manner.

Phase 8: Re-evaluation

At the beginning of the next session, the client assesses and reviews the week, talking about any new sensations or experiences. The disturbance of the previous session's target experience is assessed to help decide on the course of action

EMDR *Research-Based* Session Protocol

(Shapiro, 1995, 2001, 2008)

- ◆ Explain Trauma Paradigm
- ◆ Explain Session (What and How)
- ◆ Decide on type of ABLS (visual, auditory, tactile)
- ◆ Establish safety word/hand signal if client should need to stop
- ◆ Establish metaphor
- ◆ Resource client via installation and guided visualization; safe place, protection and support, or conflict-free image, and nurturing and/or protector figures
- ◆ Identify traumatic memory
- ◆ Identify image that represents worst of the incident
- ◆ Get the NC (Negative Cognition)
- ◆ Get the PC (Positive Cognition)
- ◆ Get a VOC (Validity of Positive Cognition) Rating Scale (1-7)
- ◆ Identify emotions
- ◆ Get SUDS rating (0-10)
- ◆ Locate and identify body sensations
- ◆ Desensitize to SUDS (0-1)
- ◆ Identify PC
- ◆ Ascertain VOC rating (6 or 7)
- ◆ Install PC
- ◆ Perform a body scan
- ◆ Close
- ◆ Debrief

EMDR *Modified* Session Protocol

(Parnell, 2007)

- ◆ Identify the problem
- ◆ Resource client-using guided visualization, evoke and install safe place and/ or protection and support; and/or nurturing figure
- ◆ Identify an image or picture that represents the worst part of the memory
- ◆ Identify emotions
- ◆ Identify body sensations
- ◆ Identify NC
- ◆ SKIP SUDS
- ◆ Desensitize (Near the end of the processing i.e. when the negative affect has significantly subsided, then you can get a SUDS level and adaptive cognition)
- ◆ Get a SUDS
- ◆ Get the PC (Present, Adaptive Cognition)
- ◆ Install the AC.
- ◆ Skip the VoC
- ◆ Perform a body scan (Skip if time limited)
- ◆ Closure: Be sure that client is properly debriefed; currently embodied; and oriented to time, place, and person.

Prerequisites to Processing Memories

First & Foremost

- An empowered, informed client in a strong, therapeutic relationship with an attuned clinician.

Client Education

- Discuss EMDR and what to expect (before, during and after reprocessing)
- The nature of trauma and memory
- What is expected of the client
- Possibility of high level of affect
- If client has history of addictive behavior, may experience urges to use
- Discuss Common Issues/Problems CPTSD: Suicidal tendencies, self-harm, harm to others, cutting, dangerous addictions, DID, etc.

Informed Consent

- May be formal/verbal/written or all of the above (See manual)

Resources and Adequate Safety & Stabilization

- Emotion recognition & regulation, i.e. the ability to be regulated—(self regulation & interpersonal regulation)
- Skills: mindfulness, grounding & centering
- Guided Imagery for Container/Calm Place/Protection/Nurture
- Outside Resources (Who & what else can client count on)
- Alternative plan instead of using/addiction
- Relaxation and stress management

The Mechanics of EMDR

- Explain the process and procedures
- Explain theratapper and alternatives forms of alternating bilateral stimulation (eye movements or auditory tones).

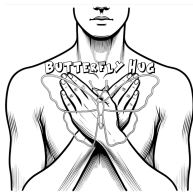
Quick Assessment (with client) EMDR for Readiness*
(Parnell, 2007, Curran, 2014)

- 1) Do you have rapport? Is there mutual trust? Do both client & clinician generally feel safe and connected. Is client committed to safety and treatment?
- 2) What supports can client consistently count on outside of therapy?
- 3) Is the client is able to to track and report his/her internal experience.
- 4) Is the client able to shift states from distressed to calm in and out of the office? Can s/he handle high levels of affect?
- 5) Have the therapist and client explored the client's "creative adaptations." Does the client appreciate how these past behaviors were once helpful (even life-saving) but presently may disrupt both connection and healing?
- 6) Is client in active addiction? Does the client self injure or engage in other self- harming behaviors?
- 7) Is client able to benefit from multisensory guided imagery for safety, protection, nurture, etc.?
- 8) Does client require a physician consultation to assess physical health? Does the client require a psychiatric and/or medication evaluation?
- 9) Does the client have a DID diagnosis? Is the client's preferred method coping dissociation? (Dissociative Experience Scale. II)
- 10) Is the client involved in an active legal case? (criminal or civil)

*This pertains to ANYBODY with whom you plan to use EMDR, e.g. colleague

(6 copies of Modified Script)

Be Very Familiar with the Following
Modified Script



- ☒ Ask client to choose the traumatic incident (Target) for trauma processing session. Ask for a label/title for the memory. Write down label. Do not open/activate memory.

TARGET: _____

- ☒ **REACTIVATE ALL RESOURCES**

- ☒ Remind the client that this is a memory; it had a beginning, a middle and an end. This process gets the body to know that it's over. (Rothschild)

NO TAPPING WHILE ACTIVATING MEMORY NETWORK

Phase Three: Assessment ACCESS-MENT (accessing entire traumatic neural network)

Begin “accessing the entire neural network” using the questions below. (***EXCEPTION: If the client reports s/he is activated, instruct client begin tapping; you have just begun Phase 4, Desensitization*** (Continue script from there. Do Not return to this page...No more questions, client is processing)

1. Ask client to evoke the image that represents the worst part of the traumatic incident

IMAGE: _____

2. Ask client, “When holding that **IMAGE**, what emotions come up?”

EMOTIONS: _____

3. “When holding that **IMAGE** and feeling those **EMOTIONS**, what do you notice in your body? What body sensations do you notice?”

BODY SENSATIONS: _____

4. When holding that **IMAGE** and feeling those **EMOTIONS** and noticing all of those **BODY SENSATIONS**, what do you believe about yourself?

NEGATIVE BELIEF*: _____

* The negative belief may be about the self or the world (depending on locus of control)

5. With that belief, while holding that **IMAGE** and feeling those **EMOTIONS** and noticing all of those **BODY SENSATIONS**, where zero is neutral or no disturbance and 10 is the worst disturbance or distress that you can imagine, where are you now? (with this **ENTIRE NEURAL NETWORK ACTIVATED**)

0..... 1.....2..... 3..... 4..... 5..... 6..... 7..... 8..... 910

Neutral/No Distress/Disturbance

Worst Disturbance

Once client reports SUDs rating, **Instruct the client to begin tapping.**

Phase 4: Desensitization

Read: “OK, now you are just going to ‘run the scene’ ‘Allowing whatever happens to happen, you’ll just notice. ‘Whatever comes up, without censoring anything, just notice.’ Just allow the scene to play out.’ (Reminder: therapist can offer the client imaginal resources at any time)

Continuously monitor client’s non-verbals for signs of processing i.e., facial expression, breathing rate and pattern, change in affect, (and of course, his/her verbal cues as well)

After several minutes of monitoring, ask the client, “Is this an OK time to check in, **OR would like more time?**” If clients says **yes** to check in, then instruct him/her to **Stop tapping**. Ask the client to “Take a deep breath in and out and let go of everything.” Then, “What are noticing now?” or “What comes up for you now?”

(If the client wants to give a short description or share anything, that's fine (but not necessary))

When client finishes the description (*unless client says, “Nothing is coming up” or “I’m stuck,”*) instruct him/her to just notice whatever is up, and ask “Is it OK to go with that? If yes, **Instruct client to begin tapping**.

(Reminder: therapist should continue breathing deeply and audibly to remind client's neurobiology to do the same)

Read “Again, just let whatever happens, happen. You are just allowing the scene to go by. Again, you are just observing”

(Reminder: therapist can offer the client imaginal resources at any time)

Continuously monitor client's non-verbals for signs of processing i.e., facial expression, breathing rate and pattern, change in affect, (and of course, his/her verbal cues as well)

After several rounds, **Instruct client to stop tapping**. Ask the client to bring up the original image. When client has image, re-rate the level of disturbance (SUDS)

Read: “With that image up, please rate your disturbance level, where zero is neutral or no disturbance and ten the worst disturbance or distress that you can imagine, where are you now?”

0..... 1.....2..... 3..... 4..... 5..... 6..... 7..... 8..... 910

Neutral/No Distress/Disturbance

Worst Disturbance

If >0 Say, “What keeps it from being a zero?” **Whatever** the client says, therapist responds, “Is it OK to you go with that?” **Instruct client to begin tapping**.

Continuously monitor client's non-verbals for signs of processing i.e., facial expression, breathing rate and pattern, change in affect, (and of course, his/her verbal cues as well)

(Reminder: therapist can offer the client imaginal resources at any time)

After several minutes of monitoring, ask the client, “Is this an OK time to check in or would like more time?” If clients says yes to check in, then instruct client to **Stop tapping**. Ask the client to take a deep breath in and out. Ask client, “What are noticing now?” or “What comes up for you now?” Unless client says, “nothing” or “I’m stuck,” instruct him/her, “Is it OK to go with that?” Instruct client to **Begin tapping**.

(Reminder: therapist can offer the client imaginal resources at any time)

After several rounds, instruct the client to **Stop tapping** and bring up the original image and re-rate the level of disturbance (SUDS)

Read: “With that image up, please rate your disturbance level, where zero is neutral or no disturbance and ten the worst disturbance or distress that you can imagine, where are you now?”

0..... 1.....2..... 3..... 4..... 5..... 6..... 7..... 8..... 910

Neutral/No Distress/Disturbance

Worst Disturbance

If >0 Say, “What keeps it from being a zero?” **Whatever** the client says, therapist responds, “Is it OK to you go with that? Now, we’ll **begin the tapping again**” or “Just focus on that as we begin tapping again.” **Instruct client to start tapping**.

After several minutes of monitoring, ask the client, “Is this an OK time to check in or would like more time?” If clients says yes to check in, then instruct client to **Stop tapping**. Ask the client to take a deep breath in and out. Ask client, “What are noticing now?” or “What comes up for you

now?” Unless client says, “nothing” or “I’m stuck,” instruct him/her, “Is it OK to go with that?” Instruct client to **Begin tapping.**

(Reminder: therapist can offer the client imaginal resources at any time)

After several rounds, instruct the client to **Stop tapping** and bring up the original image and re-rate the level of disturbance (SUDS)

Read: “With that image up, please rate your disturbance level, where zero is neutral or no disturbance and ten the worst disturbance or distress that you can imagine, where are you now?”

0..... 1.....2..... 3..... 4..... 5..... 6..... 7..... 8..... 910

Neutral/No Distress/Disturbance

Worst Disturbance

If >0 Say, “What keeps it from being a zero?” **Whatever** the client says, therapist responds, “Is it OK to you go with that? Now, we’ll **begin the tapping again**” or “Just focus on that as we begin tapping again.” **Instruct client to start tapping.**

Repeat until traumatic material is fully processed (SUDS 0–1)

When Suds is zero. Begin **Phase 5**

DO NOT MOVE ON TO PHASE 5 UNTIL SUD's =0

Phase 5: Installation of Positive Cognition

“Keeping that original image up, What do you believe about yourself now? If adaptive, instruct client to keep image up and **begin tapping** **Shorter sets-only about 5-10 seconds**

Phase 6: Body Scan

With the original image up, begin to mentally scan your body. “Beginning at the crown of your head and going down to your feet, I want you to pay attention for any discomfort any unpleasant sensations. Tell me if you notice any” If client reports any unpleasant sensations, instruct client to focus on sensation and “**begin tapping.**” **Shorter sets-only about 5-10 seconds.** Instruct client to **Stop tapping.** Continue to scan the remainder of body. If client reports any unpleasant sensations, instruct client to focus on sensation and “**begin tapping.**” **Shorter sets-only about 5-10 seconds.** Instruct client to **Stop tapping.** Have client continue the scan until negative sensation subsides or a positive feeling is experienced.

Phase 7: Closure

Explain to the client that it is very common that s/he will continue to process the session’s material for a bit of time. Explain to the client that s/he should prepare for insights, vivid dreams, strong feelings, intrusive thoughts, or recollections of past experiences. Encourage client to write down anything that feels pertinent and bring it to the next session. Be clear that although these experiences may feel unfamiliar, disorganizing and confusing, they are indeed, part of the healing process.

Phase 8: Next Session reevaluate memory (check original image and re-rate SUDS)

Steps to EMDR

When and how long to use ABLS

1. Create safety - the client must have the skills to stay stable or you **DO NOT move out of phase 1.**
2. Activate all imaginal resources (**add shorts sets of Alternating Bilateral Stimulation, ABLS**) to bring on relaxation (you cannot be anxious and relaxed simultaneously).
3. Access memory network (no **ABLS**) until memory network is fully activated.
4. Desensitization (continuous **ABLS**)

(* If using the Theratapper is only off during check in. While on, you are continuously varying the rate (speed) so the brain does not acclimate to the pattern and stop paying attention (recall the example of the noise of the air conditioner, we do not notice it when it is consistently on, but we notice a change when it turns off).

5. Adaptive Cognition gets paired with original image (**ABLS** short sets).
6. Body Scan - scan body for residual arousal connected to memory (**ABLS** short sets).
7. Close session - get patient back into the here and now, embodied and oriented x3: Who are you? Where are you? When are you?
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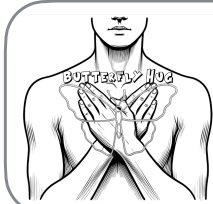
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5. With that belief, while holding that **IMAGE** and feeling those **EMOTIONS** and noticing all of those **BODY SENSATIONS**, where zero is neutral or no disturbance and 10 is the worst disturbance or distress that you can imagine, where are you now? (with this **ENTIRE NEURAL NETWORK ACTIVATED**)

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After several minutes of monitoring, ask the client, “Is this an OK time to check in, **OR would like more time?**” If clients says **yes** to check in, then instruct him/her to **Stop tapping**. Ask the client to “Take a deep breath in and out and let go of everything.” Then, “What are noticing now?” or “What comes up for you now?”

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Repeat until traumatic material is fully processed (SUDS 0–1)

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Phase 5: Installation of Positive Cognition

“Keeping that original image up, What do you believe about yourself now? If adaptive, instruct client to keep image up and **begin tapping** **Shorter sets-only about 5-10 seconds**

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With the original image up, begin to mentally scan your body. “Beginning at the crown of your head and going down to your feet, I want you to pay attention for any discomfort any unpleasant sensations. Tell me if you notice any” If client reports any unpleasant sensations, instruct client to focus on sensation and “**begin tapping.**” **Shorter sets-only about 5-10 seconds.** Instruct client to **Stop tapping.** Continue to scan the remainder of body. If client reports any unpleasant sensations, instruct client to focus on sensation and “**begin tapping.**” **Shorter sets-only about 5-10 seconds.** Instruct client to **Stop tapping.** Have client continue the scan until negative sensation subsides or a positive feeling is experienced.

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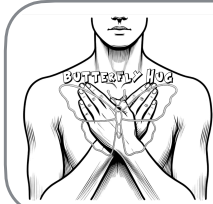
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(Reminder: therapist can offer the client imaginal resources at any time)

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Repeat until traumatic material is fully processed (SUDS 0–1)

When Suds is zero. Begin **Phase 5**

DO NOT MOVE ON TO PHASE 5 UNTIL SUD's =0

Phase 5: Installation of Positive Cognition

“Keeping that original image up, What do you believe about yourself now? If adaptive, instruct client to keep image up and **begin tapping** **Shorter sets-only about 5-10 seconds**

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With the original image up, begin to mentally scan your body. “Beginning at the crown of your head and going down to your feet, I want you to pay attention for any discomfort any unpleasant sensations. Tell me if you notice any” If client reports any unpleasant sensations, instruct client to focus on sensation and “**begin tapping.**” **Shorter sets-only about 5-10 seconds.** Instruct client to **Stop tapping.** Continue to scan the remainder of body. If client reports any unpleasant sensations, instruct client to focus on sensation and “**begin tapping.**” **Shorter sets-only about 5-10 seconds.** Instruct client to **Stop tapping.** Have client continue the scan until negative sensation subsides or a positive feeling is experienced.

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Phase 8: Next Session reevaluate memory (check original image and re-rate SUDS)

Steps to EMDR

When and how long to use ABLS

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5. Adaptive Cognition gets paired with original image (**ABLS** short sets).
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7. Close session - get patient back into the here and now, embodied and oriented x3: Who are you? Where are you? When are you?
8. If session was completed and closed, when the client returns for following session you will re-activate the original image and rates SUDS (if above 0-1, continued desensitization until SUDS equals zero, then to steps 5-8).

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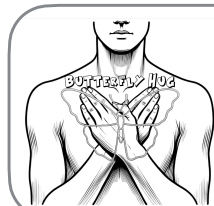
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 3. Wrap up (put memories in container), then bring patient back to present and embodied*
- *Remember EMDR produces an altered state
3. **Modify Intelligently:** Know what you're modifying and why you're doing it..

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- 1) Do you have rapport? Is there mutual trust? Do both client & clinician generally feel safe and connected. Is client committed to safety and treatment?
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- 10) Is the client involved in an active legal case? (criminal or civil)

*This pertains to ANYBODY with whom you plan to use EMDR, e.g. colleague



- ☒ Ask client to choose the traumatic incident (Target) for trauma processing session. Ask for a label/title for the memory. Write down label. Do not open/activate memory.

TARGET: _____

- ☒ **REACTIVATE ALL RESOURCES**

- ☒ Remind the client that this is a memory; it had a beginning, a middle and an end. This process gets the body to know that it's over. (Rothschild)

NO TAPPING WHILE ACTIVATING MEMORY NETWORK

Phase Three: Assessment **ACCESS-MENT** (accessing entire traumatic neural network)

Begin “*accessing the entire neural network*” using the questions below. (**EXCEPTION: If the client reports s/he is activated, instruct client begin tapping; you have just begun Phase 4, Desensitization** (Continue script from there. Do Not return to this page...No more questions, client is processing)

1. Ask client to evoke the image that represents the worst part of the traumatic incident

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4. When holding that **IMAGE** and feeling those **EMOTIONS** and noticing all of those **BODY SENSATIONS**, what do you believe about yourself?

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** The negative belief may be about the self or the world (depending on locus of control)*

5. With that belief, while holding that **IMAGE** and feeling those **EMOTIONS** and noticing all of those **BODY SENSATIONS**, where zero is neutral or no disturbance and 10 is the worst disturbance or distress that you can imagine, where are you now? (with this **ENTIRE NEURAL NETWORK ACTIVATED**)

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Read: “OK, now you are just going to ‘run the scene’ ‘Allowing whatever happens to happen, you’ll just notice. ‘Whatever comes up, without censoring anything, just notice.’ Just allow the scene to play out.’ (Reminder: therapist can offer the client imaginal resources at any time)

Continuously monitor client’s non-verbals for signs of processing i.e., facial expression, breathing rate and pattern, change in affect, (and of course, his/her verbal cues as well)

After several minutes of monitoring, ask the client, “Is this an OK time to check in, **OR would like more time?**” If clients says **yes** to check in, then instruct him/her to **Stop tapping**. Ask the client to “Take a deep breath in and out and let go of everything.” Then, “What are noticing now?” or “What comes up for you now?”

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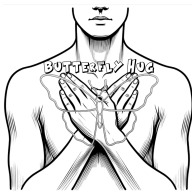
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Behavioral Rehearsal/Future Template Script

1. List any needed future actions or behaviors that came up as a result of processing the memory. Which of these actions do you feel would be difficult or impossible to confront/perform now or in the future?

2. From the above actions or behaviors, choose the one that would be most helpful for you presently?

3. ***“Now, imagine yourself performing that action. Let me know if there is any distress or disturbance.”***

- If distress or disturbance is reported, add a short set (5-10 seconds) of alternating bilateral stimulation, while the client continues imagining him/herself performing the action/behavior.

4. ***“Now, as you imagine yourself performing the action. Let me know if there is any distress or disturbance.”***

- If distress or disturbance is reported, add a short set (5-10 seconds) of alternating bilateral stimulation, while the client continues imagining him/herself performing the action/behavior.

5. Once the client is able to imagine the scene without disturbance, begin installing the future template:

“Now, imagine yourself performing that action/behavior. Only this time you will hold both (the scene of performing the action or behavior) along with a positive, self-referencing thought.”

6. Once the client is holding both, add a short set (5-10 seconds) of alternating bilateral stimulation.

7. Repeat these short sets as long as you continue to get positive change.

Definitions of Key Terms

(Excerpted from EMDR Deconstructed, Curran, Ilaria, 2025)

Adaptive Information Processing (AIP) Model The theoretical framework developed by Francine Shapiro that explains how unresolved traumatic memories are stored dysfunctionally and contribute to distress. EMDR helps reprocess these memories into an adaptive state (Shapiro, 2001)

Alternating Bilateral Stimulation (ABLS) A fundamental component of EMDR therapy involving alternating stimuli to the left and right sides of the body. This can be done through guided eye movements, tactile tapping, or auditory cues. The process aims to facilitate the reprocessing of traumatic memories by enhancing cognitive and emotional regulation.

Types of Alternating Bilateral Stimulation:

- Eye Movements: Guiding clients to move their eyes side-to-side.
- Tapping: Alternating taps on the hands or knees.
- Auditory Stimuli: Alternating sounds played between ears.
- Rhythmic Movements: Physical actions such as drumming, swaying, and dancing movements, which can also provide bilateral stimulation through body awareness and rhythm.

Key Benefits:

1. Decreased Emotional Charge: Reduces emotional intensity linked to memories.
2. Integration: Helps incorporate memories into adaptive cognitive frameworks.
3. Hemispheric Synchronization: Proposes that alternating stimulation enhances synchronized activity between both brain hemispheres, facilitating communication.
4. Dual Attention: Indicates that focusing on both external stimuli and internal memories can balance emotional experiences and cognitive processing.
5. Brainwave Modulation: Posits that ABLS may influence brainwave patterns, leading to a change in mental state conducive to memory processing (e.g., Harper et al., 2014; Shapiro, 2001).
6. Memory Activation: Prompts the brain to activate and process traumatic memories.

Altered States of Consciousness (ASC) A shift in awareness or perception that can occur during trauma work, dream states, meditation, or psychedelic-assisted therapy. EMDR can help process and integrate insights or distressing content from these states.

ART (Accelerated Resolution Therapy) A therapeutic approach developed by Laney Rosenzweig that incorporates elements of EMDR and uses voluntary image replacement and eye movements to help clients reduce distress associated with traumatic memories.

Behavioral Rehearsal A therapeutic practice where clients mentally rehearse adaptive actions or responses to future challenges. ABLS is used to reinforce the emotional and cognitive associations tied to these mental rehearsals.

Body Scan A structured EMDR step where clients tune into their body to detect and reprocess any lingering distress related to a trauma memory. This differs from a mindfulness body scan, which focuses on present-moment awareness without reprocessing.

Closure The final phase of an EMDR session, aimed at returning the client to their window of tolerance and reorienting them to the present. This step may involve guided imagery, ABLS, grounding exercises, and reminders of client resources.

Completion of Truncated Survival Responses The process of guiding clients to notice and symbolically or physically “complete” a survival response (e.g., fight, flight, freeze) that was interrupted during a traumatic event. This can involve subtle somatic gestures, guided imagery, or ABLS to facilitate emotional and physical release.

Constant Installation of Present Orientation and Safety (CIPOS) A grounding technique developed by Joany Spierings designed to help clients stay oriented and present during trauma work by using ABLS and orientation cues to reduce dissociation. Spierings' contributions to CIPOS are outlined in EMDR-related training materials and workshops.

Depersonalization A dissociative experience where an individual feels detached from their own thoughts, feelings, or body, as though they are observing themselves from the outside. Clients may describe a sense of unreality or emotional numbness.

Derealization A dissociative experience where the external world feels unreal, dreamlike, or distorted. Clients may describe a sense of detachment from their surroundings.

Dissociation A disconnection between thoughts, memories, emotions, or sense of self. Dissociation ranges from mild (e.g., daydreaming) to severe (e.g., dissociative amnesia). It can be a protective response to overwhelming trauma.

Ego States A concept that describes distinct parts of the self, each holding specific memories, emotions, and beliefs. Ego states may function independently or in response to particular triggers and are often categorized into protective, wounded, and nurturing roles. These states can be worked with in therapy to foster communication and integration.

Ego States Therapy An approach that integrates the concept of ego states to support internal communication, enhance self-compassion, and achieve greater internal harmony. It is often used in trauma therapy to help clients process complex trauma and work toward reintegration of dissociated parts. Techniques may include dialoguing with parts, using imaginal rescripting, and employing ABLS to stabilize and support collaboration between ego states.

EMD (Eye Movement Desensitization) The original version of EMDR, focusing solely on desensitizing disturbing memories by using eye movements and reducing emotional distress without linking adaptive beliefs.

EMDR (Eye Movement Desensitization and Reprocessing) The standard EMDR approach that includes desensitization, re-pairing adaptive beliefs, and integration of somatic sensations during processing.

EMDR 2.0 An adaptation of EMDR that emphasizes the use of faster bilateral stimulation, heuristics for detecting stuck points, and enhanced cognitive interweaves to improve the efficiency and outcomes of trauma processing.

EMDR R-TEP (Recent Traumatic Episode Protocol) A comprehensive early EMDR intervention (EEI) protocol developed by Elan Shapiro and Brurit Laub that incorporates and extends the EMD and EMDr protocols to address a traumatic episode rather than a single event. The protocol is outlined in Shapiro & Laub's publications (e.g., Shapiro & Laub, 2008) and emphasizes multiple Points of Disturbance (PoDs) that require desensitization and reprocessing.

Flash Technique A modified approach developed by Philip Manfield designed to reduce distress without directly accessing the trauma memory by focusing on a low-distress positive image while using ABLS. This method is often used for clients who are highly dysregulated.

Manfield's work on this technique is documented in his publications and workshops, such as Manfield et al. (2017).

Flash-Forward Protocol A method used to address anticipatory anxiety and fears of future events, originally developed by Roger Solomon and Andrew Leeds, by reprocessing imagined scenarios with ABLS to build adaptive responses.

Fractionated Processing A technique in EMDR where the processing of trauma memories is broken into smaller, manageable segments to avoid overwhelming the client. This approach allows for gradual desensitization and integration of traumatic material while maintaining the client's sense of safety and stability.

Imaginal Rescripting A technique used to rework painful or distressing memories by visualizing adaptive, supportive scenarios. This may include:

- ◆ Introducing a protective figure to intervene in the memory.
- ◆ Creating a "do-over" where the client's current self acts differently.
- ◆ Altering the narrative to reinforce the client's sense of agency and control.

Imaginal Resources Tools used in therapy to build internal stability, confidence, and resilience through guided imagery and ABLS. The resources listed below are examples, and many more can be created and adapted based on client needs:

- ◆ Competent Adult Self: A representation of the client's present-day self who is capable of making thoughtful, adaptive decisions.
- ◆ Comfortable Place: A guided imagery exercise that helps clients access a sense of calm, comfort, and well-being.
- ◆ Container: A mental image designed to contain distressing thoughts and emotions temporarily
- ◆ Nurturer: An imaginal resource representing care and compassion.
- ◆ Protector: An imaginal resource representing strength and safety.
- ◆ Triumphant Self: A version of the client embodying courage and success.
- ◆ Wise Self: A resource symbolizing wisdom and perspective.

◆ **Motorway Analogy** A metaphor used to describe different levels of processing focus in EMDR protocols (EMDR Solutions Online Ltd., 2022):

- ◆ EMD: A single narrow lane, focusing solely on desensitization.
- ◆ EMDr: A few lanes with a slightly broadened focus to stay within the target memory's network.
- ◆ Full EMDR: All lanes open, allowing free association and integration across memory networks.

Dual Attention Stimulus (DAS) A component of EMDR that involves maintaining focus on both an external stimulus (e.g., eye movements, tapping, auditory cues) and an internal memory or thought. This process helps the client balance emotional responses and cognitive processing while accessing traumatic memories.

Neurolinguistic Programming (NLP) A therapeutic and communication approach that explores the connection between neurological processes, language, and behavior patterns. NLP techniques, such as reframing and anchoring, are referenced in discussions about EMDR due to overlapping elements in eye movements and sensory processing.

PREC1 (Progressive Counting and EMDR Integration) A technique that integrates progressive counting with EMDR principles to help clients process trauma in a structured, step-by-step way, reducing overwhelm and promoting stability.

Re-pairing (also known as Installation of Positive Cognition) The process of linking an updated, adaptive belief (e.g., "I am strong") to the original trauma image during EMDR processing.

Recheck A follow-up during later sessions to assess whether the trauma memory has been fully desensitized and the adaptive belief feels true. If residual distress remains, processing may continue.

Resource Development and Installation (RDI) A method that strengthens positive internal resources (e.g., calmness, courage, nurturance) by combining guided imagery, adaptive beliefs, and ABLS to "anchor" these resources into the client's nervous system. Developed by Korn and Leeds (2002) as part of EMDR's preparation phase.

Restricted Processing A structured, contained form of EMDR that focuses on a manageable aspect of distress without processing all associated trauma memories or networks.

Unrestricted Processing A comprehensive approach to EMDR that allows for the full desensitization and integration of associated trauma memories, often accessing multiple connected memories

Frequently Asked Questions

Question: What's the difference between EMDR:RDI *Resource Development and Installation* protocol developed by Korn & Leeds (2002) and Parnell's *Resource Tapping*™?

“RDI refers to a set of EMDR-related protocols which focus exclusively on strengthening connections to resources in functional (positive) “memory networks” (Leeds & Shapiro, 2000; Shapiro, 1995) while deliberately not stimulating dysfunctional (traumatic) memory networks. The addition of bilateral stimulation differentiates RDI from earlier hypnotic ego-strengthening methods in the hypnotherapeutic tradition. Again, the inclusion of the bilateral stimulation in the protocol appears to lead to spontaneous, rapid increases in affective intensity within an initially selected memory network and to rich, emotionally vivid associations to other functional (positive) memory networks. These increases in intensity of positive emotions and new functional associations bring additional ego-strengthening material into consciousness. Patient reports of these changes during RDI lead to other RDI procedural steps that may further reinforce the patient's ability to access affective, cognitive, and behavioral coping skills linked to these functional memory networks when the patient is later confronted by stress-related stimuli.”*

The term *Resource Tapping*™ a.k.a. *Tapping In* was coined and written about by Laurel Parnell in her book of the same name. *Tapping In* is using a combination of imaginal resources and alternating bilateral stimulation (in this case, tactile stimulation, where the client taps on his or her own knees or collar bones—first on the left side, then on the right side, then the left side, then the right side, etc..) The clinician instructs the client to bring up positive imagery of comfort, nurture, empowerment, connection, etc.. Once the client has the image up, s/he is instructed to experience it as fully as possible, while noticing the emotions and body sensations that accompany the positive imagery. As the client experiences the positive imagery, emotions and body sensations, s/he is then instructed to begin tapping alternate sides of the body (the tapping is added to bring on the relaxation response.)

Citation: Korn DL, Leeds AM. Preliminary evidence of efficacy for EMDR resource development and installation in the stabilization phase of treatment of complex posttraumatic stress disorder. *J Clin Psychol.* 2002;58(12):1465-1487. doi:10.1002/jclp.10099

Question: What is *EMDR Early Intervention (EMDR EI)*?

EMDR Early Interventions (EIs) are EMDR-based procedures that were developed to treat individuals and groups after a recent traumatic event. They are used to address the fragmented nature of memories of recent events, before the memory is consolidated into an integrated whole. The interventions are usually provided as short-term treatments, and can be administered in an intensive (e.g., daily) manner, as group therapy or individual therapy. ...a number of research studies have shown that EMDR EI treatments significantly reduce traumatic stress, and there is preliminary evidence that they may foster resilience.

The most commonly used and most researched interventions:

- *EMDR Protocol for Recent Critical Incidents (EMDR-PRECI)* and *EMDR Integrated Group Treatment Protocol (EMDR-IGTP)* Jarero and Amame
- *Shapiro and Laub's Recent Traumatic Episode Protocol (R-TEP)* and *Group Traumatic Episode Protocol (G-TEP)*. Elan Shapiro and Brurit Laub in Israel

What is *Feeling-State Image Protocol* According to its developer, Robert Miller, PhD: <http://www.imttherapy.com/> The FS treatment breaks the fixation between feeling and behavior. This fixation is the cause of addictions. By identifying the exact feeling and behavior, the fixation can be processed using a modified form of the 'EMDR protocol. Once the fixation is broken, there are no further cravings or urges that have to be controlled or behavior that has to be managed. In fact the person is able to perform the behavior as appropriate.

Because any feeling can become fixated with any behavior, identifying the exact feeling and behavior are crucial steps in the FS treatment procedure. For example, shopping has many different sub-behaviors such as going into the store, having people wait on you, trying on clothes, buying the items etc. any one of these parts of shopping may be behavior that creates the most intense positive feeling. The behavior that creates the most intense positive feeling is the particular behavior that has to be identified.

In addition to identifying the exact behavior, the exact feeling also has to be identified. A shopping compulsion might be connected with the feelings of power, status, relaxation or being special. Whatever the feeling is, FS treatment requires the the intensely desired positive feeling underlying the compulsive fixation be identified.

Once the exact feeling and behavior has been identified then the ImTT processing protocols are used to process the fixation. The exact number of sessions varies due to the fact that more than one feeling may become fixated with the same behavior in order to completely eliminate the compulsive fixations, all the feelings must be processed.”

Treatment of Behavioral Addictions Utilizing the Feeling-State Addiction Protocol: A Multiple Baseline Study

What Is VirtualEMDR? <https://virtualemdr.com/>

According to the website:

The program is developed and tested extensively with practitioners. It is specially designed to:

- Use at home without a therapist
- Suit both beginners and experienced EMDR users
- Provide easy, interactive step-by-step guidance
- Utilize latest technology to deliver effective Eye Movement processing
- Address all interaction preferences through customizable multimedia options
- Require only a computer or tablet, no special equipment needed!

What Is remotEMDR?

According to the website <https://remotemdr.com/>, **remotEMDR** is a patent based platform, that uses a unique technology, in order to equip EMDR therapists with holistic solution for online EMDR therapy. It enables the therapist to control and monitor the presentation of the BLS remotely, while it runs synchronously on both his computer and his client's computer. Virtual EMDR is an online, self-guided mental health treatment program based on the established science of Eye Movement therapy. It is a full remote EMDR therapy platform, featuring:

- A wide variety of visual and auditory BLS stimuli
- Client management system
- Embedded video-chat
- Secure HIPAA compliant solution, including BAA
- Continuous software updates
- Full support - by email and online meetings

FAQ's Regarding Evergreen's EMDR Certification

◆Do I have to be certified to use EMDR?

Certification is optional and not required to use EMDR; however, going through the EMDR-C certification process demonstrates that you are competent in both knowledge and understanding of complex trauma and EMDR skills. It is important to note that, while EMDR is a relatively easy skill to learn, processing traumatic memories is very difficult and requires additional training in complex and developmental trauma. Having the EMDR-C credential establishes trust with both clients and employers that you not only learned the EMDR skills, you have the proper training in trauma to use those skills, and have practiced using them with an EMDR expert.



◆How do I know if I can use EMDR within my scope of practice?

There is no such thing as an EMDR regulatory board that holds any authority or power over clinicians. Your licensing board is the regulatory entity that defines your scope of practice and is the entity that grants you an independent license to practice psychotherapy. Any questions about what you're "allowed" to do should be directed to your licensing board.

◆Is there a "correct" way to be trained in EMDR?

In terms of ethics, there is nothing in any mental health ethics code that states that you cannot utilize EMDR techniques unless you complete a particular training from a specific organization. Ethics codes are not prescriptive, of course. If the concern is competence, that you are not competent in EMDR after a certain training course, and that makes the practice of EMDR unethical, the burden is on the individual making the accusation of an ethical breach to show that the clinician is incompetent to practice EMDR (not just to casually state it). There has not been a precedent set for this, as clinicians are ill-equipped to judge other clinicians' competence unless we are sitting in sessions with them to see whether we personally believe them to be competent. When we attempt to limit other clinicians' work we inadvertently may hurt those clients, as we rob clinicians of the ability to practice in a manner that is consistent with, and faithful to, their licensure, with techniques that can benefit their clients.

◆How much training does it take for a licensed clinician to learn and use EMDR?

Part of being an independently licensed professional is that the licensing board puts trust in you to be able to determine, for yourself, when and under what circumstances you are competent to practice different psychotherapeutic skills. This clinical judgment is part of your licensure, part of the trust that is put in you when you become licensed. When you attend a CBT training and receive a worksheet on cognitive restructuring, do you use that worksheet with clients, to help them, if you understand the worksheet and feel competent in using it? What about a narrative therapy course? Might you incorporate narrative tools after taking a narrative course? Of course you do. The same applies here; the idea that EMDR is fundamentally different from other therapies is incorrect; it is a trauma-focused, exposure-based therapy that includes mindfulness, relaxation, cognitive restructuring, and somatic work, and none of these elements are unique to EMDR. The way they are put together is in fact unique, but the building blocks of EMDR are the same for many therapies. And many have argued that the BLS component of EMDR actually makes it "safer," not less safe, than other trauma-focused therapies. There is nothing inherently complicated or "dangerous" about EMDR; it holds the same risks as Cognitive Processing Therapy or Prolonged Exposure, which are also evidence-based, trauma-focused therapies that clinicians are expected to be able to implement in their practice after 2-3 days of training.

◆Why should I become an Evergreen Certified EMDR Clinician (EMDR-C)?

Emphasis on becoming a trauma treatment expert is a unique facet that sets this EMDR certification apart from others in the field. To be truly trained and skilled at EMDR, you need to know quite a bit about trauma, including having some level of expertise in complex, developmental trauma. Earning the EMDR-C credential demonstrates that you are not only trained in EMDR skills, you also have the proper training and expertise in trauma to fully integrate EMDR into your clinical repertoire. Once your certification application is approved, you will receive a digital badge that can be used to display your achievement online.

For information regarding Evergreen Certification, please visit:

<https://www.evergreencertifications.com/>

EFT Basic Recipe

Before You Begin

Identify the specific problem and observe how it feels: thoughts, sensations, and emotions that are associated with the issue. Using a SUDS (Subjective Units of Distress Scale) rate your distress from 0– 10 (0=no distress, 10= the worst distress you can imagine)

Follow the four components of the “Basic Recipe”

1. The Setup

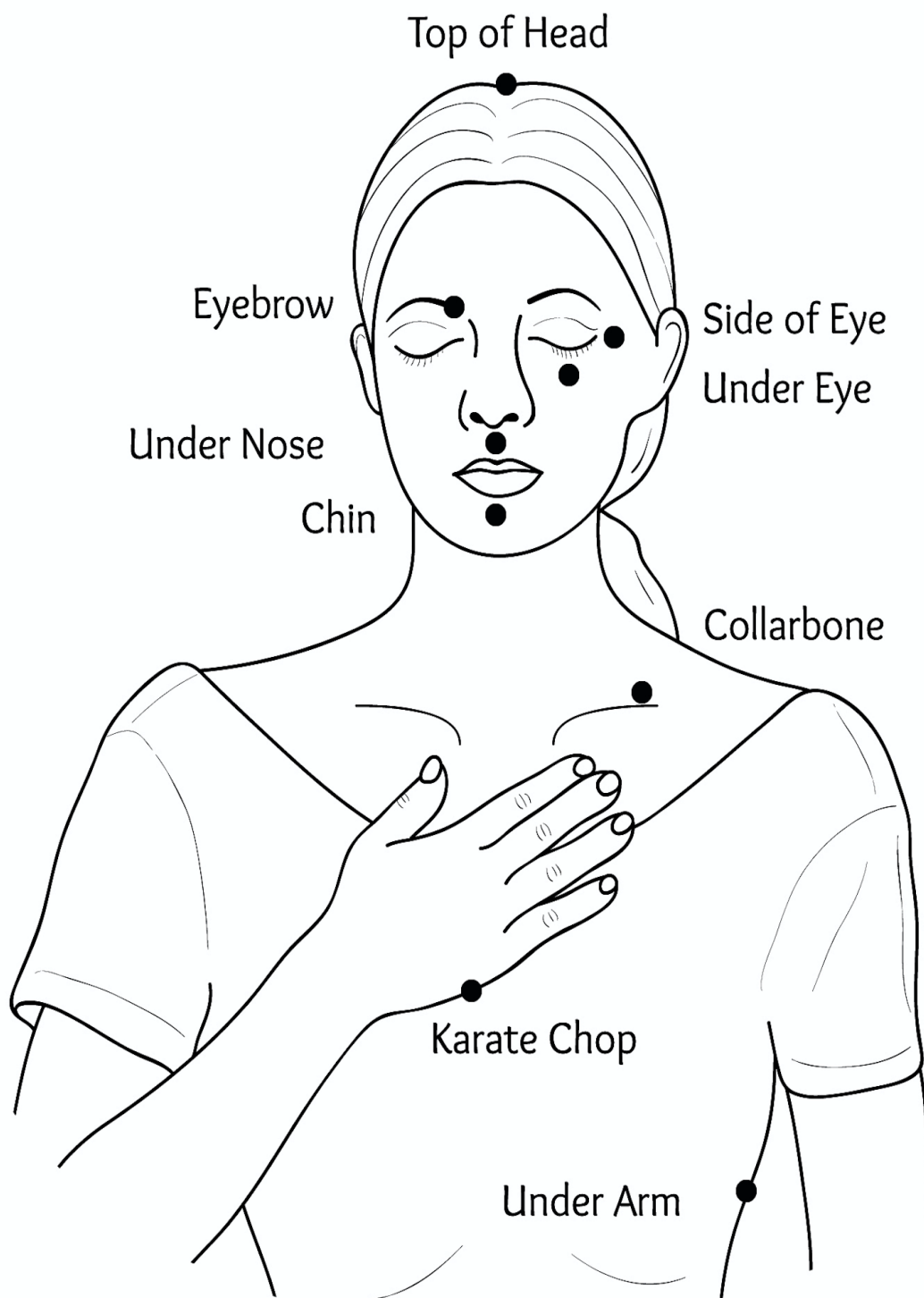
- Start your EFT process by tapping firmly on your Karate Chop point.
- Setup Phrase: Next, bring up the negative emotion and/or problem you want to address.
- Note the SUDS level from 0 to 10 (0=none 10=worst).
- Then say the following statement three times and with some degree of conviction, (aloud if possible-though not necessary), as you firmly tap on the Karate Chop point: “Even though I have this _____, I accept myself.” (Fill the blank with the negative emotion or issue you want to address.) For example: “Even though I have this craving for chocolate, I completely accept myself” or “Even though I feel so angry at him, I completely accept myself.”

2. The Sequence

- Once the setup step is complete, place your index finger and middle finger together.
 - Using the tips of these fingers, tap about seven times on each of the following meridian points.
 - Tap firmly, but not so hard that you bruise or hurt yourself. (Most of the tapping points exist on either side of the body. It doesn’t matter whether you tap on the right side or the left, nor does it matter if you switch sides during the Sequence. For example, you can tap under your right eye and, later in the Sequence, tap under your left arm.)
 - As you tap on these points, it is necessary to keep your mind tuned to the issue you are resolving with EFT.
 - To do that, say a Reminder Phrase: “This _____ (issue)…” as you tap on each of the points.
 - Using the above example for the problem of chocolate craving, the Reminder Phrase would be, “This craving for chocolate.”
 - Going down the face and the body, gently tap on the following points as you say your Reminder Phrase, “This _____ (issue),” starting from:
 - ❖ EB = Beginning of the Eye Brow (either the left or right one).
 - ❖ SE = Side of your Eye (of either left or right eye, tap on the boney part the eye socket right at the corner of your eye.
- (Don’t get too close to the eye that you hurt yourself, but don’t go too far off that you are tapping on your temple.)
- ❖ UE = Under the Eye (of either left or right eye, again on the boney part of the eye socket, about 1 inch below the pupil.)
 - ❖ UN = Under the Nose (on top of the lip)
 - ❖ CH = Chin (midway between chin and the bottom of lower lip).
 - ❖ CB = Beginning of the Collar Bone (where the breastbone, collarbone, and first rib meet)
 - ❖ UA = Under the Arm (about 4 inches below your arm pit on either side).
 - ❖ TH = Top of the Head
 - ❖ Sore Spot
 - ❖ Karate Chop

3. The 9 Gamut Procedures

After completing the Sequence, you are now ready to carry out “The 9-Gamut Procedure.” This procedure fine-tunes the brain via eye movements, humming, and counting so as to enhance the effects of the tapping. It tunes the brain to the right frequency for the problem. Through connecting nerves, certain parts of the brain are stimulated when eyes are moved. Likewise, the right side of the brain is engaged when you hum a song and the left side is engaged when you count. During this procedure, nine of these brain stimulating actions are performed



EFT Tapping Points

while simultaneously and continuously tapping “the Gamut Point.” While continually tapping on the Gamut Point, carry out all the following:

Brain-Balancing steps

1. Close your eyes
2. Open your eyes
3. Eyes hard down right while holding the head steady (stimulates kinesthetic sensations and memory)
4. Eyes hard down left while holding the head steady (internal dialogue)
5. Roll the eyes in a circle clockwise (stimulates visual and auditory memory and imagination)
6. Roll the eyes counter-clockwise (as above)
7. Hum “Happy Birthday”, or any song, for 2 bars (this engages the right brain)
8. Count to 5 (this engages the left brain)
9. Hum “Happy Birthday”, or any song, for 2 bars again (this engages the right brain)

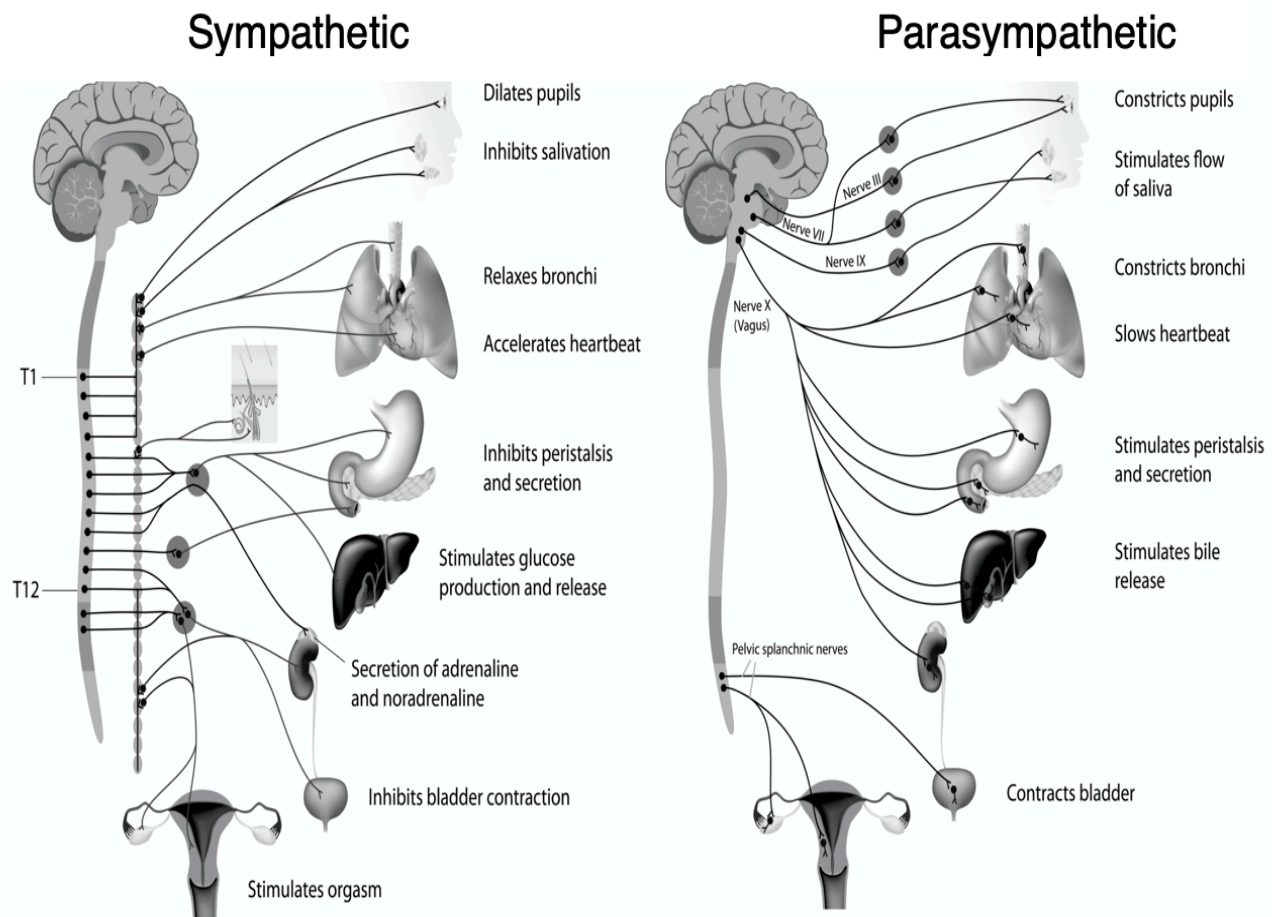
4. The Sequence (once again):

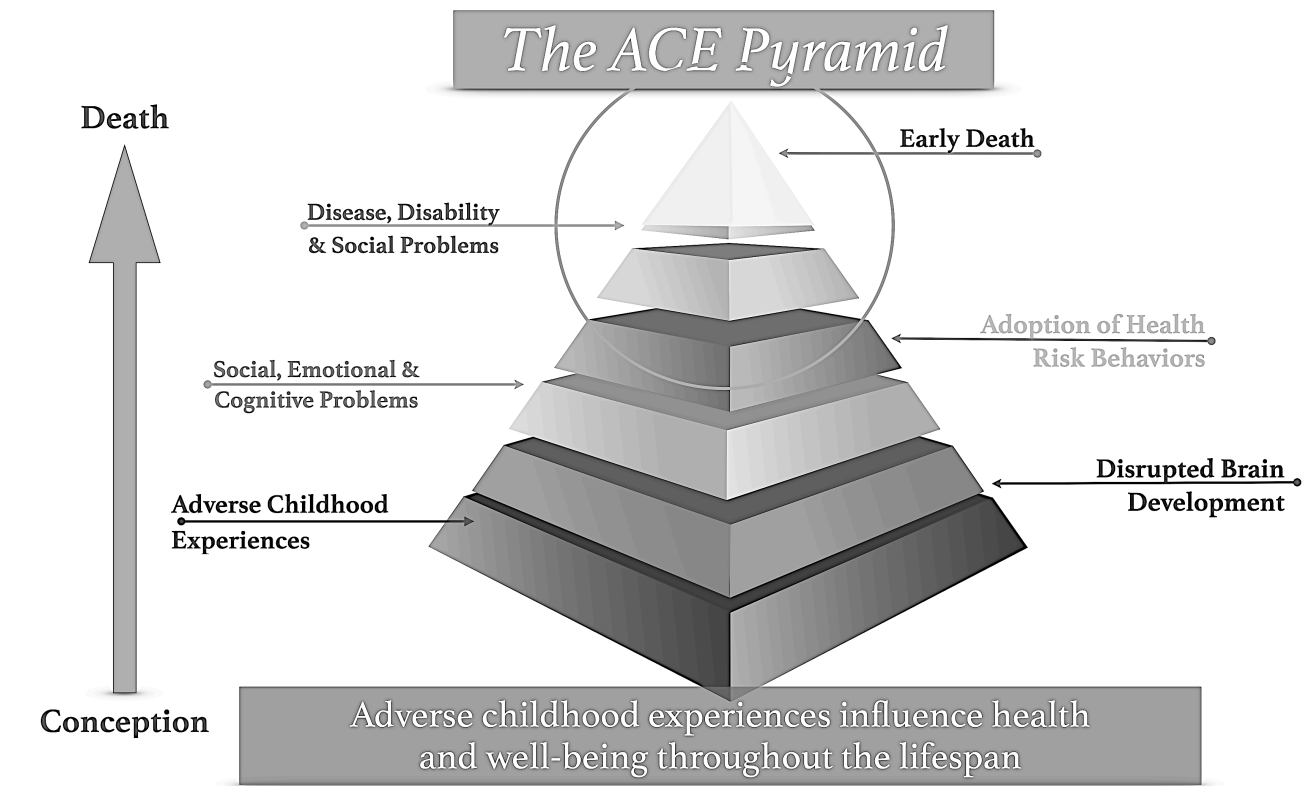
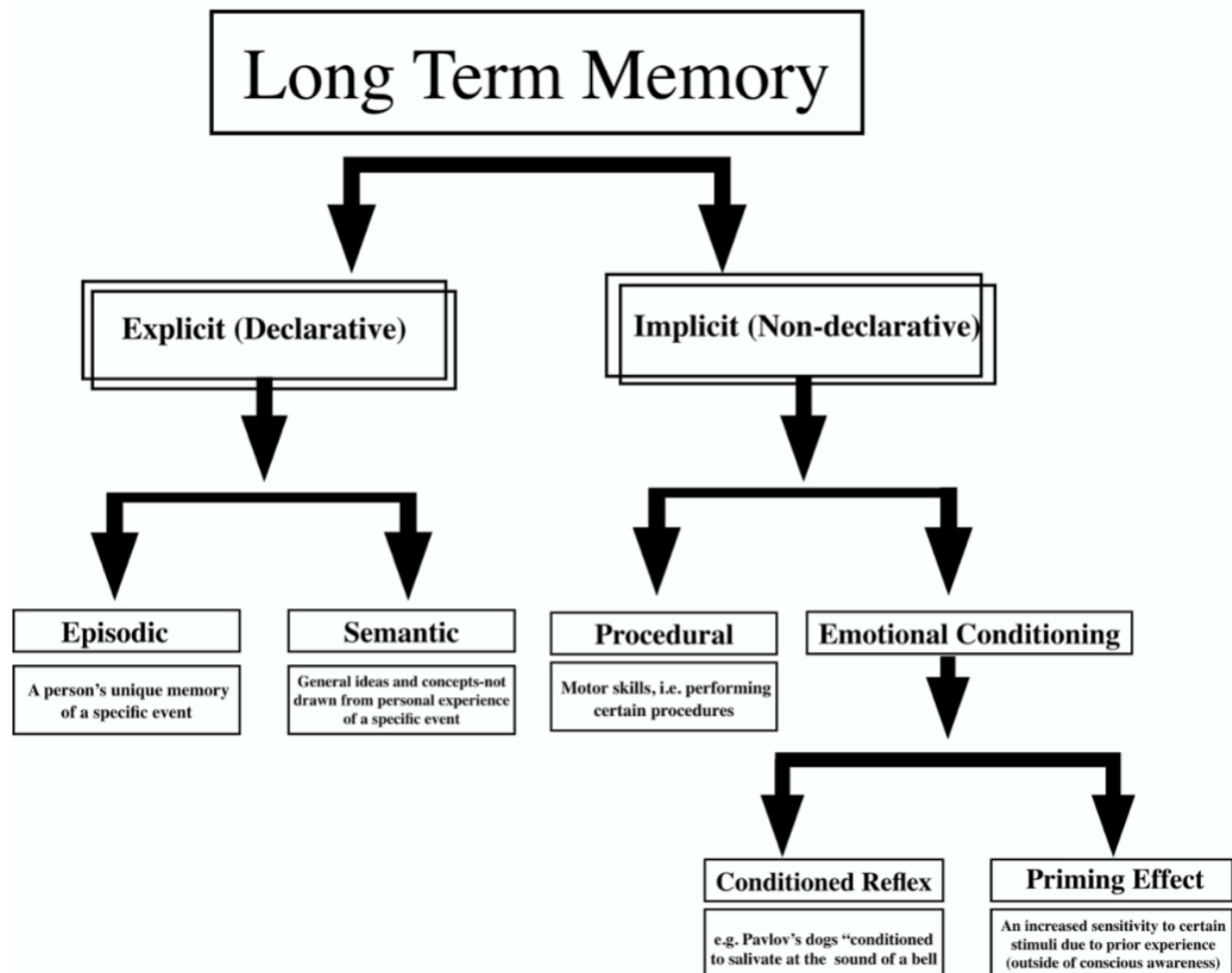
After completing The 9-Gamut Procedure repeat the whole Sequence.

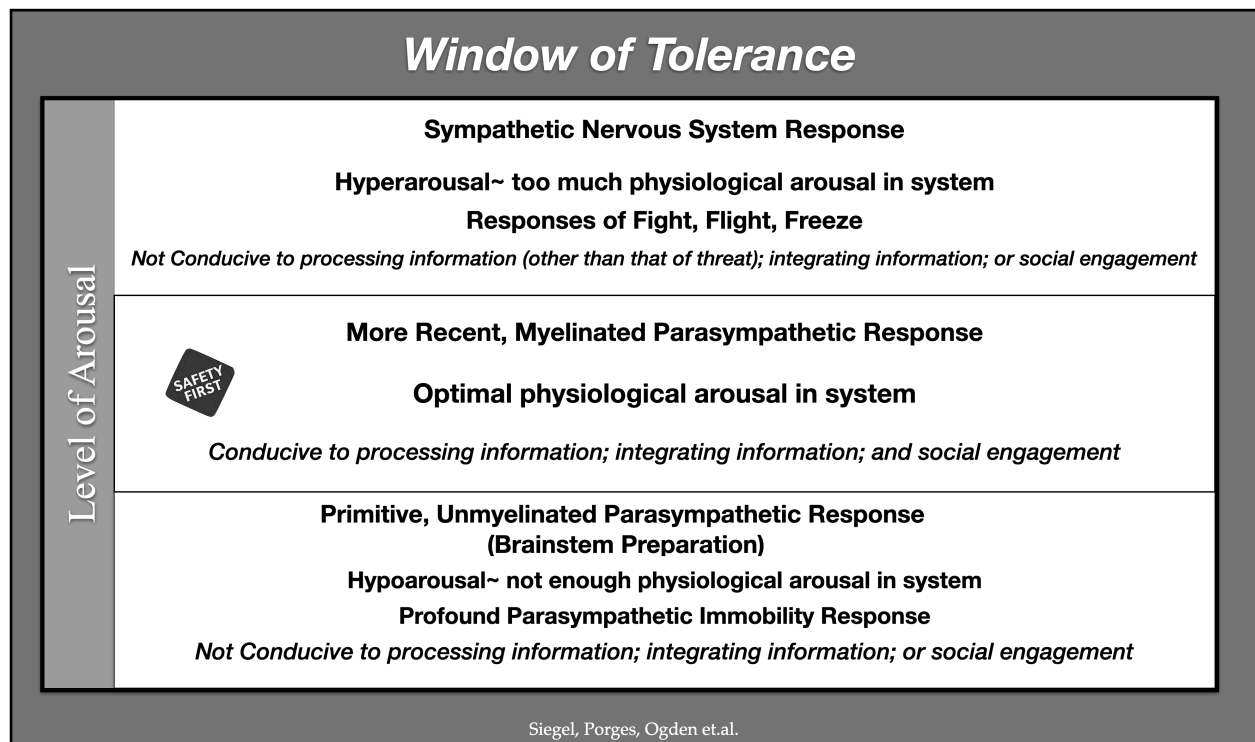
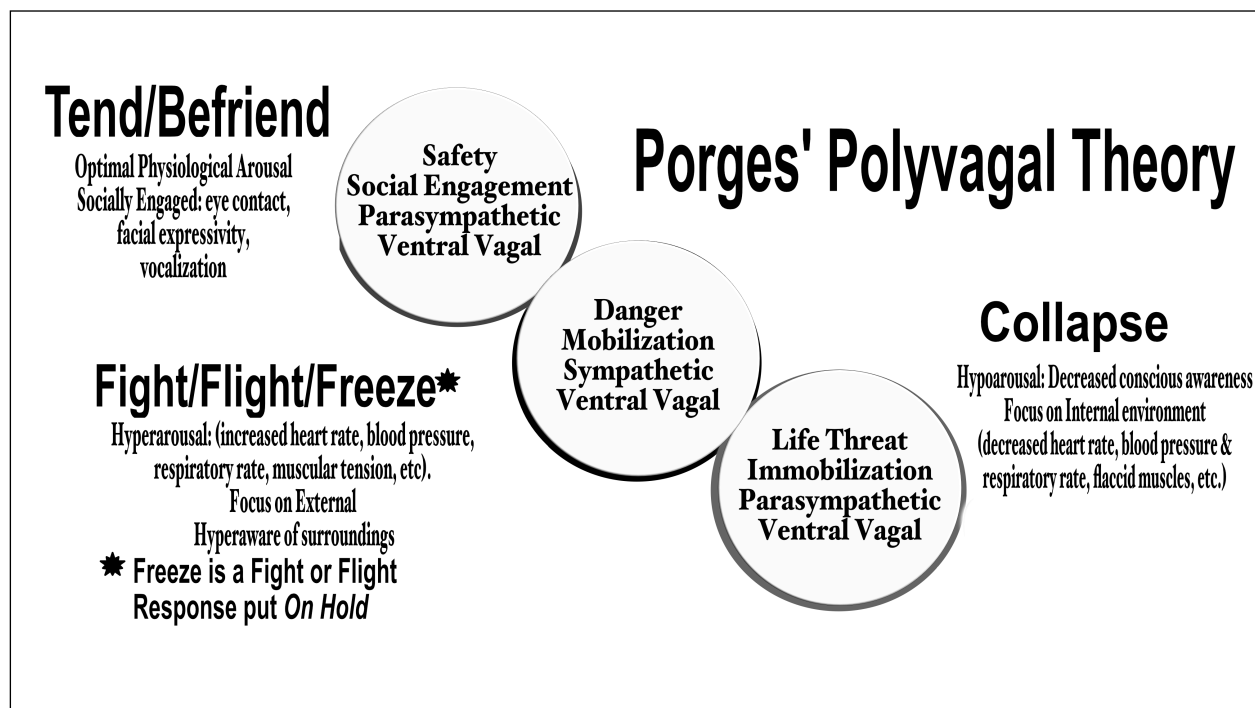
- ❖ Take a Deep Breath, Check-In, and Reassess.
- ❖ After each round of EFT, take a deep breath in and gently breathe out.
- ❖ Take a moment to check in with yourself.
- ❖ Notice how you are feeling now, physically and emotionally; notice what thoughts, memories, or emotions are up for you
- ❖ Without judging yourself right or wrong, just observe.
- ❖ Next, reassess the intensity level of the problem.
- ❖ What is the intensity level now? If you are at a 0, you are done.
- ❖ Congratulations! If not, you may need to do one or more subsequent rounds until you feel the intensity has gone down to 0.

ENLARGED SLIDES

Autonomic Nervous System







Mandatory Readings

1. Quick and Dirty: EMDR's Development, Research & Current Modifications for Developmental & Complex Trauma (where EMDR is today)
2. Trauma 101: A Prerequisite for the Use of Any and All Trauma Technique
3. Virtual EMDR Therapy: A Clinician's Reference
4. Chapter 2: Dissociation and Complex Trauma: Comprehensive Assessment and Strategies for Modifying Treatment The Most Important Chapter (**everything in red**)
5. Window of Tolerance
6. Assessing for Complex Trauma and Dissociation: A Practical Clinical Resource for Trauma Clinicians
7. Stabilization & Readiness Assessment
8. Chapter 3: Enhancing Resilience: Integrating Multisensory Guided Imagery and ABLS for Resource Development

Reading #1 (Extra Copy)

Quick and Dirty: EMDR's Development, Research & Current Modifications for Developmental & Complex Trauma

The myth*: In 1987, graduate student Francine Shapiro was walking in the park when she made a personal discovery; she observed that involuntary randomized eye movements seemed to diminished her own disturbing thoughts (Colwell, 2000). From that initial experience, Shapiro brought those eye movements under voluntary control and integrated them with “other treatment elements” and created a new psychotherapy that she called Eye Movement Desensitization (EMD) (EMDR 2004). To investigate this new psychotherapy further, she conducted a controlled study with twenty-three (23) participants with traumatic memories and Post-Traumatic Stress Disorder (PTSD) symptoms. In the study, the participants were first asked to rate their feelings of distress and/or discomfort regarding a particular traumatic memory using the Subjective Units of Disturbance (SUDs) scale, which is a 0-10 rating system. Participants were also asked to think of a Positive SelfStatement (PSS) that they would like to attach to the memory, erasing and replacing the negative one currently associated with the memory. Participants when evaluated their confidence in the veracity of the PSS (now called Validity of Cognition) on a Likert scale from 1-7, where 1 was completely false, and 7 was completely true.

On average, before treatment the participants reported a SUDs score of seven and reported the validity of the PSS as four. After only one EMD session, participants on average rated the memory as less than one on the SUDs scale, and the positive self-thought was receiving ratings above six. These results remained unchanged three months later (Lipke & Botkin, 1992), leading Shapiro to assert “a single session of the procedure was sufficient to desensitize participants” (EMDR, 2004).

By 1991, Shapiro changed the name of the therapy to Eye Movement Desensitization and Reprocessing (EMDR) to reflect how the therapy not only desensitizes traumatic material, but also changes negative self-thoughts. Shapiro refers to this shift as the Adaptive Information Processing (AIP) Theory (EMDR Institute, 2004).

Historical Context: the Construction of EMDR

EMDR wasn't created out of thin air. Francine Shapiro developed it in the late 1980s by integrating techniques from existing psychotherapeutic approaches, including exposure therapy, cognitive therapy, Neuro-Linguistic Programming (NLP), and psychodynamic therapy.

This history underscores that EMDR's tools are built on well-established practices. They aren't just effective—they're adaptable, giving clinicians the freedom to use them flexibly and safely.

- **Influence of Exposure Therapy (Systematic Desensitization)** (Not Flooding) Joseph Wolpe's systematic desensitization (1958) paired gradual exposure to fears with relaxation techniques to reduce anxiety. It was a breakthrough for its time, but Shapiro made it better. She kept the gradual exposure but replaced relaxation with alternating bilateral stimulation (ABLS). 156

Why ABLS instead of relaxation? Progressive muscle relaxation (PMR), commonly used in systematic desensitization, helps create a temporary state shift, calming the nervous system. But that's where it stops—it doesn't process the underlying trauma. ABLS, on the other hand, not only calms the nervous system but also facilitates information processing.

Shapiro initially believed eye movements mimicked REM sleep, helping the brain "digest" trauma. While that hypothesis didn't hold up, research supports ABLS as effective for reducing distress and integrating traumatic memories (Lee & Cuijpers, 2013). By swapping relaxation for ABLS, Shapiro turned desensitization into a more dynamic, trauma-processing tool.

• **Some Heavy Lifting from Neuro-Linguistic Programming (NLP)** Shapiro's background in NLP heavily influenced EMDR's core techniques. NLP, developed by Richard Bandler and John Grinder in the 1970s, focused on creating rapid emotional and cognitive shifts through methods like anchoring, submodality adjustments, and dissociation (Bandler & Grinder, 1979). Shapiro adapted and reframed these strategies for trauma therapy.

- ❖ **Anchoring → Resource Development and Installation (RDI)** In NLP, anchoring links a positive emotional state to a specific trigger (e.g., a touch or sound). Shapiro took this concept and added ABLS, turning it into Resource Development and Installation (RDI). With RDI, ABLS strengthens internal resources like calmness or confidence, making them more accessible when clients face challenges.
- ❖ **Submodality Adjustments → Desensitization with ABLS** NLP uses submodality adjustments altering the sensory qualities of a memory (e.g., making it smaller or farther away)—to weaken its emotional impact. EMDR achieves a similar outcome with ABLS, which naturally reduces the intensity of distressing memories without requiring clients to consciously manipulate their mental imagery.
- ❖ **Safe Distancing → Visual-Kinesthetic**
- ❖ **Dissociation (VKD)** NLP's "movie theater technique" asks clients to imagine watching a memory on a screen to create emotional distance. Shapiro adopted this distancing but paired it with ABLS, which allows clients to stay detached while actively reprocessing traumatic material.

• **Massive Contribution from Cognitive Therapy** Cognitive therapy, developed by Aaron Beck in the 1960s, focuses on identifying and changing distorted thinking patterns that fuel distress. Shapiro integrated several key elements into EMDR:

Identifying Negative Beliefs: Like cognitive therapy targets automatic thoughts, EMDR identifies trauma-related beliefs (e.g., "I am powerless").

- ❖ **Cognitive Restructuring:** EMDR uses ABLS to reprocess these beliefs, transforming them into adaptive alternatives (e.g., "I am strong and capable").
- ❖ **Cognitive Interweave:** When clients get stuck, EMDR's interweave introduces helpful perspectives, similar to cognitive therapy's guided questioning.
- ❖ **Behavioral Integration:** Cognitive therapy reinforces new beliefs through experiments. EMDR achieves this with "future templates," where clients visualize and rehearse healthier responses to future situations.
- ❖ **Finally and Obviously, Psychodynamic Therapy** Psychodynamic therapy emphasizes the role of unconscious processes and relational dynamics in shaping emotional distress. Shapiro incorporated these principles into EMDR to address how unresolved trauma affects present beliefs, emotions, and relationships.

Uncovering Deep-Seated Traumas: EMDR facilitates access to unconscious material, helping clients address the root causes of symptoms.

Addressing Relational Patterns: EMDR explores how past relationships influence present-day behaviors and beliefs, allowing clients to break harmful cycles.

Holistic Healing: By combining psychodynamic insights with ABLS, EMDR integrates emotional, cognitive, and relational healing, creating a comprehensive trauma resolution process.

Conclusion: EMDR isn't a standalone invention—it's a remix of proven techniques. Shapiro took the best of systematic desensitization, NLP, cognitive therapy, and psychodynamic therapy, then layered in ABLS to create a trauma processing modality that's both effective and adaptable. Understanding this history shows that EMDR's tools aren't rigid—they're modular. Clinicians can break them down, adapt them, and use what works best for each client without compromising effectiveness or safety.

EMDR, the Eight-Phase Process:

First, the therapist determines whether the client is appropriate for EMDR. (THIS ASSESSMENT IS THE MOST CRITICAL STEP).

In phase two, the therapist ensures that the client has the skills to stay stable during and after revisit his/her traumatic experience. Along with building the therapeutic alliance, the development of safety and stability, (via skills building, i.e., emotion regulation, distress tolerance, mindfulness, etc.) is generally the bulk of trauma treatment. (Most Clients DO NOT come to us with single incident trauma, therefore Phases one and two of Shapiro's 8 Phase model may take a week or it may take several years{LAC}).

Phase three begins the actual modality of trauma processing: "accessing" the traumatic memory and rating the distress or disturbance associated with the memory. (Choose which memory to work on: first or worst) As in the initial study, clients evaluate the disturbance caused by the memory, and rate the validity of the new positive self-statement.

Phase four is the desensitization phase, in which the client recalls the memory and its associated imagery, while the therapist provides bilateral stimulation. This can be done by: 1. Instructing the client to shift his/her eyes side to side-visually crossing the midline; 2. Instructing the client to follow a moving light or the clinician's waving finger; 3. Rhythmic hand taps; or 4. Alternating musical tones. (We will be using tactile stimulation via the Theratapper)

In phase five short sets of alternating bilateral stimulation are provided, as the client associates his/her new adaptive cognition with the traumatic memory. Followed by

phase six, where the client scans his/her body to assess for any remaining tension. The client scans his body to assess and release remaining tension in phase six. At this point the actual EMDR modality ends as **phase seven is closure** of the session and reviewing what has been done in the session. **Phase eight** occurs at the following session, when the client once again is instructed to access and re-rate distress currently caused by the memory and the validity of his positive self-statement (Soderlund, 2000).

Similar to both exposure treatments—systematic desensitization and flooding therapies—, EMDR is a kinder, gentler (some would say exposure) method, in that it does not require days, or even weeks, of continued activation of the stress response for desensitization to occur. In fact, it requires fewer sessions and no homework is required. Shapiro's theory, the AIP (Adaptive Information Processing) model posits that ["EMDR activates] an information processing mechanism that is inherent within all of us" (Soderlund, 2000). Shapiro asserts that traumatic experiences are often left "undigested", i.e not adaptively processed, and that EMDR can help clients identify these unprocessed memories and reactivate the mechanism. The EMDR Institute

website explains that the therapy seeks to link traumatic memories and adaptive information that the clients already knows but that has not been connected to the traumatic material.

EMDR's popularity is growing, however, its efficacy is still in dispute due in part to the small size of Shapiro's 1989 study, to the ever-evolving guidelines she and the EMDR Institute impose regarding educational requirements and practice. Initially, Shapiro claimed that the eye movements were an essential part of the therapy, saying, "[T]he primary component of the EMD procedure is the generation of rhythmic, multi-saccadic eye movements while the client concentrates on the memory to be desensitized" (Erwin, 2004). In the late 1980s and early 1990s, EMDR practitioners who were working with blind clients had success using musical tones and hand-tapping. Today, evidence suggests that EMDR can be practiced with bilateral stimulation using auditory, tactile, or visual stimuli (EMDR Institute, 2004).

Early on, Shapiro believed that her dissertation explained EMDR thoroughly enough to enable clinicians to begin to use the technique (Erwin, 2004). As time went on, she thought that therapists could benefit from additional training so she created a one-day workshop for clinicians, which eventually evolved into a lengthy certification process. Initially—and problematically—, clinicians being trained through the EMDR Institute were not allowed to share the technique with other practitioners, which created a “walled-garden” of knowledge that has been criticized by both clinicians and scientists.

Despite the polarizing opinions on EMDR, research continues to be done with particularly positive outcomes in civilian and military populations. Although EMDR's exact mechanism of action remains unknown, given the empirical data, EMDR is “strongly recommended” for treatment of PTSD by the Department of Veterans Affairs/Department of Defense (EMDR Institute, 2004). In an exclusive interview By John Soderlund with Francine Shapiro on why EMDR is a prototypically integrative approach:

“It doesn't matter whether it's eye movements or hand tapping that's being used. It's still the attentional shift. The orienting response has been suggested by a number of researchers as contributing to this. And so at this time, as with any form of therapy, it's impossible to define the neurobiological causes for the effect, but there have been studies by van der Kolk that show neurological differences pre and post EMDR treatment. So, after the EMDR treatment you have different brain structure activation.”

Evidence suggests that modified EMDR can be helpful with patients who have a history of complex trauma (Twombly, 2000). In 2000, Joanne Twombly's study showed that EMDR adaptations helped “facilitate learning, intervene in [Dissociative Identity] Disorder, decrease some negative transferences and provide a protective format for processing traumatic material.” (Twombly, 2000) In a study focusing on the use of EMDR with Dissociative Identity Disorder, Lazarove and Fine recommend modifying EMDR. The changes to the original protocol are minor, and including the addition of the creation of a visualized safe place that can be utilized by the client during sessions, as well as de-emphasizing the post treatment body scan. The researchers suggested that “[Modified] EMDR complements existing strategies for treating DID by offering an alternative method for managing the processing of trauma.” (Lazarove & Fine, 1996) In this training, we will be using a script that has been modified for complex trauma, however, it is important for clinicians to be familiar with the original protocol, script, and justification for each clinical modification.

Reading #2 (Extra Copy)

Trauma 101: A Prerequisite for the Use of Any and All Trauma Techniques

DISCLAIMER: EMDR is an efficient and effective tool for treating clients who have had traumatic experiences and continue to suffer from the aftereffects. Although touted as a complete, complex psychotherapy in and of itself, this training will treat EMDR as in one modality to be added to the skilled clinician's repertoire.

EMDR: A (as in just one, singular, solo) Tool for Trauma Treatment Over thirty years ago, Shapiro (1989) modified Wolpe's (1958) systematic desensitization therapy by replacing progressive muscle relaxation with purposefully induced eye movements. Designed originally as a treatment for traumatic memories, Shapiro dubbed it, Eye Movement Desensitization (EMD). The general idea of it was; the client identified a traumatic target memory, then the therapist would have the client verbalize a self-referent (global, irrational) negative cognition associated with the memory (e.g., I am bad or It's my fault) along with a positive cognition (e.g., I am fine or I did the best I could) to replace the negative one. The therapist would then wave his/ her fingers back and forth in front of the client's eyes, instructing the client to track her fingers visually while focusing on the target memory. After each set of 10-12 eye movements, the therapist would ask the client to provide ratings of distress (Subjective Units of Distress or SUDS) and strength of belief in the positive cognition (Validity of Cognition or VoC). The therapist would repeat this procedure until the client's distress subsided and belief in the positive cognition increased.

It is really a pretty simple protocol-easy to master. Indeed, the protocol is easy to master, but when administered by clinicians without prerequisite knowledge to effectively address and treat trauma's sequelae, this simple protocol proves challenging, fear-inducing and oftentimes traumatizing for clinicians and re-traumatizing for clients.

So there's no misinterpretation of the last sentence, the EMDR protocol is not dangerous. However, any type of trauma work that deliberately activates traumatic memory networks without insisting that client and clinician are adequately prepared to tolerate the effects of that activation is dangerous and irresponsible.

Throughout trauma treatment, the clinician must continuously and vigilantly attend and re-attend to client safety and stabilization. Regardless of the type of trauma processing employed, there can be no substitute for the following; the therapeutic relationship; clinical assessment and judgment; an explicit crisis plan; and instruction in-and acquisition of- skills for affect and emotion regulation, arousal reduction and distress tolerance prior to trauma work. "...EMDR is a trauma resolution method. A trauma resolution method is most appropriately offered as a late stage intervention within a comprehensive trauma informed treatment approach. As therapists who use EMDR, we don't just say to a new client, "Hi, I'm Dr. X. Tell me the worst thing that ever happened to you and follow my fingers." The treatment approach must include a case conceptualization that specifies how the trauma memories are contributing to the presenting complaint--otherwise why do EMDR? And the treatment approach must also provide a systematic way of helping the client to get to a point of being willing and able to tolerate, and benefit from, EMDR." (Greenwald, 2006)

~Excerpted from: The Peanut Butter and Jelly Problem: In Search of a Better EMDR Training Model
Ricky Greenwald, Child Trauma Institute, Greenfield, MA, USA May 2006.

Reading #3

Virtual EMDR Therapy: A Clinician's Reference

Adapted Rollins, Hughes, Cordes, Cohen-Peck & Watson-Wong (2020)

The Therapeutic Alliance Comes First

An Alliance Built On

- Hope, empathy, and trust
- Collaboration on goals and needs
- Mutual understanding and flexibility
- Genuine curiosity and respect

In virtual EMDR, the relationship carries everything proximity normally carries: regulation, attunement, safety, repair. Build it deliberately. The nine practices below apply throughout treatment and are essential during onboarding and Phase 2.

1. Communicate Logistics

- Informed consent specifically for virtual delivery.
- Documented "what if" plan for connection drops — agreed with the client.
- Confirm the client has a private, uninterrupted space.
- Address openly how the screen affects the relationship.

2. Ease Into Online Therapy

- Allow extra time for trust to build in the new environment.
- Extend stabilization and preparation as needed.
- Review and activate all imaginal resources, container, comfortable place, wise self, etc.

3. Establish Safety

- Help the client set up a safe therapy space — door closed, do-not-disturb signal, white noise outside.
- Suggest a water, tissues, comfortable seat/exercise ball, or soft item nearby.
- Use voice, eye contact, and presence to create a calming environment from your end.

4. Normalize Stress And Creative Adaptations

- Anxiety is the body's protective response, not failure.
- Work with the brain and body together to bring the stress response down.
- Teach grounding and self-soothing techniques actively — butterfly hug, alternating knee taps, paced breathing — and use them in early sessions.

5. Attunement Across the Screen

- Slower pacing — give space for screen-delay to settle
- Explicit verbal check-ins ("What are you noticing right now?")
- Watch micro-expressions and breathing rhythm, not just content.
- Name what you observe out loud ("I notice your shoulders just dropped")
- Pre-agreed signals for "slow down," "stop," or "keep going"

6. Assess Before Reprocessing

- Assess the client's appropriateness for reprocessing in a virtual format.
- Determine the client's preferred ABLS/DAS method online.
- Specific plan for what happens if the connection drops during reprocessing.
- Always do full assessment followed by stabilization work before accessing past memory networks.

7. Ground at the End

- Discuss self care and concrete ways for the client to feel safe after the session.

- Confirm the clients oriented *3 Who are you? Where are you? When are you?
- Suggest a transition routine — a walk, a hot or cold beverage, a round of 4/7/8 breaths outside.

8. Instill Hope

- “You do hard things all the time.”
- “We’ll get through this together.”
- “We got this.”

9. Continue to Evaluate

- Check in about ways to improve the experience.
- Ask directly what they like and dislike about the online format.
- Adjust based on what you learn — and tell them you are doing so.

Sources

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Eight Guidelines for Virtual EMDR Practice

These are the structural conditions for safe, ethical, effective virtual delivery.

1.	Ethical Integrity	Applicable laws and licensing standards.
2.	Preparation and Training	Tele-mental health certification plus virtual EMDR training.
3.	Relational Attunement	Adult-ego-state alliance and presence across the screen.
4.	Technical Considerations	Secure electronic office; HIPAA-compliant tools; documented backup.
5.	EMDR-Specific Technique	Clinician-administered DAS; full-midline screen; extended Phase 1–2.
6.	Crisis Management	Plans for abreaction, dissociation, and emergencies in the client's locality.
7.	Payor Sources & Insurance	Verify telehealth coverage. Track changing reimbursement.
8.	Malpractice Insurance	Confirm coverage for virtual delivery and cross-jurisdictional work.

1

Ethical Integrity

Applicable laws and licensing standards.

- **HIPAA compliance.** Use only video platforms with a Business Associate Agreement (BAA). Maintain encryption across video, email, billing, and records storage.
- **Informed consent for virtual delivery.** Beyond standard therapy consent, document the back-up plan for technology failures and crises, agreed communication channels, and the client's option to choose in-person care.
- **Licensing and jurisdiction.** Most states limit practice outside the licensing zone. Consult your board, and the licensing board where the client is physically located, regarding temporary licensure or applicable rules.
 - PSYPACT permits some psychologists to practice tele-health across participating states. Track developments.
- **Cultural awareness.** When working with clients in unfamiliar communities, learn the population. Cultural humility supports outcomes and crisis management.
- **Client environmental security.** Discuss "shoulder surfing," risks of shared computers, and vulnerabilities of public Wi-Fi.

Informed Consent Must Address

- Plans for technology failures and how to respond
- Confidentiality limits when exchanging information online
- Use of HIPAA-compliant tools (BAA in place)
- Billing, payment, and insurance coverage
- Consent to share information with third-party payors

2

Preparation and Training

Tele-mental health certification plus virtual EMDR training.

Standard EMDR training is necessary but not sufficient for virtual delivery. Pursue tele-mental health certification, then advanced training in virtual EMDR. A complete program covers:

Electronic Office

- Hardware setup for professional online practice
- Software for email, video, intake forms, and billing
- Securing equipment, records, and data transmissions
- Insurance considerations specific to virtual delivery
- Legal and ethical responsibilities, including consent

Online Presence

- Webcam and microphone use that supports attunement
- Clarifying unclear processing or speech without interrupting
- Fixing technical issues without disrupting the client

Online EMDR

- DAS methods, equipment, and software
- Attunement across the screen
- Resourcing and containment in the virtual environment
- Preparing new clients for online work

3

Relational Attunement

Adult-ego-state alliance and culturally aware presence across the screen.

- **Adult-ego-state alliance.** Build a working alliance with the client's adult ego state before reprocessing. This is the part of the client you will need when technology fails or processing becomes unclear.
- **Presence across the screen.** Voice, face, pacing, and clarification keep a client engaged and in the window of tolerance.
- **Additional screening.** Use dissociation screens (DES, MID), affect tolerance assessment, and life-stability review before virtual reprocessing.
- **Cultural humility.** When the client lives in a community different from yours, ask. Stay curious. The cultural distance can be larger online than it appears.

4

Technical Considerations

Functional, secure, reliable electronic office. Updated regularly.

Hardware and Peripherals

- Dedicated, high-speed computer that handles video, email, and secure record storage
- HIPAA-compliant video conferencing software with a Business Associate Agreement
- Password protection, anti-virus, and an active update policy
- Reliable, high-bandwidth internet
- Adequately sized screen for full view of the client
- External webcam, headphones, microphone, secure backup, and surge protection where needed
- Smartphone with headphones — required for managing technical or client emergencies
- Any DAS hardware or software needed for bilateral stimulation

Network Security

- Password-protected home or office network, reviewed regularly
- Documented policy for sessions on insecure connections (hotel Wi-Fi, public networks)

Maintenance

- Scheduled equipment maintenance and a documented backup plan
- Annual review of software, encryption, insurance, jurisdictional rules, consent forms, and emergency contacts

5

EMDR-Specific Technique

DAS, pacing, and safety adapted for the virtual environment.

Dual Attention Stimulation

- Delivered in discrete sets, regardless of modality
- **Visual.** Screen large enough for full eye-movement breadth across the midline.
- **Auditory.** Client uses reliable headphones; verify alternating audio is clear and well-timed.
- **Tactile.** Butterfly hug — client crosses arms over chest and alternately taps shoulders — is the primary tactile DAS method in virtual EMDR. Alternatives: alternating knee taps, alternating shoulder taps, or client-controlled tappers and apps.

Safety in Online Sessions

- **Extended Phase 1 and Phase 2.** Clients with affect phobia or limited affect tolerance are at higher risk for dissociation or abreaction. Plan for additional preparation time.

- **Graduated targeting.** Start with smaller, more contained targets. Monitor SUDs closely. Watch for ego-state shifts.
- **Extended closure.** Allow more time for closure than in-person work. The client transitions back to their environment without a shared walk to the parking lot.
- **Consistent follow-up.** Check in at the start of each session about between-session effects. Provide resourcing homework where indicated.

6

Crisis Management

Plans in place before crisis. Local resources, not yours.

Your 9-1-1 cannot respond to a crisis in another locality. Crisis preparation must precede crisis.

Abreaction & Dissociation

- Build the alliance before approaching Phases 3–7.
- Develop a written, agreed-upon plan for what happens if abreaction or dissociation occurs — clinician interventions, client resources, steps for pausing or ending the session.
- Address dissociation that may emerge between sessions, not only during them. Establish how the client will reach you and your response window.

Emergency Preparedness

- Obtain emergency contacts for the client's locality before the first reprocessing session — first responders, local clinics, crisis lines.
- Verify each contact in advance.
- Include releases in consent paperwork so you can act from a distance if safety requires.

Rural Suicide Risk

Suicide *ideation* rates are similar in urban and rural areas, but suicide *mortality* is higher in rural zones (Tarlow, Johnson & McCord, 2018). With rural clients, screen carefully for depression and anxiety, assess impulse control, and address access to lethal means including firearms.

7

Payor Sources and Insurance

Verify telehealth coverage. Tell the client.

- Confirm — for each insurer and each client — whether telehealth is covered.
- APA updates billing codes annually; new telehealth codes have been added. Review at each annual update.
- Each state has its own telehealth policy. Know yours. Know the policies of any state your client is participating from.
- Communicate coverage and cost implications to the client at intake. Document the discussion.

8

Malpractice Insurance

Confirm coverage for virtual delivery and cross-jurisdictional work.

Malpractice policies were not all written with telehealth in mind. Some cover virtual delivery, some exclude it, some are silent. Silence is not coverage.

- Read your current policy and identify the language describing covered services.
- Confirm in writing with your carrier whether telehealth is covered.
- Confirm whether coverage applies across state and provincial lines.
- Identify any limitations or jurisdictional restrictions and adjust your practice.
- Keep the carrier's response with your practice records.

Reading #4

Dissociation and Complex Trauma: Comprehensive Assessment and Strategies for Modifying Treatment *The Most Important Chapter*

Outline

1. Overview of Complex Trauma and Dissociation
 - Define complex trauma and discuss its long-term impact on clients, including chronic dysregulation and dissociative symptoms.
2. Definitions
 - **Complex Trauma:** Overview of how complex trauma affects clients, emphasizing developmental and relational trauma.
 - **Dissociation:** Explanation of dissociation as a division of consciousness, memory, or identity in response to overwhelming experiences.
3. Symptoms of Dissociation
 - **Core Symptoms:** Examination of depersonalization, derealization, dissociative amnesia, and emotional numbing.
 - **Structural Dissociation:** Overview of Apparently Normal Parts (ANP) and Emotional Parts (EP) as adaptive responses.
 - **Levels of Structural Dissociation:** Description of primary, secondary, and tertiary dissociation, illustrating varying degrees of complexity.
4. Assessing Dissociation
 - **Screening Tools:** Introduction to the Dissociative Experiences Scale (DES2) as a general assessment tool.
 - **Advanced Diagnostic Tools:** Overview of the Dissociative Disorders Interview Schedule (DDIS) and the Multidimensional Inventory of Dissociation (MID) for deeper evaluation of complex dissociative patterns.
 - **Real-Time Monitoring:** Techniques such as the Back of the Head Scale (BHS) and Constant Installation of Present Orientation and Safety (CIPOS) for in-session assessment and grounding.
5. Working with Dissociation and Immobility
 - **Understanding Shutdown:** Differentiate between “freeze” responses and the dorsal vagal state of “collapse and immobility” to clarify intervention strategies.
 - **Body-Based and Mind-Body Reconnection Techniques:** Practical grounding tools, including mini trampolines, BOSU Balance Trainers, and Sanchez Tuning Boards, along with proprioceptive and kinesthetic exercises.
 - **Applying ABLS:** Guidelines for gradually introducing ABLS to stabilize clients without overwhelming shifts in arousal.
6. Mind-Body Reconnection Exercises
 - **Depersonalization Re-Connection:** Exercises such as creative body mapping to help clients reconnect with physical sensations.
 - **Emotion Wheel:** Using color as a tool for increasing emotional awareness.
 - **Body Part Greetings and Color Palette Exercise:** Mindfulness practices to enhance body awareness and emotional reflection.
7. Ego-State Therapy Techniques
 - **Ego-State Mapping and Internal Conference:** Visual mapping and guided internal dialogues to promote self-awareness and cooperation among parts.
 - **Dissociative Table Technique:** Visualization method for facilitating safe communication with fragmented parts, incorporating ABLS for cohesion.
8. Chapter Summary
 - Recap of the chapter's main concepts and techniques.
9. Further Reading, References, and Client Resources
 - **Further Reading and References:** Suggested resources for clinicians to deepen their understanding of complex trauma, dissociation, and therapeutic techniques.
 - **Client Resources:** Includes the Dissociative Experiences Scale (DES2) for screening and self-assessment and client worksheets for depersonalization and derealization, designed to support grounding and reconnecting with physical sensations.

Introduction

If you're thinking of skimming or skipping this chapter, think again. This is the most critical chapter in the book. Here's why: habitual dissociation—a common feature of complex trauma—often blocks real progress in therapy. Dissociation is an adaptive survival response that persists long after the conditions that required it have changed. When left unaddressed, dissociation can prevent, undermine, or even undo therapeutic gains.

Complex trauma disrupts self-regulation and attachment, leaving clients chronically dysregulated and highly dissociative. While dissociation initially serves to protect by compartmentalizing overwhelming experiences, over time, it becomes maladaptive, leading to fragmentation, emotional disconnection, and symptoms like depersonalization, derealization, dissociative amnesia, and emotional numbing.

Effective treatment of complex trauma and dissociation involves thorough assessment with tools like the *Dissociative Experiences Scale (DES2)* for screening and advanced tools such as the *Dissociative Disorders Interview Schedule (DDIS)* and the *Multidimensional Inventory of Dissociation (MID)* for complex cases. In-session tools, including the *Back of the Head Scale (BHS)* and *Constant Installation of Present Orientation and Safety (CIPOS)*, help monitor dissociation and maintain present orientation.

The *Theory of Structural Dissociation of the Personality (TSDP)* is presented to assist clinicians navigate dissociative structures without inadvertently overwhelming or retraumatizing clients. Foundational skills in emotion regulation, self-care, and social engagement are essential to effective support. These grounding practices help clients differentiate between "freeze" responses and the dorsal vagal "collapse and immobility," each requiring distinct therapeutic strategies.

Practical mind-body reconnection tools—such as mini trampolines, BOSU Balance Trainers, Sanchez Tuning Boards, and proprioceptive exercises—are presented, along with guidelines for using *Alternating Bilateral Stimulation (ABLS)* to aid grounding. Further, exercises like creative body mapping, the *Emotion Wheel* for emotional exploration, *Body Part Greetings*, and the *Color Palette Exercise* enhance body awareness and emotional reflection. Techniques from Ego-State Therapy, including *Ego-State Mapping* and the *Dissociative Table Technique* (with ABLS), support safe internal communication between parts.

This chapter provides an essential foundation, covering core concepts and tools for assessing and working with dissociation. Understanding dissociation is not optional in trauma therapy; it's fundamental. By grasping these core elements and applying tailored interventions, clinicians can create a stable therapeutic process that empowers clients to integrate traumatic experiences safely and avoid further harm.

Overview of Complex Trauma and Dissociation

Definitions

1. Complex Trauma

Complex trauma develops from repeated or prolonged harmful experiences, particularly within relationships that are supposed to provide safety and support, such as those with caregivers or intimate partners. Unlike single-event trauma, complex trauma shapes the individual's emotional, cognitive, and relational development on a fundamental level. These repeated betrayals of trust lead to enduring emotional instability and complex relational patterns, fundamentally altering the way individuals perceive the world, themselves, and others (Courtois & Ford, 2009; Herman, 1992). This form of trauma leaves clients with a disrupted ability to establish a secure sense of safety and trust.

2. Dissociation

Dissociation is the mind's way of shielding itself from unmanageable experiences by dividing consciousness, memory, or identity. This defense mechanism compartmentalizes distressing emotions and memories, preserving a sense of psychological stability during overwhelming times (APA, 2013). For many clients, dissociation may feel like being disconnected from their own bodies, as though observing themselves from an outside perspective, or experiencing "spacing out" or "blanking." While initially protective, this dissociation can become maladaptive, leaving individuals with a fragmented experience of self that impedes their ability to connect with their full range of emotions and memories (Nijenhuis, van der Hart, & Steele, 2006).

Core Symptoms of Dissociation

Dissociation manifests in a range of symptoms that can vary in intensity, often reflecting the individual's need to disconnect from overwhelming emotions and memories. Key symptoms include:

- **Depersonalization:** A feeling of detachment from oneself, as if observing from outside the body, which can make individuals feel disconnected from their own identity and physical presence (APA, 2013).
- **Derealization:** The perception of the external world as unreal or dreamlike, where familiar surroundings feel strange, distorted, or detached, leading to an ongoing sense of disconnection from reality (Nijenhuis, van der Hart, & Steele, 2006).

- **Dissociative Amnesia:** The inability to recall personal information or traumatic events, often specific to the periods of overwhelming stress or trauma. These gaps in memory serve to shield the individual from traumatic recall but result in fragmented memories (Carlson & Putnam, 1993).
- **Emotional Numbing:** A reduced ability to experience emotions, where feelings are flattened or absent. Emotional numbing serves as a protective mechanism, allowing individuals to manage distressing experiences without the full impact of the associated emotions (Courtois & Ford, 2009).

It is the core symptoms of dissociation that prevent therapeutic change primarily because it disconnects individuals from the present moment, their emotions, and their sense of self. In a dissociative state, clients are often disconnected from the traumatic material that needs to be processed, as well as from the therapist, who serves as a supportive, grounding presence. This disconnection hinders the development of insight, self-awareness, and emotional processing—essential components for healing.

- **Interference with Mindfulness and Presence:** Dissociation is the opposite of mindfulness, which is foundational for therapeutic progress. If clients are unable to stay in the present moment, they miss vital opportunities for insight and healing.
 - **Impacts on the Therapeutic Relationship:** Dissociation can create a barrier to the therapeutic alliance, which is essential for safety and trust. Without a strong connection to the therapist, clients may not fully benefit from interventions that rely on relational support.
 - **Fragmented Identity and Memory:** Severe dissociation leads to compartmentalized identities or states, isolating parts of the self that hold key traumatic memories. This fragmentation hinders the integration of trauma experiences necessary for healing.
 - **Reduced Awareness of Self and Body:** Dissociation disrupts body awareness, making it difficult for clients to engage in grounding techniques and body-centered interventions, which are important for processing trauma and building self-awareness.
 - **Emotional Numbing:** While emotional numbing protects clients from overwhelming feelings, it also blocks access to emotions that need to be processed. This lack of emotional depth limits healing.
-

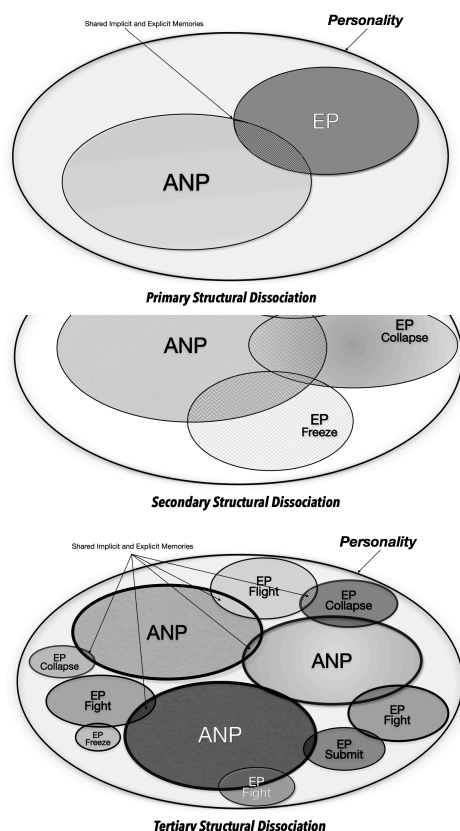
Theory of Structural Dissociation of the Personality (TSDP)

The Theory of Structural Dissociation proposes that dissociation divides the psyche into distinct parts, each holding separate roles, memories, and functions, as a protective adaptation in response to trauma. This division creates internal barriers that prevent full integration, with parts of the self becoming specialized for different aspects of life:

- **Apparently Normal Parts (ANP):** These parts are responsible for day-to-day functioning and tend to avoid trauma-related memories and emotions in order to maintain stability. The ANPs allow individuals to function in social and occupational settings, although they may feel distant from the underlying emotional content of traumatic experiences (Nijenhuis et al., 2006).
- **Emotional Parts (EP):** The EPs hold traumatic memories and the emotions tied to those experiences, surfacing when triggered by reminders of the trauma. These parts often exist in a state of re-experiencing or emotional reactivity, which can be disruptive to daily life (van der Hart et al., 2006).

Levels of Structural Dissociation

Structural dissociation exists on a continuum, reflecting varying degrees of complexity and fragmentation within the psyche. These levels help clinicians understand the scope of dissociative symptoms and guide treatment accordingly:



Primary Dissociation: Found in post-traumatic stress, where a single ANP manages daily life and a single EP holds traumatic memories. This level of dissociation reflects a basic separation between coping and survival parts.

Secondary Dissociation: Common in complex PTSD, where one ANP manages day-to-day functioning, while multiple EPs each hold specific trauma memories. This division allows the individual to compartmentalize multiple aspects of traumatic experiences.

Tertiary Dissociation: Seen in dissociative identity disorder (DID), which involves multiple ANPs and EPs. Each part takes on distinct roles, managing different areas of life or specific trauma memories, creating a complex and highly fragmented internal landscape (Nijenhuis et al., 2006; APA, 2013).

In essence, TSDP suggests that the more severe and prolonged the trauma, the more likely it is for multiple dissociative parts to form. These parts allow individuals to compartmentalize traumatic memories and responses, thus preserving a semblance of functionality in daily life (Van der Hart et al., 2006; Steele et al., 2001).

Successful treatment of structural dissociation requires integrating the divided subsystems—ANPs and EPs—so that the traumatic memories held by EPs can be processed and incorporated into the individual's overall identity. Traumatic memories within EPs are often sensorimotor and emotional, lacking the cognitive processing that characterizes ANPs. Integrating these memories involves joint, coordinated activation of both ANPs and EPs, allowing the parts to recognize and recontextualize traumatic experiences as events from the past, separate from the safe present (Levine, 2010; Porges, 2007).

Research has shown that ANPs often employ avoidance strategies to protect themselves from trauma-related cues, while EPs remain highly reactive. This dynamic requires careful therapeutic navigation, encouraging both ANPs and EPs to collaboratively engage in trauma processing while maintaining grounding in the present (Schoore, 2003; Nijenhuis & Van der Hart, 2011).

Assessing Dissociation

Accurate assessment of dissociative symptoms is essential in understanding the extent of fragmentation and tailoring treatment for clients with complex trauma. Clinicians can begin with screening tools to gauge the presence of dissociative symptoms and follow up with in-depth diagnostic assessments when indicated.

Screening Tools

- **Dissociative Experiences Scale (DES2):** The DES2 is a 28-item self-report scale designed to screen for dissociative symptoms, including depersonalization, derealization, amnesia, and identity confusion. Each item is scored on a scale of 0–100%, measuring the frequency of

these experiences. A total score above 30 is typically viewed as indicative of significant dissociation and signals a need for further assessment (Carlson & Putnam, 1993). The DES2 allows clinicians to quickly evaluate the extent of dissociative symptoms and identify clients who may benefit from more detailed diagnostic tools.

- **Instructions for Clinicians:** The DES2 can be administered at the beginning of treatment to establish a baseline for dissociative symptoms. Review individual items that score above 20% to identify specific dissociative patterns, and if the total score suggests moderate to high dissociation, consider using one of the diagnostic tools described below for a comprehensive assessment.

Advanced Diagnostic Tools

If the DES2 indicates significant dissociation, clinicians may use a structured diagnostic tool to gain a fuller understanding of the client's dissociative profile. While both the DDIS and MID provide valuable information, only one tool needs to be selected based on clinical needs.

- **Dissociative Disorders Interview Schedule (DDIS):** The DDIS is a structured clinical interview that evaluates a range of dissociative symptoms and co-occurring conditions, such as borderline personality disorder, major depressive disorder, and substance use. It includes specific sections for assessing positive symptoms of schizophrenia and the secondary symptoms of dissociative identity disorder (DID). This thorough interview provides a comprehensive assessment of dissociative symptoms and aids in distinguishing dissociative disorders from other psychological conditions (Ross et al., 1989).
 - **Instructions for Clinicians:** The DDIS is most useful for clinicians who prefer a structured interview format. By evaluating multiple aspects of dissociation and related conditions, it provides a well-rounded diagnostic profile that complements initial screening results from the DES2.
 - It's Free: Download Copy: <https://www.rossinst.com/ddis>
- **Multidimensional Inventory of Dissociation (MID):** The MID is a self-report inventory with 168 items that measure a wide range of dissociative symptoms, including identity confusion, identity alteration, amnesia, and emotional numbing. This tool offers a highly detailed view of dissociative experiences, allowing clinicians to understand specific symptom patterns and assess the level of dissociative fragmentation. The MID is especially valuable for identifying dissociative symptoms that may not be immediately evident in clinical interviews (Dell, 2006).
 - **Instructions for Clinicians:** The MID is suitable for clinicians seeking a comprehensive, client-completed assessment. It can provide insights into the severity and complexity of dissociative symptoms, particularly useful for developing treatment strategies tailored to highly dissociative clients. Choose either the DDIS or the MID based on the client's presentation and your preferred assessment approach.
 - It's Free: Download Copy <https://www.mid-assessment.com/>

Real-Time Monitoring of Dissociative States

Back of the Head Scale (BHS)

The *Back of the Head Scale (BHS)* (Knipe, 2003, 2018) is a clinical tool used to assess a client's subjective sense of presence, particularly useful for identifying when a client may be shifting into a dissociative state during a session. The scale leverages the concept of “where the client feels located” in their head as a marker for assessing how present and engaged they are.

- **Mechanics of the BHS:** The BHS asks clients to gauge their awareness along a continuum of locations in their head—from the back of the head (indicating detachment or disengagement) to the front (indicating full presence). A client's ability to report feeling located closer to the front of their head suggests greater engagement with the here and now, while a sensation toward the back may reflect increased dissociation or detachment from present experience.
- **Application in Therapy:** During sessions, especially when engaging in trauma-focused interventions, the therapist can periodically check in with the client's location on the BHS. If the client indicates feeling towards the back of the head, the therapist can adjust the pacing, use grounding techniques, or encourage the client to focus on the physical environment to

promote a return to a more present-focused state. This tool is particularly valuable in real-time adjustments, allowing the therapist to maintain client safety by preventing excessive dissociation or potential re-traumatization.

- **Clinical Significance:** The BHS can help therapists make in-the-moment decisions to prevent clients from becoming overwhelmed. It also promotes the client's awareness of their own dissociative responses, encouraging self-monitoring and gradual mastery over their dissociative tendencies.

Constant Installation of Present Orientation and Safety (CIPOS)

Constant Installation of Present Orientation and Safety (CIPOS) (Knipe, 2003, 2018) is a technique developed to help clients maintain a sense of safety and grounding, particularly during trauma processing. CIPOS integrates various grounding and orientation strategies to keep the client connected to the present moment, reducing the likelihood of dissociation.

- **Core Principles of CIPOS:** The CIPOS approach emphasizes the use of body-based grounding techniques, such as Alternating Bilateral Stimulation (ABLS), to continuously anchor the client in the present. Techniques like tapping, foot-to-ground awareness, and focusing on physical sensations serve to remind the client of their physical presence and safety in the therapy environment. By continually returning to these physical cues, clients are better able to manage overwhelming emotions that arise during sessions.
- **Using CIPOS in Practice:** At key moments when clients show signs of dissociation, anxiety, or distress, the therapist can employ CIPOS techniques. For example, ABLS can be integrated into the session through gentle bilateral hand taps or foot movements, helping the client to “stay in the room” while working with traumatic material. Visual or verbal cues may also be used, like reminding the client to notice specific elements in their surroundings or to feel the support of their chair beneath them.
- **Benefits for Highly Dissociative Clients:** For clients with a high dissociative threshold, CIPOS provides a framework to safely engage with trauma processing while maintaining stability. By promoting a constant sense of orientation to the present, CIPOS reduces the risk of the client becoming lost in traumatic memories or entering a dissociative shutdown. This technique fosters client autonomy as well, equipping them with practical skills for grounding that they can use independently between sessions (Knipe, 2015; Porges, 2011).

By using a combination of initial screening, advanced diagnostic tools, and real-time monitoring, clinicians can assess and address dissociation comprehensively. These tools not only support diagnosis but also provide critical information for treatment pacing and the application of stabilizing techniques. Real-time monitoring, in particular, offers clinicians an in-session approach to keep clients grounded, helping to maintain therapeutic safety and effectiveness.

Working with Dissociation and Immobility

Dissociation, often tied to the body's dorsal vagal response, reflects a state of profound hypoarousal. According to Polyvagal Theory (Porges, 2007; Porges & Dana, 2018), the autonomic nervous system organizes its responses to threat in a hierarchy, progressing from ventral vagal social engagement (safety and connection) to sympathetic fight-or-flight (arousal and mobilization), and, as a last resort, to dorsal vagal shutdown (immobility and collapse). This final state, where the body slows down and awareness diminishes, allows individuals to detach from overwhelming experiences. Understanding this progression and recognizing the differences between “freeze” and “collapse” states is essential for effective therapeutic intervention.

Understanding Shutdown: Differentiating Freeze from Dorsal Vagal Collapse

- ◆ **Freeze Response:** This state is associated with sympathetic activation, where clients feel immobilized yet hyperaware. Physically, this may present as muscle tension, shallow breathing, or heightened alertness as the body prepares for fight or flight without an immediate release.
- ◆ **Dorsal Vagal Collapse (Shutdown):** In this deeper state of hypoarousal, associated with the dorsal vagal complex, clients may feel disconnected, numb, and unaware of their surroundings. This state, often experienced as “collapse” or dissociative shutdown, represents the body's most

primal survival response when fight, flight, or freeze responses are ineffective. It manifests as slowed breathing, diminished muscle tone, and a pervasive sense of detachment or numbness (Porges & Dana, 2018).

Recognizing the difference between these states helps clinicians tailor interventions appropriately. Clients in freeze may benefit from techniques that allow gradual release of energy, while those in shutdown need grounding techniques that gently re-engage their awareness and sensory experience.

Body-Based Techniques

Grounding tools and proprioceptive exercises are effective for helping clients transition out of dissociative states. These methods encourage clients to focus on physical sensations in a structured, gradual manner, which helps bring them back into connection with their bodies. Here are practical tools and exercises to use:

1. Practical Grounding Tools

- **Mini Trampolines, BOSU Balance Trainers, and Sanchez Tuning Boards:** These tools provide proprioceptive feedback, stimulating physical awareness without overwhelming. By requiring clients to maintain balance or rhythm, they help clients feel more grounded and connected to their bodies.
- **Instructions for Clinicians:**
 - **Introduce Tools Slowly:** Explain the purpose of each tool and allow clients to choose which feels most comfortable to them. For instance, clients might begin by gently bouncing on a mini trampoline or balancing on a BOSU trainer.
 - **Sensory Prompts:** Use statements like, “Notice the sensation in your feet as you bounce,” or “Feel how your body adjusts to keep balance.” These prompts help clients tune into their physical sensations.
 - **Client Reflection:** Encourage clients to describe any changes in sensation or body awareness, reinforcing connection to their physical experience without overwhelming.

2. Proprioceptive and Kinesthetic Exercises

Proprioceptive exercises, such as **rocking or gentle walking**, help clients reconnect with their sense of position and movement, promoting grounding and bodily awareness.

- **Instructions for Clinicians:**
 - **Guided Rocking or Walking:** Ask clients to rock gently in their seat or take slow, deliberate steps, encouraging them to notice each shift in weight. Use prompts like, “Feel the pressure of your feet on the ground” or “Notice the movement in your hips as you sway.”
 - **Sensory Observations:** Encourage clients to describe what they notice in their body, such as tension releasing or a feeling of warmth, which helps them stay grounded and connected to their physical experience.

Applying ABLS: Gradual Introduction for Stabilization

Alternating Bilateral Stimulation (ABLS) can be helpful for stabilizing clients who dissociate, but it must be introduced carefully to prevent overwhelming shifts in arousal. ABLS activates both

hemispheres of the brain through rhythmic, alternating taps or movements, which can help clients feel more present and grounded without abruptly increasing arousal.

1. Guidelines for ABLS Integration

- **Start with Short, Gentle Sets:** Begin with small ABLS sets (6-10 taps or eye movements) to gently stimulate awareness. Frequent pauses help monitor the client's response to ensure they remain within their window of tolerance (Leeds, 2016).

◆ Instructions for Clinicians:

- **Observe and Prompt:** Encourage clients to notice any changes, using prompts like, "How does your body feel with this rhythm?" or "Notice if there's any shift in your breath or awareness." These prompts support grounding while minimizing the risk of overwhelm.
- **Adjust Intensity Based on Feedback:** Depending on the client's response, adjust the length or intensity of ABLS. For clients who feel more connected, you may gradually increase the sets, always monitoring their comfort level.

2. ABLS for Safe Discharge of Sympathetic Energy

For clients moving out of a freeze or shutdown state into sympathetic activation, ABLS can provide controlled way to discharge heightened energy safely. Pairing ABLS with grounding movements (like rhythmic walking or controlled breathing) helps clients process sympathetic arousal without reactivating dissociation.

○ Instructions for Clinicians:

- ◆ **Integrate Movement with ABLS:** Ask clients to walk slowly or gently move while focusing on the ABLS rhythm, saying, "Feel the connection between the movement and the tapping" or "Notice how the rhythm affects your sense of stability."
- ◆ **Client Reflection:** Periodically check in to see how clients are experiencing the combined movement and ABLS, adjusting based on their comfort and feedback. Encourage clients to express sensations that arise, such as relaxation or energy release, which reinforces their sense of control.

Using these techniques, clinicians can address both hypoaroused (shutdown) and hyperaroused (freeze) states in clients experiencing dissociation. Polyvagal Theory provides a foundation for understanding how to meet clients in their current autonomic state, tailoring interventions to support gradual re-engagement, awareness, and a return to social engagement. By maintaining attunement to the client's response and carefully introducing tools and techniques, clinicians facilitate grounding and stabilize dissociative responses, paving the way for deeper trauma processing (Porges, 2007; Porges & Dana, 2018)

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Reading #5

The Window of Tolerance

**HYPERAROUSAL ZONE**

Sympathetic Activation • Fight/Flight

Click to expand

⚠️ Signs & Symptoms

- Racing heart, rapid breathing
- Anxiety, panic, fear
- Hypervigilance, racing thoughts
- Muscle tension, sweating
- Fight or flight response

⬇️ Interventions to Regulate Down

- ✔️ Extended exhales (longer out-breath)
- ✔️ Grounding (5-4-3-2-1 sensory)
- ✔️ Bilateral stimulation
- ✔️ Orienting to present environment
- ✔️ Cold water on face/wrists

**WINDOW OF TOLERANCE**

Ventral Vagal • Optimal Arousal Zone

Click to expand

✔️ Characteristics

- Able to think clearly and make decisions
- Emotionally regulated and responsive
- Socially engaged and connected
- Grounded in the present moment
- Flexible and adaptive responses

💡 Therapeutic Goal

The goal of trauma therapy is to help clients **widen their window of tolerance** so they can:

- ✔️ Process traumatic material without overwhelm
- ✔️ Return to regulation more quickly
- ✔️ Tolerate greater emotional intensity

**HYPOAROUSAL ZONE**

Dorsal Vagal • Freeze/Collapse

Click to expand

⚠️ Signs & Symptoms

- Numbness, emotional flatness
- Dissociation, feeling disconnected
- Foggy thinking, confusion
- Fatigue, low energy, collapse
- Shame, hopelessness, depression

⬆️ Interventions to Regulate Up

- ✔️ Movement and physical activation
- ✔️ Orienting to environment (look around)
- ✔️ Strong sensory input (cold, texture)
- ✔️ Vocalization (humming, singing)
- ✔️ Social engagement (eye contact)



Do NOT use release breathing

for hypoarousal—it will deepen shutdown.

↑
AROUSAL
↓



Hyperarousal Zone Sympathetic Activation – Fight/Flight



When we move **above** our window of tolerance, the sympathetic nervous system takes over, preparing us for fight or flight. This is characterized by increased heart rate, blood pressure, muscle tension, and heightened alertness.

Physical Signs

- ⊗ Racing heart
- ⊗ Rapid breathing
- ⊗ Muscle tension
- ⊗ Increased blood pressure
- ⊗ Sweating

Cognitive Signs

- ⊗ Hypervigilance
- ⊗ Racing thoughts
- ⊗ Difficulty concentrating
- ⊗ Intrusive thoughts

Emotional Signs

- ⊗ Anxiety
- ⊗ Panic
- ⊗ Anger/Rage
- ⊗ Irritability
- ⊗ Fear

Behavioral Signs

- ⊗ Fight response
- ⊗ Flight response
- ⊗ Restlessness
- ⊗ Aggression



Window of Tolerance Ventral Vagal – Social Engagement



Within our window of tolerance, we can experience emotions without being overwhelmed by them. We can think clearly, connect with others, and respond flexibly to challenges. This is the **optimal zone for processing trauma**.

- | | |
|--|---|
| ✓ Able to think clearly and make decisions | ✓ Emotionally regulated and responsive (not reactive) |
| ✓ Socially engaged and connected | ✓ Able to process and integrate new information |
| ✓ Grounded in the present moment | ✓ Flexible and adaptive responses |



Hypoarousal Zone Dorsal Vagal – Freeze/Collapse



When we move **below** our window of tolerance, the dorsal vagal system activates, causing shutdown, freeze, or collapse. This is the body's last-resort defense when fight/flight isn't possible or has failed.

Physical Signs

- ⊗ Decreased heart rate
- ⊗ Shallow breathing
- ⊗ Low muscle tone
- ⊗ Decreased blood pressure
- ⊗ Fatigue

Cognitive Signs

- ⊗ Foggy thinking
- ⊗ Dissociation
- ⊗ Memory gaps
- ⊗ Confusion

Emotional Signs

- ⊗ Numbness
- ⊗ Emptiness
- ⊗ Shame
- ⊗ Hopelessness
- ⊗ Depression

Behavioral Signs

- ⊗ Freeze response
- ⊗ Collapse
- ⊗ Withdrawal
- ⊗ Immobilization

Why This Matters for Window of Tolerance Work

Aron's research shows that highly sensitive persons are the **majority of therapy clients** — not a minority. Knowing this before the first session allows the clinician to:

- ✓ Calibrate the pace of trauma processing to avoid overwhelming a sensitive nervous system
- ✓ Anticipate a narrower Window of Tolerance and plan for more frequent grounding
- ✓ Differentiate sensitivity from pathology — avoiding misdiagnosis of BPD traits as personality disorder
- ✓ Adjust the therapeutic environment (lighting, sound, pacing) to support regulation

WORKSHEET 1: UNDERSTANDING YOUR NERVOUS SYSTEM

THE 3 NERVOUS SYSTEM STATES

VENTRAL VAGAL STATE (Social Engagement / "Green Zone")

What it is: Your "all is well" state - calm, connected, and able to engage with life

When I'm in this state, I feel:

 VENTRAL VAGAL STATE (Social Engagement / "Green Zone")	
When I'm in this state, I feel:	Physical signs in my body:
☐ Calm ☐ Grounded ☐ Connected ☐ Safe ☐ Open ☐ Curious ☐ Present ☐ Peaceful ☐ Clear-headed ☐ Other:	☐ Relaxed muscles ☐ Easy breathing ☐ Warm hands/feet ☐ Open body language ☐ Good digestion ☐ Clear thinking ☐ Other:

Activities/situations that help me feel this way:

People/places that help me feel safe and connected:

SYMPATHETIC STATE (Fight-or-Flight / "Red/Yellow Zone")

What it is: Your "mobilization" state - body preparing to take action against threat

 SYMPATHETIC STATE (Fight-or-Flight / "Red/Yellow Zone")	
When I'm in this state, I feel:	Physical signs in my body:
☐ Anxious ☐ Angry ☐ Panicky ☐ Restless ☐ On edge ☐ Irritable ☐ Hypervigilant ☐ Overwhelmed ☐ Tense ☐ Other:	☐ Racing heart ☐ Fast/shallow breathing ☐ Tight muscles ☐ Cold or sweaty hands ☐ Stomach upset ☐ Can't sit still ☐ Tunnel vision ☐ Can't focus ☐ Other:

Things that trigger this state for me:

Early warning signs that I'm starting to activate:

What I typically do when I'm in this state:

DORSAL VAGAL STATE (Shutdown / "Blue Zone")

What it is: Your "freeze/shutdown" state - body conserving energy or "playing dead"

 DORSAL VAGAL STATE (Shutdown / "Blue Zone")	
When I'm in this state, I feel:	Physical signs in my body:
☐ Numb ☐ Disconnected ☐ Spacey ☐ Foggy ☐ Exhausted ☐ Hopeless ☐ Empty ☐ Frozen ☐ Flat ☐ Other: _____	☐ Heavy/hard to move ☐ Slow movements ☐ Low energy ☐ Hard to think ☐ Flat emotions ☐ Dissociation ☐ Feel "far away" ☐ Can't feel much ☐ Other: _____

Things that trigger this state for me:

Early warning signs that I'm starting to shut down:

What I typically do when I'm in this state:

MY NERVOUS SYSTEM PATTERNS

I spend most of my time in this state:

- ☐ Ventral Vagal (Green - calm/connected)
- ☐ Sympathetic (Red/Yellow - activated/anxious)
- ☐ Dorsal Vagal (Blue - shutdown/numb)
- ☐ Mixed states
- ☐ Oscillating between states

My typical pattern when stressed is:

- ☐ Go UP into activation (sympathetic)
- ☐ Go DOWN into shutdown (dorsal)
- ☐ Go UP first, then crash DOWN
- ☐ Stay stuck in one state
- ☐ Other: _____

Times I'm most likely to be in my window (ventral vagal):

Times I'm most vulnerable to dysregulation:

- ☐ When tired
- ☐ When hungry
- ☐ When sick
- ☐ After conflict
- ☐ In crowded places
- ☐ When alone too long
- ☐ When overwhelmed
- ☐ During transitions
- ☐ Other: _____

UNDERSTANDING WITHOUT JUDGMENT

REMEMBER:

- ✓ All three states are **PROTECTIVE** responses
- ✓ There's nothing "wrong" with any of these states
- ✓ They developed to keep you safe
- ✓ The goal isn't to stay in ventral vagal 24/7 (not realistic!)
- ✓ The goal is to **RECOGNIZE** which state you're in and have tools to help

What did I learn about my nervous system from this worksheet?

Questions I have for my therapist/coach:

Reading #6 Assessing for Complex Trauma and Dissociation: A Practical Clinical Resource for Trauma Clinicians

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 Key References

Quick Reference Guide

When to suspect dissociation instead of psychosis:

- ✓ Client has documented trauma history, especially childhood abuse/neglect
- ✓ "Psychotic" symptoms began during or after trauma
- ✓ Voices are experienced as internal parts rather than external entities
- ✓ Client describes "losing time" or finding evidence of behavior they don't remember
- ✓ Multiple prior diagnoses with poor response to standard treatments
- ✓ Antipsychotics provide minimal benefit or worsen symptoms

Key Clinical Principle: In clients with trauma histories, actively explore and rule in dissociation before diagnosing primary psychotic disorder.

Section 1: Understanding the Diagnostic Challenge

Why Dissociation is Misdiagnosed as Psychosis

Research shows that **60-80% of patients with Dissociative Identity Disorder (DID) are initially misdiagnosed** with depression, bipolar disorder, or schizophrenia. This happens because:

- ♦ **Symptom Overlap:** Schneiderian first-rank symptoms (voices, thought interference, passivity phenomena) occur in both schizophrenia and dissociative disorders. Recent research by Krüger and Fletcher (2024) demonstrates that these symptoms actually **predict dissociative disorders** more strongly than previously recognized.
- ♦ **Clinician Training Gaps:** Many clinicians lack training in recognizing dissociative disorders and may not ask the right questions to uncover dissociative symptoms.
- ♦ **Client Secrecy:** Clients hide dissociative symptoms due to shame, fear of being disbelieved, or concern about being labeled "crazy."
- ♦ **Consequences of Misdiagnosis:** Years of ineffective antipsychotic treatment while underlying trauma remains unaddressed, leading to poor outcomes and "treatment resistance."

Section 2: Schneiderian First-Rank Symptoms

Kurt Schneider identified eleven symptoms he believed were specific to schizophrenia. However, **these symptoms are common in dissociative disorders** and should increase, not decrease, suspicion of dissociation in trauma survivors.

The Complete List First-Rank Symptoms

Auditory Hallucinations:

1. Hearing your own thoughts spoken aloud
2. Hearing voices arguing or discussing you in third person
3. Hearing voices providing running commentary on your actions

Thought Alienation:

4. Thoughts being inserted into your mind by external force
5. Thoughts being removed from your mind by external force
6. Your thoughts being broadcast so others can hear them

Passivity Phenomena:

7. Feelings imposed by external force
8. Impulses imposed by external force
9. Actions controlled by external force
10. Bodily sensations imposed by external force

Delusional Perception:

11. Normal perception followed by delusional interpretation of profound personal significance

Clinical Significance

The **presence** of these symptoms doesn't tell you the diagnosis. The **quality** of the experience does. Ask: "**Does it feel like an outside force, or like another part of you?**"

Section 3: Understanding Structural Dissociation

The Basic Concept

Structural dissociation theory explains how personality becomes divided in response to overwhelming trauma. Think of it as the mind creating separate "compartments" to survive unbearable experiences.

Two Types of Parts:

- **ANP (Apparently Normal Part):** Handles daily life, avoids trauma memories
- **EP (Emotional Part):** Stuck in traumatic experiences, holds trauma memories and emotions

Primary Structural Dissociation

Structure: 1 ANP + 1 EP

Diagnoses: Single incident PTSD

What You'll See: Characteristic of simple (single incident) PTSD. The client may not appear dissociative to an untrained eye. They function, they present with a coherent narrative, they engage. But the EP holds traumatic material that will surface under activation. Processing is possible with adequate preparation.

Secondary Structural Dissociation

Structure: 1 ANP + Multiple EPs

Diagnoses: Complex PTSD, BPD with dissociative features, OSDD-1

What You'll See:

- Client functions in daily life but experiences intrusive emotions or flashbacks
- Different emotional states that feel overwhelming or "not like me"
- Partial amnesia for traumatic events or "emotional amnesia" (remembering events but not feelings)
- Client may describe feeling "taken over" by rage, terror, or shame
- EPs experienced more as "emotional states" than distinct identities

Example: A client who is generally calm and professional at work but experiences sudden, overwhelming rage at home that feels "not like me" and leads to behavior they later regret but don't fully remember.

Tertiary Structural Dissociation

Structure: Multiple ANPs + Multiple EPs

Diagnosis: Dissociative Identity Disorder (DID)

What You'll See:

- Multiple distinct identities or "parts" with their own names, ages, genders
- Significant amnesia between parts—client finds evidence of behavior they don't remember
- Parts may have relationships with each other (alliances, conflicts)
- Observable "switching"—sudden changes in voice, posture, facial expression, mannerisms
- Client may refer to themselves as "we" or "they"
- Highly variable functioning across different contexts

Example: A client who has distinct child parts, protector parts, and persecutor parts, each with their own memories and ways of relating to the world. The client may not remember entire conversations, may find purchases they don't recall making, and may be told by others about behavior that seems completely foreign to them.

Section 4: Two Pathways of Trauma Response

Why This Matters (Lanius)

Ruth Lanius's research shows that trauma survivors respond in two distinct neurobiological ways. Understanding this prevents misinterpreting dissociative shutdown as psychotic "negative symptoms."

Table 1 Two Pathways of Trauma Response

Feature	Hyperarousal (Classic PTSD)	Dissociative Shutdown (Complex Trauma)
What it looks like	Agitated, restless, hypervigilant, easily startled	Detached, "flat," emotionally distant, "spaced out"
What's happening physiologically	Increased heart rate, rapid breathing	Decreased heart rate, slowed breathing
What's happening in the brain	Amygdala overactive, prefrontal cortex can't shut it down	Prefrontal cortex actively shutting down the amygdala
What client experiences	Overwhelming emotions, intrusive memories, panic	Numbness, feeling "dead inside," watching self from outside, world feels unreal
Defensive response	Fight or flight	Freeze, submit, "play dead"
Risk of misdiagnosis	Anxiety disorder, agitated depression	Negative symptoms of schizophrenia , catatonia

Critical Clinical Point

Dissociative shutdown is NOT a deficit. It's an active, protective response when escape is impossible. What looks like "flat affect" is actually a state of high internal tension. Clients describe it as feeling "frozen," "dead inside," or "watching from outside my body."

Clients may **alternate between these states**—hyperaroused in one session, shut down in the next, or shifting within a single session.

Critical Clinical Point

Clients may **alternate between these states**—hyperaroused in one session, shut down in the next, or shifting within a single session.

Section 5: Differential Diagnosis at a Glance

The Key Question

"Does it feel like an outside force, or like another part of you is taking over?"

This single question often reveals whether the experience is external (psychosis) or internal (dissociation).

Table 2 Quick Comparison Table

Symptom	Psychosis	Dissociation
Voices	External, bizarre ("The devil commands me")	Internal parts ("The angry one took over"; child voices)
Thought interference	Bizarre explanation ("CIA satellite")	"Thought bleed-through" from parts ("It's his thought, not mine")
Control/passivity	External controller (demons, technology)	Internal part taking over ("I didn't do it, the angry one did")
"Paranoia"	Bizarre, non-relational (conspiracy theories)	Relational hypervigilance from real trauma ("Everyone I've trusted has hurt me")
Flat affect	Deficit state across all contexts	Dissociative shutdown that fluctuates with triggers
Identity disturbance	Delusional ("I am Jesus")	Fragmented self with distinct parts and amnesia between them

Section 6: Essential Assessment Questions

How to Ask About Voices

 **Don't just ask:** "Do you hear voices?"

 **Ask these follow-up questions:**

"Do the voices sound like they're coming from inside or outside your head?"

"Do the voices have names, ages, or genders?"

"What do the voices say? Do they talk to each other about you?"

"Do the voices feel like parts of you, or like completely separate beings?"

What suggests dissociation: Internal voices with distinct identities, often protective or related to trauma ("Don't trust anyone," "You're not safe," child voices crying)

How to Ask About Identity and Parts

 **Ask:**

"Do you ever feel like you're made up of different parts?"

"Do these parts have different feelings, memories, or ways of seeing things?"

"Do these parts ever take control? What's that like?"

"Do your feelings change so dramatically that it confuses you or others?"

What suggests dissociation: Client describes distinct parts with their own characteristics, or describes feeling like "a different person" at different times

How to Ask About Amnesia and Lost Time

✓ **Ask:**

"Do you ever lose time or find yourself somewhere without knowing how you got there?"

"Do people tell you about things you did that you don't remember?"

"Have you found items you don't remember buying, or notes you don't remember writing?"

"Are there big gaps in your childhood memories?"

What suggests dissociation: Significant amnesia for both past and present, especially with evidence of complex behavior during amnesic periods

How to Ask About Depersonalization and Derealization

✓ **Ask:**

"Do you ever feel detached from your body, like you're watching yourself in a movie?"

"Do you feel disconnected from your emotions or physical sensations?"

"Does the world ever feel unreal, foggy, or like you're looking through a veil?"

"Does this happen more when you're stressed or reminded of difficult things?"

What suggests dissociation: Depersonalization/derealization that intensifies with trauma triggers

How to Ask About Thought Interference and Control

✓ **Ask:**

"When thoughts feel like they're not your own, does it feel like an outside force putting them there, or like thoughts from another part of you?"

"When you feel controlled, what's that experience like? External or internal?"

What suggests dissociation: "It's not my thought, it's *his* thought" (referring to a part) or "The angry one took over"

How to Ask About Attachment and Relational Trauma

✓ **Ask:**

"Given what you've been through, does it make sense that you'd have trouble trusting people?"

"Tell me about your fear of abandonment. Where does that come from?"

"What were your relationships like with your parents or caregivers growing up?"

What suggests dissociation:

Relational hypervigilance that makes sense given documented trauma history

How to Ask About Somatic Symptoms

✓ **Ask:**

"Do you have physical symptoms doctors can't explain?"

"Do you have a difficult relationship with your body? Does it ever feel like it's not yours?"

"Do you experience physical pain or sensations connected to memories or emotions?"

What suggests dissociation: Unexplained somatic symptoms, body disconnection, somatic flashbacks

Section 8: Standardized Assessment Tools

For Screening

DES II (Dissociative Experiences Scale)

- 28-item self-report questionnaire
- Takes 10-15 minutes
- Score above 30 suggests significant dissociation → do full assessment

For Diagnosis

EITHER

MID (Multidimensional Inventory of Dissociation)

218-item self-report

Takes 45-60 minutes

Provides detailed profile of dissociative symptoms

OR

Dissociative Disorders Interview Schedule

132 item structured interview or self-report

Takes 30-45 minutes

Provides detailed profile of dissociative symptoms: makes DSM-5 diagnoses of somatic symptom disorder, borderline personality disorder and major depressive disorder, as well as all the dissociative disorders.

For Complex PTSD Diagnosis

ITQ (International Trauma Questionnaire)

- Brief self-report (5-10 minutes)
- Assesses ICD-11 PTSD and Complex PTSD
- Measures affect dysregulation, negative self-concept, relationship disturbances

Section 9: Clinical Implementation Tips

1. **Create Safety First**
Before asking about trauma or dissociation, establish safety and rapport. Clients with complex trauma are exquisitely sensitive to threat cues in relationships. What looks like "resistance" may be an attachment-based survival response.
2. **Normalize Dissociation**
Frame dissociative symptoms as adaptive survival responses to overwhelming trauma, not as "crazy" or pathological. This reduces shame and increases disclosure.
Example: "Many people who've experienced severe trauma develop different parts as a way to survive. It's actually a very creative way the mind protects itself."
3. **Ask Direct Questions**
Don't wait for clients to spontaneously report dissociative symptoms—they won't. Shame and fear of disbelief lead clients to hide these experiences. You must ask directly and compassionately.
4. **Listen for the Quality of Experience**
Pay attention to how clients describe symptoms, not just whether symptoms are present. Listen for descriptions of internal parts versus external forces.
5. **Take a Comprehensive Trauma History**
Before finalizing any diagnosis, conduct a thorough trauma and attachment history. Use trauma-informed interviewing that prioritizes safety.
6. **Use Standardized Instruments**
Supplement clinical interviewing with validated tools (DES II, MID, DDIS, ITQ). These reveal symptoms clients may not spontaneously report.
7. **Consider the Therapeutic Relationship**
Pay attention to attachment patterns in your relationship with the client. These patterns provide important diagnostic information.
8. **Remember the Context**

In trauma survivors, psychotic-like symptoms often make sense when understood in the context of trauma history. What seems bizarre may be a logical response to unbearable experiences.

Section 10: The Bottom Line

When to Assess for Dissociation

- Client has trauma history AND psychotic-like symptoms
- Client has multiple prior diagnoses with poor treatment response
- Antipsychotics provide minimal benefit
- Client describes "losing time" or finding evidence of behavior they don't remember
- Voices are described as "internal" or "parts of me"
- Client has unexplained somatic symptoms and body disconnection
- Functioning is highly variable across contexts

The Critical Clinical Principle

When psychosis is suspected in a traumatized individual, the most effective path forward is to assess thoroughly for dissociation before settling on a primary psychotic disorder diagnosis. This doesn't mean trauma survivors can't develop psychotic disorders. It means dissociative disorders are frequently overlooked and misdiagnosed, and accurate diagnosis is essential for effective treatment.

A client who receives appropriate trauma-focused treatment for a dissociative disorder has a **much better prognosis** than a client misdiagnosed with schizophrenia and treated with antipsychotics for years.

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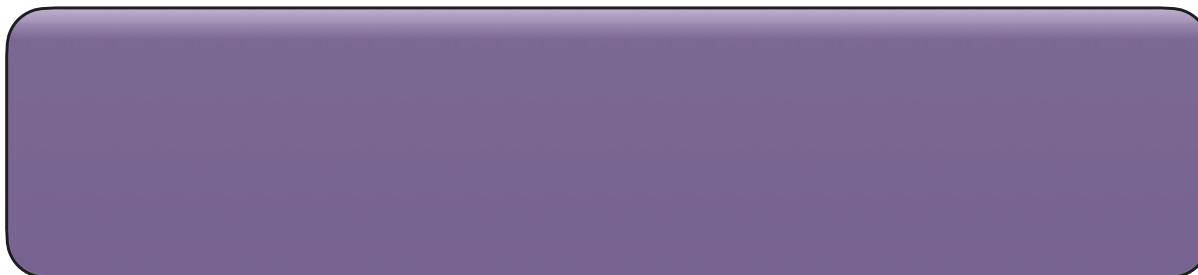
Reading #7 Stabilization & Readiness Assessment: *The Therapy Before the Therapy* Let's Start with the Uncomfortable Truth

Here's something that doesn't fit on a CE certificate: the most elegant trauma processing in the world will fail—or actively harm your client—if their nervous system can't handle it.

I've heard this story in consultation more times than I can count: clinician reports technically flawless EMDR protocol on a client who wasn't ready. They identified a target image, emotions, body sensations, and a believable negative cognition. SUD was a 7. They began processing.

And the client dissociated during the first set, couldn't find their way back to safety, and spent the next week in a trauma vortex that undid six months of progress and relational trust.

Because the clinician skipped the part that actually matters: making sure the client's nervous system could handle what it was being asked to do.



Why We Skip It (And Why That's a Problem)

Let's be honest about the pressures:

- Clients want relief now. They've been suffering for years; they don't want to spend three months learning to breathe.
- Insurance wants measurable progress in six sessions. "Stabilization" doesn't code well.
- Training programs teach protocols like recipes. Follow the steps, get the result.
- We feel like frauds if we're not processing trauma. That's what trauma therapists do, right?
- And underneath all of it: sitting with someone's pain without fixing it is excruciating. Processing feels like doing something.

I get it. I've felt all of it. But here's what three decades have taught me: rushing stabilization doesn't save time—in fact, it's costly. The clients I've helped the most are the ones who spent the necessary time building capacity before touching their trauma directly.

The ones I've harmed? The ones I rushed because someone told me the protocol said it was time. The ones I let rush me because I mistook desperation for readiness.

What We're Actually Assessing

Checklists have their place—I use them. But readiness isn't a form you complete in session three and forget. It's a background process, an ongoing clinical judgment about capacity that runs underneath every session. Here's what I'm tracking:

1. Window of Tolerance: Can They Stay in the Room?

When this client gets activated—and they will—can they notice it? Can they name it, even vaguely? Do they have any way to bring themselves back, or does activation mean immediate flooding or shutdown? I'm not asking if they can regulate perfectly. I'm asking: is there any working thermostat at all?

If someone can't stay present for a conversation about their commute, they cannot stay present for bilateral stimulation while visualizing their father's hands. That's not pessimism. That's reality.

2. Relational Capacity: Can They Use Me?

Is there enough therapeutic alliance to tolerate the vulnerability that processing requires? When they look at me, does their nervous system settle or spike? For clients with attachment trauma—which is most complex trauma clients—my presence can be as dysregulating as any memory. The relationship has to become safe before it can become useful. That takes time. There's no shortcut. If a client can't yet tell me they're overwhelmed, they can't tell me when processing goes sideways. And it will go sideways. That's when the alliance matters most.

3. Life Stability: Is the House on Fire?

If someone is actively in crisis—eviction notice, custody battle, medical emergency, active abuse—their nervous system is already maxed out managing survival. Their nervous system is already at max capacity. Trauma processing requires bandwidth they don't have. Same principle applies to less dramatic instability: chronic sleep deprivation, malnutrition, isolation. Integration requires metabolic resources. If the tank is empty, processing doesn't fill it—it drains the reserve.

This isn't about having a perfect life. It's about having enough stability that a hard session doesn't tip them into crisis.

4. Dissociative Complexity: How Fragmented Is the System?

Dissociation exists on a spectrum, and where your client falls on that spectrum determines how much stabilization they need.

- Primary structural dissociation (simple PTSD): the personality is basically unified, with one emotional part holding the trauma. These clients can often move to processing relatively quickly.
- Secondary structural dissociation (complex PTSD, OSDD): multiple emotional parts, often with conflicting agendas. You can't process a memory when one part wants to approach it and another is slamming the brakes. Parts work first.
- Tertiary structural dissociation (DID): multiple apparently normal parts, extensive fragmentation. Processing is months or years away. The work is building internal communication, establishing co-consciousness, developing trust between parts who may not know each other exist.

Trying to process trauma in a highly dissociative client without adequate parts work is like trying to have a family meeting when half the family weren't invited and the other half have no idea they're even related.

5. Resources: Is There Anything to Build On?

- Does this person have any felt sense of safety anywhere in their body? Even a neutral spot—the elbow, the left foot, the space between breaths? Somewhere the nervous system isn't on fire?
- Do they have one person outside therapy who would notice if they disappeared?
- Do they have any activity that brings them back to the present—a dog, a garden, a video game, anything?

If the answer to all of these is no, that's your starting point. Not the trauma. The utter absence of resource. You can't pendulate between activation and calm if there's no calm to pendulate to.

Red Flags: Stop Here

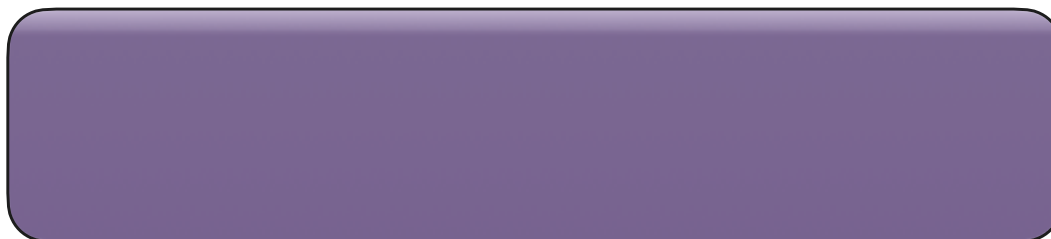
If any of the following are present, trauma processing is contraindicated. Not "proceed with caution"—contraindicated:

- Active suicidality without a robust support system in place. Processing will increase distress before it decreases it. Make sure they can survive that.
- Unable to maintain dual attention for even 30 seconds. If they can't hold "I'm here in the room AND I'm remembering the event," they will get lost in the memory. That's retraumatization, not processing.
- No observable window of tolerance. Everything is flooding or shutdown, no space between. They need a window before you can work within it.
- Active substance dependence. Not use—dependence. The nervous system is already hijacked. Stabilization means addressing the dependence first, or you're building on quicksand.
- Ongoing contact with perpetrator without safety boundaries. You cannot heal from trauma that is still happening.
- Severe dissociation without internal communication. Parts who don't know each other can't collaborate on healing.
- Zero working regulation strategies. Not "limited"—zero. They need at least one exit ramp before you put them on the highway.

Signs of Approaching Readiness

These don't mean "start processing tomorrow." They mean "we're heading in the right direction":

- Can name a body sensation connected to an emotion. Doesn't have to be precise—"my chest feels tight when I'm anxious" is enough.
- Shows capacity to pendulate. Activation goes up, activation comes down. There's movement, not just stuck-on or stuck-off.
- Can use at least one regulation strategy with prompting. Not automatically, not gracefully—but when reminded, something works.
- Demonstrates curiosity about internal experience. "Huh, that's interesting" instead of pure avoidance or pure overwhelm.
- Alliance ruptures can be repaired. This is huge. If they can be upset with you and come back, they can handle processing going sideways.
- Basic life stability. Roof overhead. Physical safety. One person who'd notice they were gone.
- For dissociative clients: some internal communication, however tentative. Parts who are at least aware of each other. Notice what's not on this list: symptom-free. Regulated. Healed. Stabilization doesn't mean the nervous system is calm. It means the nervous system has enough flexibility to tolerate controlled activation and come back.



What Stabilization Actually Looks Like in Practice

Stabilization isn't sitting across from your client waiting for them to spontaneously become ready. It's active, deliberate skill-building. Here's what we're teaching:

Grounding: Orienting to the room. Name five things you can see. Feel your feet on the floor. Notice the temperature of the air. These interventions are boring and they work. We're training the nervous system to find the present moment when it wants to time-travel to the trauma.

Containment: Teaching the system it can put things away. The container exercise isn't about pretending the trauma doesn't exist—it's about building the experience that intense material can be approached and then set aside. That approach-and-retreat capacity is what makes processing possible.

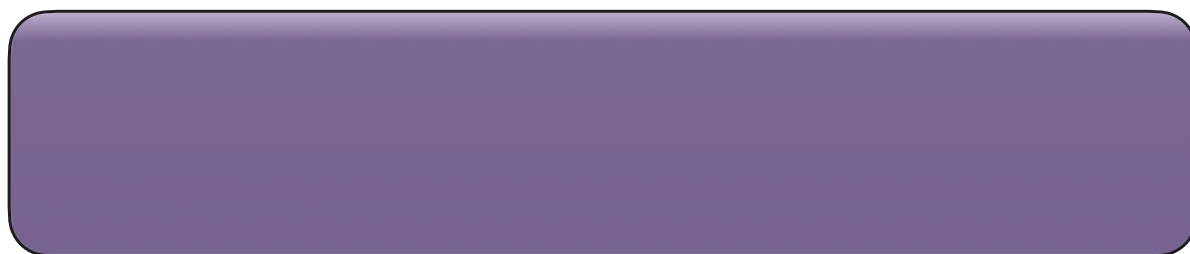
Somatic resourcing: Finding any place in the body that isn't activated. For some clients, this takes weeks. They've never experienced their body as anything other than a threat or a burden. We're looking for one square inch of neutral territory. The left earlobe. The space behind the knee. Something.

Titration: Approaching difficult material in doses the system can metabolize. Think of it like physical therapy after surgery: you don't run a marathon the week after knee replacement. You flex the joint, rest, flex again. We're building tolerance incrementally.

Affect labeling and scaling: "What would you call this feeling? On a scale of 0-10, how intense is it?" This isn't just assessment—it's intervention. Naming and measuring create distance. Distance creates capacity.

Parts work (when indicated): Mapping the internal system. Who's here? What do they need? What are they protecting? You cannot process a memory that belongs to a part who doesn't trust you yet. The relationship with the part comes first.

Co-regulation: Using your own regulated nervous system to help regulate theirs. This is half of what we actually do, and we almost never talk about it. Your calm is contagious—if they can borrow it.



Every Major Trauma Model Says the Same Thing

This isn't my personal opinion. Every evidence-informed trauma framework emphasizes stabilization before processing:

Different language, same principle: you have to build the container before you pour in the contents. Skip that step and everything spills.

Model	What They Call It
Judith Herman (1992)	Stage 1: Safety & Stabilization
EMDR Standard Protocol	Phases 1-2: History, Preparation
Sensorimotor Psychotherapy	Phase 1: Stabilization & Symptom Reduction
ISSTD Treatment Guidelines	Stage 1: Stabilization (often years)
IFS	Building Self-energy before unburdening
Somatic Experiencing	Resourcing before titrated trauma work

The Hardest Part

Stabilization work doesn't feel like trauma therapy. That's the problem.

Clients get frustrated. "I've been coming here for three months and we still haven't talked about it."

They want to lance the wound. They're tired of hurting and they think confronting the memory will make it stop.

Sometimes they're right. Sometimes they're not ready, and confronting the memory makes everything worse, and they lose faith in therapy, and they don't come back.

Supervisors raise eyebrows. "You've seen this client 40 times and you're still doing stabilization?"

They're thinking about outcomes measures and utilization review and best practices that were developed for single-incident PTSD, not the developmental chaos that walked into your office.

And you doubt yourself. Am I avoiding? Am I colluding with the client's avoidance? Am I just not skilled enough to do the "real" work?

Here's what I want you to know:

- If you're building regulatory capacity, you are doing trauma therapy.
- If you're strengthening the therapeutic alliance with someone who has never trusted anyone, you are doing trauma therapy.
- If you're helping someone develop their first working grounding technique after forty years of flooding, you are doing more than most processing-focused clinicians accomplish in months of protocol work.

Readiness Is Not Static

One more thing: readiness changes. It's not a threshold you cross once and stay across.

- Major life event? Reassess. A job loss or breakup or death in the family can knock someone from ready to not-ready overnight.
- Intense session last week? Check capacity before going further. Sometimes a good session depletes resources for the next one.
- Client seems eager to process? Still check. Eagerness isn't the same as capacity. Sometimes the push to process is itself a trauma response—flight into action to avoid feeling.
- Been stable for months? Don't assume. Life happens. Check anyway.

Expect two steps forward, one step back. That's how nervous systems actually heal. The linear progress narrative is a fantasy we tell ourselves to feel better about the messiness of the work. Protocol timelines are suggestions written for research samples, not for the specific human in front of you. The client's nervous system sets the pace. Your job is to follow it—not drag it where you think it should go.

The Bottom Line

I didn't learn any of this in grad school. I learned it by making mistakes—by moving too fast, pushing too hard, by confusing my timeline with my client's, by believing that some technique could override neurobiology.

What I know now: everything I thought was just setup—the part we had to get through to get to 'the trauma'—was the trauma work. Grounding. Resourcing. Relationship. Stabilization. It's not preliminary to trauma therapy. It IS trauma therapy. And when it's done well, it makes everything that comes after possible.

The clients who heal aren't the ones who processed the most memories. They're the ones who built the most capacity. Start there.

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Appendix: Nervous System Regulation Strategies

Practical techniques for building regulatory capacity

What follows is a toolkit—not a prescription. Different nervous systems respond to different interventions. Your job is to help clients find what works for their system, not to march them through every technique in order. I've organized these by what they're best for. Match the intervention to the state.

Practices for Calming Sympathetic Arousal

Use these when the client is activated, anxious, hypervigilant, or stuck in fight/flight.

Physiological Sigh

What it is: A double-inhale followed by an extended exhale. This is the fastest evidence-based way to reduce acute stress in real time.

How to do it:

1. Inhale through your nose until lungs feel about 75% full
2. Immediately take a second, shorter inhale through your nose to maximally inflate the lungs
3. Exhale slowly and completely through your mouth until lungs feel empty
4. The pattern: inhale-inhale-long exhale
5. Repeat 1-3 times as needed

Why it works: The double inhale reinflates collapsed alveoli in the lungs. The long exhale activates the parasympathetic nervous system. This pattern occurs naturally during crying and sighing—we're just doing it deliberately.

Best for: Panic attacks, acute anxiety, moments of overwhelm, anytime you need to calm down fast. Can work in 1-3 breaths.

4-7-8 Breathing

What it is: A specific breath pattern with extended exhale that activates the parasympathetic nervous system.

How to do it:

1. Exhale completely first
2. Inhale through nose for 4 counts
3. Hold breath for 7 counts
4. Exhale slowly through mouth for 8 counts
5. Repeat 4-8 cycles

Why it works: The extended exhale is key—it activates the vagus nerve and shifts the nervous system from sympathetic to parasympathetic dominance. The hold builds CO2 tolerance, which reduces anxiety sensitivity.

Best for: Sleep preparation, general anxiety, deep calming. Good for clients who like structure.

Left Nostril Breathing (Chandra Bhedana)

What it is: Breathing exclusively through the left nostril to activate the parasympathetic nervous system.

How to do it:

1. Sit comfortably with spine straight
2. Use your right thumb to gently close your right nostril
3. Inhale slowly and deeply through your left nostril for 4-6 counts
4. Close both nostrils briefly
5. Release right nostril and exhale through it for 4-6 counts
6. Continue this pattern for 5-10 minutes

Why it works: In yogic tradition, the left nostril is associated with cooling, calming energy.

Best for: Before sleep, when feeling overheated or overstimulated, for general calming. Some clients find this more accessible than other breath practices.

Humming / Vocal Toning

What it is: Using vocal vibration to stimulate the vagus nerve and create internal resonance.

How to do it:

1. Take a breath in
2. On the exhale, make a humming sound (mmmmm) or a low "voo" sound
3. Feel the vibration in your head, chest, and body
4. Repeat for several breaths
5. Can vary pitch—lower tones resonate in the chest, higher in the head

Why it works: Vocalization with long exhale directly stimulates the vagus nerve. The vibration itself is soothing to the nervous system. The extended exhale does the same work as other breath practices.

Best for: Calming, for people who respond to sound/vibration, as meditation practice. Some clients feel self-conscious—can be done very quietly or in private.

Progressive Muscle Relaxation

What it is: Systematic tensing and releasing of muscle groups to discharge stored tension and teach the nervous system what relaxation feels like.

How to do it:

1. Start with feet—tense all muscles for 5 seconds while inhaling
2. Release completely while exhaling slowly
3. Notice the contrast between tension and release
4. Move systematically up: calves, thighs, glutes, abdomen, hands, arms, shoulders, face
5. End with whole-body tension for 5 seconds, then complete release
6. Rest for 2-3 minutes feeling the relaxation

Why it works: Releases muscular armoring that trauma creates. Teaches the nervous system the difference between tension and relaxation—many trauma survivors have forgotten. Discharges stored sympathetic activation.

Best for: Chronic tension, hypervigilance, sleep preparation, clients who are disconnected from body sensations.

Hand on Heart (Self-Compassion Touch)

What it is: Using self-touch to activate the parasympathetic nervous system and provide soothing.

How to do it:

1. Place one or both hands over your heart
2. Feel the warmth of your hands through your chest
3. Notice your heartbeat if you can
4. Breathe naturally
5. Optionally add a phrase: "I'm here. I'm safe. This is hard and I can handle it."
6. Stay for 1-5 minutes

Why it works: Self-touch releases oxytocin. The pressure on the chest activates the vagus nerve. The gesture itself signals safety and self-compassion to the brain.

Best for: Self-soothing, emotional distress, self-compassion practice, grounding. Very accessible—can be done discreetly anywhere.

Practices for Activating from Shutdown

Use these when the client is numb, dissociated, foggy, collapsed, or stuck in dorsal vagal shutdown. The goal is gentle activation—bringing them back into the window of tolerance from below.

Cold Water / Temperature Contrast

What it is: Using cold temperature to rapidly activate the nervous system and trigger the dive reflex, which paradoxically calms after initial activation.

How to do it:

1. Splash cold water on your face, especially forehead and cheeks
2. Or: Fill a bowl with cold water and immerse your face for 15-30 seconds
3. Or: Hold ice cubes in your hands
4. Or: Run cold water over wrists
5. Follow with warmth (warm water, warm hands together) to complete the regulation cycle

Why it works: Cold on the face triggers the mammalian dive reflex, which immediately slows heart rate and shifts the nervous system. The intense sensation overrides dissociation and brings attention back to the body. This is one of the most powerful tools for interrupting panic OR shutdown.

Best for: Dissociation, numbness, shutdown, panic attacks. NOT for general anxiety (can make it worse). Specifically for when someone is either flooding or shut down.

Orienting

What it is: Slowly looking around the environment with curiosity, activating the brain's natural orienting response.

How to do it:

1. Pause whatever you're doing
2. Slowly turn your head and look around
3. Let your eyes land on something, then something else
4. Don't search—let your eyes be drawn naturally
5. Really SEE what you're looking at: colors, shapes, textures, details
6. Move slowly—this is key
7. Continue for 2-5 minutes

Why it works: Activates the orienting response—the brain's natural alertness system. Brings you into present moment. Reminds the nervous system: "I'm here, now, in this room." Satisfies the nervous system's need to scan for safety.

Best for: Dissociation, shutdown, rumination, hypervigilance seeking relief. Especially powerful in nature.

Bilateral Movement (Cross-Lateral Walking)

What it is: Rhythmic cross-body movement—the mechanism isn't fully understood, but it's regulating for many people.

How to do it:

1. Stand and march in place, lifting knees to hip height
2. Touch right hand to left knee, left hand to right knee
3. Continue for 2-3 minutes with steady rhythm
4. Focus on the crossing pattern and breath
5. End by standing still and noticing sensations

Why it works: Integrates nervous system across hemispheres. Reduces hypervigilance or activates from shutdown. Metabolizes stress hormones. The rhythmic, bilateral nature is inherently regulating.

Best for: Shutdown, need to discharge energy, integration after difficult content, general regulation.

Gentle Movement / Shaking

What it is: Using physical movement to discharge stored survival energy and re-engage the body.

How to do it:

1. Stand with feet hip-width apart, knees slightly bent
2. Begin gently bouncing or shaking—let the movement come from your legs
3. Let the shake travel up through your body
4. Arms can hang loose and shake freely
5. Continue for 2-5 minutes
6. End by standing still and noticing what's different

Why it works: Animals in the wild shake after surviving a threat—it discharges the survival energy. Humans often suppress this impulse. Deliberate shaking allows the nervous system to complete the stress response. **Best for:** After triggering events, stored tension, shutdown, freeze states. Some clients feel silly at first—normalize this.

Grounding Practices

Use these to bring attention to the present moment and establish safety in the here-and-now. Good for both activation and shutdown—they bring the nervous system toward the middle.

5-4-3-2-1 Sensory Grounding

What it is: Systematically engaging all five senses to anchor in the present moment.

How to do it:

1. Name 5 things you can SEE (look around, really notice them)
2. Name 4 things you can TOUCH/FEEL (the chair, your clothes, the air)
3. Name 3 things you can HEAR (distant sounds, close sounds, your breath)
4. Name 2 things you can SMELL (or imagine smell)ing)
5. Name 1 thing you can TASTE (or take a sip of water)
6. End by taking a breath and noticing where you are

Why it works: Forces attention into present-moment sensory experience. Impossible to be fully in a trauma memory while naming what you see in this room. Creates distance from internal distress by directing attention outward.

Best for: Flashbacks, dissociation, panic, intrusive memories, any time you need to get out of your head and into the room.

Grounding Through Weighted Contact

What it is: Using pressure and weight to signal safety to the nervous system.

How to do it:

1. Lie on your back with a weighted blanket (or heavy pillow on chest)
2. Feel the weight settling into your body
3. Breathe naturally
4. Notice points of contact with the ground
5. Mentally scan from head to toe, acknowledging each body part touching the surface
6. Stay for 10-20 minutes

Why it works: Activates deep pressure receptors, which calm the nervous system. Reduces cortisol. Mimics the feeling of being held or co-regulated. Signals safety to the brainstem.

Best for: Anxiety, sensory overwhelm, sleep difficulties, general calming. Some people find it activating rather than calming—test first.

Feet on Floor / Earth Connection

What it is: Using gravity and contact with the ground to establish presence and safety.

How to do it:

1. Sit with both feet flat on the floor (remove shoes if possible)
2. Press your feet gently into the ground
3. Notice the sensation of contact—temperature, texture, pressure
4. Feel the solidity of the floor beneath you
5. Imagine roots growing down from your feet into the earth
6. Breathe and maintain this awareness for 2-5 minutes

Why it works: Gravity is constant and reliable. Connecting to it reminds the nervous system that the ground is there, you're supported, you're not falling. Simple but powerful.

Best for: Anxiety, dissociation, feeling ungrounded or "floaty," beginning or ending sessions.

Self-Soothing / Co-Regulation Practices

These practices use touch and rhythm to activate the social engagement system and provide the kind of soothing that originally comes from safe others.

Self-Havening

What it is: A specific self-touch pattern that mimics soothing touch from caregivers.

How to do it:

1. Cross arms over chest, hands on opposite shoulders
2. Slowly stroke down your arms from shoulder to elbow
3. Use slow, gentle, rhythmic strokes
4. Can also stroke down face (forehead to cheeks) or stroke palms
5. Continue for 3-5 minutes or until you feel a shift
6. Can add calming statements: "I'm safe. I'm here. This is now."

Why it works: Self-touch releases oxytocin. The slow rhythmic movement activates the parasympathetic nervous system. The bilateral nature (both sides) promotes integration. Mimics the soothing we needed as children.

Best for: Distress, need for comfort, self-soothing practice, nightmares, before sleep. Very accessible.

Butterfly Hug with Bilateral Tapping

What it is: A self-administered bilateral stimulation technique that promotes integration and calm.

How to do it:

1. Cross arms over chest, hands on opposite shoulders
2. Alternate tapping: left shoulder, right shoulder, left, right
3. Keep rhythm slow and steady—about one tap per second
4. Continue for 10-30 seconds per set
5. Take a breath, notice what's shifted
6. Can do multiple sets

Why it works: Bilateral stimulation helps integrate both brain hemispheres. The rhythm is inherently soothing. The self-hug position activates self-compassion. SHORT sets promote calm; longer continuous stimulation may bring up material.

Best for: Emotional overwhelm, need for grounding, integration after difficult content, self-soothing.

Emergency / Crisis Tools

When nothing else is working and the client is in acute distress, these are your circuit-breakers.

- Cold water on face: Fastest intervention for panic. Triggers dive reflex. 15-30 seconds.
- Physiological sigh: Double inhale, long exhale. Can work in 1-3 breaths.
- Ice cube in hand: Intense sensation overrides dissociation. Hold until it melts.
- Strong taste or smell: Peppermint, lemon, ammonia capsule. Jolts attention to present.
- Stamp feet hard: Creates sensation, discharges energy, grounds to floor.
- Count backwards from 100 by 7s: Engages prefrontal cortex, interrupts limbic hijack.

The goal of an emergency intervention isn't to feel good—it's to interrupt the crisis state long enough to access other resources. Stabilize first, process later.

Quick Reference: Match the State to the Practice

Client State	Try These
Panic / Acute Anxiety	Cold water on face, Physiological sigh, 5-4-3-2-1
General Anxiety	4-7-8 breathing, Hand on heart, Progressive muscle relaxation
Dissociation / Numb	Cold water, Orienting, Movement, Strong sensation
Shutdown / Collapsed	Gentle movement, Bilateral walking, Temperature contrast
Hypervigilance	Orienting, Humming, Left nostril breathing
Flashback	5-4-3-2-1, Feet on floor, Orienting, Cold water
Anger / Need to Discharge	Movement, Shaking, Bilateral walking
Sleep Difficulty	4-7-8 breathing, Self-havening, Progressive relaxation
Need for Self-Compassion	Hand on heart, Self-havening, Butterfly hug

Remember: these are starting points. Some clients will respond to certain practices and not others. Part of stabilization is helping them build a personalized toolkit that actually works for their nervous system.

The best regulation strategy is the one your client will actually use. A technically perfect intervention that sits unused is worthless. A "good enough" strategy that becomes automatic is gold.

Reading #8 Excerpt Chapter 3: Enhancing Resilience: Integrating Multisensory Guided Imagery and ABLS for Resource Development

The Role of Imagination in Healing

Imagination is at the heart of healing trauma. Without it, how can we plan, create, or even conceive of change? As van der Kolk (2014) puts it, “Imagination gives us the opportunity to envision new possibilities—it is an essential launchpad for making our hopes come true.” Guided imagery taps into this capacity, creating reparative experiences that counteract trauma’s impact. Research shows that imagination can change the brain’s response to traumatic memories, making them less overwhelming (Reddan, Wager, & Schiller, 2018).

Trauma and the Nervous System

The parasympathetic nervous system supports "rest and digest" functions, helping the body and mind recover from states of hyperarousal and chronic stress. Within this system, the ventral vagal complex—the "social engagement system"—fosters safety, connection, and emotional regulation. Trauma disrupts these systems, leaving clients stuck in chronic dysregulation. This often shows up as emotional instability, trouble managing stress, difficulty maintaining relationships, and a pervasive inability to feel safe.

Resource development directly addresses these challenges, guiding the nervous system toward states of connection and calmness (Porges, 2011). At the core of Resource Development is guided imagery, which engages the imagination to create sensory-rich, reparative experiences. These experiences activate the ventral vagal complex, countering trauma’s grip on emotional well-being, relationships, and overall stability.

Evidence of Efficacy

The integration of multisensory guided imagery with Alternating Bilateral Stimulation (ABLS) represents a powerful therapeutic approach, leveraging the brain's sensory processing to enhance emotional and cognitive resilience. This combination is notably effective in enhancing the vividness and accessibility of positive memories, crucial for building adaptive resources clients can rely on in stressful situations (Christman et al., 2003; Christman et al., 2006; Lipke, 1994). Additionally, ABLS induces a state of relaxation by activating the parasympathetic orienting response, facilitating the integration of positive resources during therapy sessions (MacCulloch & Feldman, 1996; Sack et al., 2007).

Recent studies validate this approach, demonstrating that multisensory guided imagery combined with ABLS significantly augments alpha brainwave activity, which is associated with reduced stress levels and improved attentional control (Sedek et al., 2023). Moreover, in trauma therapy, this technique effectively engages the brain's right hemisphere, crucial for processing sensory and emotional experiences, bypassing the logical functions of the left brain to impact the limbic system directly. This allows clients to process traumatic memories in a non-verbal, sensory-oriented manner, offering a profound route for emotional healing (Naparstek, 2023).

These findings underscore the importance of multisensory approaches in psychological therapies, particularly in scenarios where traditional verbal-based methods may be inadequate. While EMDR claims these processes as innovative, it's crucial to acknowledge that the use of guided imagery combined with sensory stimulation has been a component of various psychotherapeutic

techniques long before its formal integration into EMDR, such as those found in Gestalt therapy and cognitive-behavioral approaches (Yontef, 1993; Beck, 1976). Recognizing these contributions can enrich the EMDR community's understanding and implementation of these techniques, ensuring that EMDR therapy is informed by a comprehensive, ethically grounded perspective that builds upon a rich tradition of clinical practice.

In a nutshell, *Resource Development* is a highly effective approach within trauma-informed therapy, helping clients build resilience and emotional capacity. It combines guided imagery and alternating bilateral stimulation (ABLS) to create reparative experiences that shift the nervous system into states of calmness and connection (Korn & Leeds, 2002; Porges, 2011). These experiences not only enhance clients' present-day well-being but also prepare them for trauma processing—if and when they choose to pursue it.

Introducing RDI to Clients

Clients often find guided imagery unfamiliar or even intimidating. Introducing RDI with a relatable and experiential exercise, like the Lemon Experiment, can help them understand how imagination directly influences the body.

Lemon Experiment Script

1. Set the Stage:

Invite the client to participate:

“We’re going to do a brief exercise to show how vividly imagining something can create a physical response. You don’t need to move or say anything—just listen and imagine along with me.”

2. Ground the Client:

“Feel your feet on the ground. Notice the chair beneath you. Let’s take a breath and settle in.”

3. Begin the Imagery:

“Picture yourself standing at the doorway of your kitchen. Look around—what do you see to your left? To your right? Notice the floor beneath your feet. Now, imagine walking over to your refrigerator. You hear the sound as you open the door, and the light comes on. Inside, you see two bright yellow lemons on the top shelf. Take one in your hand. Feel its coolness. Notice its slightly bumpy texture under your fingers.”

4. Deepen Sensory Engagement:

“Now, place the lemon on a cutting surface and pick up a knife. Slowly slice the lemon in half. Notice the spray of juice and the tangy scent filling the air. Take one half and bring it to your nose—you can smell the sharp, zesty scent of lemon. Now imagine taking a big bite of the lemon. You notice the sourness on your tongue and the increase in saliva in your mouth.”

5. Check In with the Client:

“Did you notice any changes in your body, like the increase in saliva? This shows how the nervous system responds to what the mind creates. If your nervous system believed the lemon was real, imagine how it can also believe in other positive images we create together.”

Adjusting for Clients Without a Lemon Neural Network

If a client has never tasted a lemon, this imagery won’t work because the neural network for sour taste doesn’t exist. In such cases, substitute the exercise with their favorite food. For example:

- Freshly Baked Bread: Guide them to imagine the warmth, softness, and inviting scent.
- Ripe Mango: Encourage them to picture the bright orange flesh, the sticky juice, and the sweetness on their tongue.

Tailor the experience to the client’s personal associations to ensure engagement and relevance.

Key Points to Share with Clients

Perception is Reality for the Nervous System:

“Your nervous system responds to what your mind creates, whether the experience is happening or remembered. We can use this to your advantage.”

Guided Imagery Activates Positive States:

“If a flashback can bring up fear and stress, we can intentionally create positive imagery to bring up feelings of safety, comfort, and strength.”

Building Emotional Resources:

“These exercises are like building a toolkit of emotional resources you can use anytime—whether you’re feeling overwhelmed, preparing for a challenge, or just need to feel more grounded.”

The Importance of Practice:

Encourage clients to practice these exercises regularly. Repetition strengthens the neural pathways associated with the resource, making it more accessible in moments of need. Suggest clients record their resourcing sessions on their phones (e.g., using Voice Memo or Voice Recorder apps) and listen to them daily.

The Goals of RDI

RDI serves two primary purposes:

1. **Enhancing Quality of Life:** Many clients benefit from RDI alone, using their resources to improve day-to-day stability and manage distress, even if they never process trauma memories.
2. **Building Internal Stability for Trauma Processing:** For clients who wish to address trauma memories, RDI serves as a preparatory tool, increasing their capacity to tolerate emotional distress. Beyond preparation, RDI-developed resources can also be “woven” into trauma memory networks during processing. This weaving integrates positive, stabilizing elements with distressing material, facilitating emotional integration and reducing overwhelm.

Key Goals of RDI

- **Improving Self-Regulation:** RDI strengthens clients’ ability to manage emotions, reducing feelings of overwhelm.
- **Reinforcing Positive States:** By fostering safety, strength, and connection, RDI counters the negativity bias often reinforced by trauma (Porges, 2011).
- **Fostering Emotional Resilience:** RDI equips clients with tools to navigate life’s challenges with greater confidence and stability.

Core Resources in RDI

Below are key resources clinicians can introduce, with flexibility to adapt or add others based on client preferences and therapeutic goals:

1. **Container Imagery:** Provides a mental “holding space” for distressing thoughts, feelings, or worries, helping clients set aside anything interfering with their ability to be present.
2. **Goal Setting Resource:** Guides clients to imagine their goals as already achieved, helping them articulate aspirations and anchor motivation in the present.
3. **Progress Resource:** Reinforces the progress a client has made in therapy, fostering a sense of accomplishment and growth.
4. **Nurturing Figure Resource:** Offers emotional comfort and care, addressing unmet emotional needs and fostering self-compassion.
5. **Ideal Parent Resource:** Represents the qualities of an ideal parent, drawn from real experiences, imagined figures, or the client’s own moments of nurturing others.
6. **Protector Figure Resource:** Embodies strength and safety, providing clients with an internal sense of courage and security.

7. **Wise Self Resource:** Represents the client's internal guide, drawing from life lessons, role models, and future aspirations.
8. **Triumphant Self Resource:** Anchors a sense of accomplishment and resilience, focusing on moments when the client overcame challenges.
9. **Spiritual Entity Resource:** Connects clients to a greater sense of meaning or spiritual guidance through religious figures, symbolic entities, or abstract representations.
10. **Future Self Resource:** Helps clients imagine their ideal future, offering a sense of hope, direction, and motivation.
11. **Ideal Therapist Resource:** Internalizes a supportive figure who empowers the client to navigate challenges independently.

Guiding Principles for Clinicians

1. **Personalization is Key:**
Each resource should reflect the client's unique needs, experiences, and preferences. Collaborate with the client to identify what feels meaningful and effective.
2. **Grounding Before Resourcing:**
Begin each session with grounding techniques to connect the client to the present moment. This ensures they are in a calm, receptive state before engaging in guided imagery.
3. **Use the Client's Own Words:**
When creating scripts for resourcing, use language that resonates with the client. Incorporate their descriptions of safety, strength, or comfort to enhance the resource's impact.
4. **Balance Structure and Flexibility:**
While RDI involves structured exercises, allow room for flexibility. If a client struggles with a particular resource, adapt the approach or explore alternative imagery that feels more accessible.

5. Reinforce Through ABLS*

Unless aversive or distracting to the client, pair all guided imagery with ABLS to integrate the resource at a neurobiological level. This can include short sets of horizontal eye movements, alternating auditory tones or music, tactile stimulation via a mechanical device, like the TheraTapper™, or using the *Butterfly Hug*, or self-tapping on thighs.

Using Scripts

Scripts for each resource are provided at the end of this chapter, not because they're necessary, but because they offer a helpful starting point. For clinicians newer to these techniques or looking to refine their approach, scripts provide a framework to structure resourcing exercises and guide clients effectively.

These scripts are not rigid or prescriptive. Instead, think of them as flexible guides—adapt and personalize them to align with the client's unique experiences, reactions, and preferences. Let the client's words and responses lead the way while using scripts to spark ideas and maintain the flow of the session.

Why This Works

- **Clear Goals:** Establishes the purpose of RDI upfront and emphasizes its versatility for both daily functioning and trauma processing.
- **Practical Resources:** Highlights key tools with concise descriptions that clinicians can easily reference.
- **Guiding Principles:** Encourages adaptability and personalization, which are central to effective therapeutic practice.

How to Integrate Resourcing Into Therapy

Resource Development and Installation (RDI) works best when seamlessly incorporated into the therapeutic process. The following structure outlines how to guide clients through resourcing, ensuring the experience is supportive, flexible, and tailored to their unique needs. Session Flow

1. Ground the Client

Grounding prepares clients for resourcing by helping them feel stable and connected to the present moment.

Steps:

- Use grounding techniques focused on the client's senses and physical sensations.
Example: "Feel your feet on the ground and the support of the chair beneath you. Notice three things you can see, two things you can hear, and one thing you can feel."
- Emphasize slow, steady breathing to activate the parasympathetic nervous system.

Why It Matters: Grounding ensures the client begins the exercise in a receptive, calm state, reducing the risk of distress or distraction.

2. Introduce the Resource

Guide the client in choosing and visualizing a resource that feels comforting, supportive, or empowering.

Steps:

- **Collaborate to Identify the Resource:**
 - Discuss options such as a nurturing figure, protector figure, or comfortable place.
 - Use the client's own language to describe the resource, avoiding terms like "safe" if they might evoke discomfort.
- **Create Vivid Imagery:**
 - Encourage the client to visualize or describe sensory details about the resource (e.g., sights, sounds, textures, smells).
Example: "What do you notice about the space around you? What sounds do you hear, or what sensations feel grounding?"
- **Why It Matters:** Personalized, vivid imagery makes the resource more tangible and meaningful, increasing its effectiveness.

3. Integrate ABLS (Only Once Positive Elements Are Established)

Alternating bilateral stimulation (ABLS) reinforces positive imagery, emotions, or sensations at a neurobiological level.

Steps:

- Begin with the Imagery:

- Allow the client to immerse themselves fully in the resource imagery, focusing on positive elements like comfort, strength, or connection.
- Ensure the client is experiencing a clear positive sensory or emotional experience before introducing ABLS.
- **Introduce ABLS Gradually:**
 - Begin ABLS with short, gentle sets aligned with the client's breathing or imagery rhythm.
 - Reinforce specific positive elements as the client focuses on them:
 - Visuals (e.g., a glowing light or serene environment).
 - Emotions (e.g., comfort or strength).
 - Sensations (e.g., warmth or grounding).
- Adjust Based on Client Feedback:
 - Regularly check in with the client: "Does the tapping help you feel more connected to this resource?"
 - If ABLS feels distracting or overwhelming, pause or omit it and continue with imagery alone.

Why It Matters: ABLS strengthens the client's connection to the resource, enhancing its impact and reinforcing positive neural pathways.

4. Address Contamination (If Applicable)

Sometimes, a resource may become "contaminated" by distressing associations. Addressing contamination ensures the session remains positive and effective.

Steps:

- Contain the Contamination:
 - Guide the client to imagine placing distressing elements into their container for later exploration.
 - Reassure them that the distressing elements are safely stored and don't require immediate attention.
- Explore Alternatives:
 - Collaborate to identify a new resource or imagery that feels neutral or positive.
 - Use exploratory questions:
 - ♦ "What's something small that brings you comfort or grounding?"
 - ♦ "Can you think of a figure or place that feels encouraging or steady?"

Why It Matters: Containing and redirecting contamination keeps the session focused on creating positive experiences and prevents unnecessary distress.

5. Reflect and Encourage Practice

- Reflection consolidates the client's experience, while regular practice strengthens their ability to access the resource independently.

Steps:

- Reflect on the Session:
 - Ask open-ended questions to help the client process their experience:
 - "How did that feel for you?"
 - "What stood out most about this resource?"
 - "Did it feel like something you could use outside of sessions?"
- **Encourage Regular Practice:**
 - Suggest clients record their resourcing session on their phone using a voice memo app (e.g., Voice Memo for iPhone or Google Voice Recorder for Android).

○ **Provide clear instructions:**

- “I’ll guide you through the resourcing exercise while you record it on your phone. Then you can replay it as often as you like.”

- Recommend daily listening to reinforce the resource and strengthen its neural pathways.

Why It Matters: Repetition and regular engagement reinforce the resource’s effectiveness.

Listening to their resourcing session creates familiarity, helping clients access the resource in moments of distress or challenge.

Why This Works

This structure emphasizes grounding, collaboration, and personalization, ensuring resourcing is safe, meaningful, and impactful. By integrating ABLS and addressing potential challenges like contamination, clinicians can adapt the process to meet each client’s needs. Encouraging reflection and practice ensures the resources remain accessible and effective beyond the therapy room.

Summary and Concluding Remarks

Resource Development and Installation (RDI) establishes a foundation for therapeutic success by fostering internal stability and equipping clients with tools to navigate distress and life’s challenges. Through guided imagery and, when appropriate, alternating bilateral stimulation (ABLS), clinicians can help clients improve their quality of life and, if desired, prepare for trauma processing.

Key Takeaways from This Chapter:

1. **The Importance of Imagination:** Imagination is a critical component of healing, enabling clients to envision and embody positive states that counteract the disruptions caused by trauma.
2. **Personalized Resourcing:** Effective RDI is tailored to each client’s needs, experiences, and preferences, ensuring resources resonate on a deeply personal level.
3. **Integration Through Practice:** Daily practice, including listening to recorded resourcing sessions, strengthens neural connections and makes these resources more accessible in moments of need.
4. **ABLS as a Reinforcement Tool:** ABLS can enhance the impact of guided imagery by reinforcing positive experiences at a neurobiological level. However, it is not mandatory and should always be adapted to the client’s preferences and feedback.
5. **Addressing Contamination:** Resource contamination underscores the need for flexibility and collaboration. Clinicians should address or contain distressing elements as they arise, maintaining the focus on positive and empowering experiences.

Looking Ahead: Behavioral Rehearsal

This chapter focused on cultivating imaginal resources to enhance clients' emotional stability and resilience. In the next chapter, we’ll explore how these resources can be applied to behavioral rehearsal. This technique helps clients prepare for future challenges by using their resourcing skills in scenarios that evoke fear, discomfort, or avoidance.

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Scripts

Container Imagery: A Secure Holding Space

Purpose: Container imagery is a foundational resource that helps clients temporarily set aside distressing thoughts, emotions, or sensations so they can focus on the present. Like cognitive therapy's "worry time," it offers a mental "holding space," fostering control, clarity, and emotional relief. Versatile, teachable, and incredibly effective, one might use the container to:

- Set aside performance anxiety or people-pleasing behaviors.
- Safely store trauma memories until they're ready to process them.
- Manage stress before sleep, exams, or family gatherings

It's the duct tape of therapy—simple, reliable, and endlessly useful.

Guided Imagery Script: Creating a Container

Step 1: Visualize the Container

Therapist: "Let's create a container that can hold anything you want to set aside for now. It can take any shape or form—a sturdy safe, a glowing orb, a locked box, or whatever feels secure to you.

"What does your container look like? Is it large or small? What material is it made of?"

[Allow time for the client to respond and visualize.]

ABLS Integration:

"Begin a short set of tapping as you bring your container into focus. Notice how it becomes clearer and more vivid with each tap."

Step 2: Add Functionality and Security

Therapist: "Now think about how your container works. How does it open and close? Does it have a lock, latch, or another feature that makes it feel completely secure?"

ABLS Integration:

"Let's tap that in as you focus on what makes your container feel safe and functional."

Step 3: Use the Container

Therapist:

"Take a moment to think about anything keeping you from being fully present—any worries, distractions, or even physical sensations. Imagine placing those into your container one by one. You don't need to solve or deal with them right now—they're just going into the container to be held safely until you're ready to come back to them."

ABLS Integration:

"Begin a short set of tapping as you place each item into your container. Notice how the container holds everything securely."

Step 4: Anchor and Label

Therapist:

"Now that everything is in the container, imagine sealing it. Maybe you close a latch, turn a key, or press your hands together as if locking it tight. Notice how secure it feels to know that everything is safely contained."

"Would you like to name your container? Some people call it 'The Vault,' 'The Safe Zone,' or something else that resonates with them."

[Allow the client to respond and name their container.]

Step 5: Create Distance

Therapist:

“Picture yourself stepping away from the container now, leaving it behind with everything safely inside. As you walk away, notice how it feels to create this space between you and the container.

“Let me know what you’re noticing in your body as you move further and further away.”

[Pause and check in.]

Client: “My shoulders feel lighter. My chest feels more open.”

Therapist: “Great. Let’s tap that in, focusing on the lightness in your shoulders and the openness in your chest.”

Step 6: Reflect and Reinforce

Therapist: “What are you noticing now?”

Client: “It feels like I can breathe more easily. My whole body feels calmer.”

Therapist: “Good. Remember, this container is always available to you. You can use it anytime you need to set something aside. And no one else has access to it—it’s entirely yours.”

Key Adjustments for Future Use

Container imagery is an incredibly versatile resource, but like any tool, it requires practice, flexibility, and occasional adjustments to meet the client’s evolving needs. Below are practical guidelines and common scenarios to ensure container imagery remains effective and accessible.

Key Guidelines:

1. The Container is Temporary, Not a Disposal Unit:

Clients may sometimes express a desire to “get rid of” the items in their container. It’s important to remind them that the container is not for disposal. Its purpose is temporary containment—to hold material safely until they have the internal and external resources to address it. Time itself is a resource, and the container allows the client to defer engagement with the material until they are ready.

The container is also invaluable at the end of a session when the client remains activated. By placing all session material in the container, the client can leave grounded, within their window of tolerance, and ready to transition back into their day.

2. Parts of the Client Cannot Be Contained:

The container is for holding memories, thoughts, worries, emotions, and even body sensations (including pain). No part of the client or their internal system can go into the container. As we say: “All parts are in the service of the self; therefore, all parts are welcome.”

3. The Role of Practice and Repetition:

Like any skill, container imagery improves with consistent practice. Encourage clients to use their container regularly outside of sessions. Repetition strengthens the neural pathways associated with the container, making it a reliable tool for managing distress.

Common Scenarios and Practical Solutions:

1. Contamination:

Clients may find that their container holds conflicting contents, such as a worry about their child’s health alongside a memory of their perpetrator. This can be overwhelming. A simple solution is to create a separate container for the specific concern. For example: “Where would you imagine your child being happy and cared for?”

This allows the original container to stay clear and focused while providing a dedicated space for the new material.

2. **Difficulty Closing the Container:**

If a client says, “My container won’t close,” explore practical fixes:

“What could help it close? Should we expand the size of the container or shrink the material to fit better?”

These small adjustments often restore the container’s function and ease the client’s discomfort.

3. **Reluctance to Walk Away:**

Some clients may feel unable to walk away from the container. Often, this stems from a perceived need to keep some of the material with them. For example, a client might say, “I need to keep some of my anxiety because it keeps me moving.” Collaborate with the client to find balance:

“What percentage of that anxiety feels helpful to keep?”

If they choose 40%, guide them to take that amount with them and leave the rest behind. Afterward, clients often report feeling lighter and more grounded while still carrying energy that feels productive.

Reinforcing Through ABLS:

Once adjustments are made, guide the client to walk away from the container while focusing on any positive sensations. For example:

“I feel lighter and energized, but with some excitement.”

If the energy feels good, ABLS can be used to strengthen the client’s connection to the imagery and deepen their sense of relief or stability.

Goal-Setting Resource

Purpose: The Goal-Setting Resource helps clients anchor their aspirations in the present tense, fostering a sense of immediacy and possibility. By imagining their goals as if already achieved, clients can enhance motivation, alignment with values, and agency. Using alternating bilateral stimulation (ABLS) during this process reinforces neural connections to these goals, making them feel tangible and achievable.

Introduction for Clinicians

Goal-setting in therapy moves beyond mere wish lists; it taps into the client's sensory and emotional imagination, aligning their nervous system with their aspirations. Research suggests that mental rehearsal of goals as already achieved can create positive neurobiological and psychological shifts (Porges, 2011).

Clinical Tip: Always phrase goals in the present tense to reflect the client's desired state. For example:

- "I exercise regularly and feel strong and energized."
- "I feel confident and capable managing my emotions."

Framing goals this way helps clients focus on possibility and action while strengthening their belief in their ability to change.

Therapist Script for Initial Session

Step 1: Introduce the Process

Therapist: "Let's take a moment to imagine what life might feel like when things are going the way you want them to. Instead of focusing on what you hope to achieve someday, I'll guide you to picture your goals as if they are already happening now. This can help make them feel more real and achievable. Are you ready?"

[Wait for client agreement and proceed.]

Step 2: Guided Visualization with ABLS

Visual Details:

Therapist: "Close your eyes, if that feels comfortable, and picture yourself in a life where things are going the way you want them to. What do you see? Describe the environment, the people around you, or anything that stands out."

[Client responds, e.g., "I see myself in a bright kitchen, cooking dinner with my family."]

Therapist: "Great. Let's tap that in as you picture yourself in that kitchen."

[Begin ABLS to anchor the visual detail.]

Present-Tense Goals Based on Visualization:

Therapist: "How would you describe this life in the present tense? For example, 'I cook healthy meals with my family.'"

[Client responds, e.g., "I cook dinner with my family every night. We laugh and talk together."]

Therapist: "Wonderful. Let's use a set of taps to deepen your connection to this image of your life as it is now."

Auditory Details:

Therapist: "What do you hear in this moment? Are there voices, music, or other sounds?"

[Client responds, e.g., "I hear my kids talking about their day, and we're laughing about something funny."]

Therapist: "Let's tap in that laughter and connection with your family."

[Begin ABLS to anchor auditory details.]

Tactile Details:

Therapist: “What do you feel physically in this life? Is there warmth, comfort, or a sense of relaxation?”

[Client responds, e.g., “I feel calm and happy. My shoulders are relaxed, and I’m smiling.”]

Therapist: “Focus on that calmness as we do another round of tapping.”

[Begin ABLS to anchor tactile sensations.]

Present-Tense Statements for Physical and Emotional Goals:

Therapist: “Now describe this life in the present tense. For example, ‘I feel calm and happy. My body is relaxed.’”

[Client responds, e.g., “I feel good about myself. I have energy, and I take care of my body.”]

Therapist: “That’s a powerful statement. Let’s do some tapping to anchor it.”

[Begin ABLS to reinforce the statement.]

Meaning and Values:

Therapist: “Why is this life so important to you? How does it reflect what matters most?”

[Client responds, e.g., “It means I’m being the parent I want to be, and I’m taking care of myself too.”]

Therapist: “Let’s tap in that sense of meaning and alignment with your values.”

[Begin ABLS to deepen the connection to the client’s values.]

Step 3: Documenting Goals in Present Tense

After the visualization, summarize and document the client’s goals using their words as much as possible and always in the present tense.

Example Summary for Client:

- "I cook dinner with my family every night, and we laugh and talk together."
- "I feel calm and happy. My body is relaxed."
- "I have energy, and I take care of myself by eating healthy, working out, and sleeping well."
- "I'm the parent I want to be, and I feel good about myself."

Therapist: “Here’s a summary of what you shared. We’ll keep this as a guide for our work together. Does this feel accurate to you? Is there anything you’d like to add?”

[Ensure the client agrees with and feels connected to the written goals.]

Key Elements of the Goal-Setting Resource

1. **Present-Tense Goals:**
 - Encourage clients to describe their goals as if they are already happening.
 - Use the present tense to create immediacy and a sense of achievement.
2. **Sensory Exploration with ABLS:**
 - **Visual:** “What does this life look like?” (Provide ABLS after each detail.)
 - **Auditory:** “What sounds do you hear?” (Provide ABLS to anchor these sounds.)
 - **Tactile:** “What physical sensations do you notice?” (Provide ABLS to reinforce tactile sensations.)
 - **Emotional and Physical:** “How do you feel in this life, and where do you notice it in your body?” (Provide ABLS to anchor these emotions.)
3. **Documentation:**
 - Write down the goals in the present tense, using the client’s language.
 - Share the documented goals with the client to reinforce alignment and motivation.
4. **Regular Practice:**
 - Suggest the client record their visualization session on their phone.
 - Encourage them to listen to it daily to strengthen neural connections and maintain focus on their goals.

Progress Resource

Purpose: The Progress Resource helps clients reflect on and internalize their growth and achievements, whether in the current therapeutic relationship or through past self-work. This resource reinforces positive change, builds self-confidence, and creates a tangible sense of accomplishment for clients to draw upon during challenging moments.

For new clients who've worked with previous therapists or on their own, this resource can be introduced during the initial assessment to acknowledge and anchor progress they've already made.

Clinical Tips

- **Include Progress from Previous Therapy or Self-Work:**
For new clients, explore achievements from earlier therapy or personal efforts.
- **Reframe Subtle Shifts as Progress:**
If a client struggles to identify progress, highlight small but meaningful changes (e.g., seeking help, showing up for therapy).

Therapist Script for Established Clients

Step 1: Introduce the Exercise

Therapist: "Let's take some time to reflect on all the progress you've made since we started working together. This resource will represent everything you've achieved so far in therapy. If you feel unsure or hesitant, that's okay—I can help guide you. Let's begin by thinking back to where you were when we started. What comes to mind?"

[Client responds, e.g., "I remember feeling completely overwhelmed by my anxiety. I couldn't even leave the house some days."]

Step 2: Identify Accomplishments

Therapist: "You've come such a long way since then. What are some specific things you've accomplished since we began working together?"

[If the client hesitates, prompt: "For example, I remember you telling me about going to that family event last month."]

[Provide ABLs after each accomplishment mentioned by the client.]

Step 3: Explore Imagery

Therapist: "Picture these accomplishments as stepping stones, each one building on the last. What do you see in your mind when you think about all this progress?"

[Client responds, e.g., "I see myself walking on a path, with each step feeling lighter."]

[Begin ABLs to anchor the imagery.]

Step 4: Connect to Emotions and Body Sensations

Therapist: "What emotions come up as you reflect on your progress? Where do you feel them in your body?"

[Client responds, e.g., "Pride and relief. I feel a warmth in my chest."]

[Provide ABLs to deepen and anchor these emotions and sensations.]

Step 5: Create an Anchoring Gesture

Therapist: "What gesture or posture reflects the progress you've made? It could be standing tall, placing a hand over your heart, or another movement."

[Client responds, e.g., "Standing tall with my hands on my hips."]

Therapist: "That's a great choice. Let's pair that posture with foot tapping to reinforce everything you've accomplished so far."

[Guide foot tapping while the client holds the gesture.]

Step 6: Name the Resource

Therapist: “Whenever you need to remind yourself of how far you’ve come, you can use this posture and tapping. What name or title would you like to give this resource?”

[Client responds, e.g., “My Progress Path.”]

Therapist Script for New Clients

Step 1: Introduce the Exercise

Therapist: “Before we begin this new chapter together, I’d like to help you reflect on the progress you’ve already made in therapy or on your own. This resource will represent everything you’ve achieved so far, even if it feels small. What comes to mind when you think about changes or growth in your life?”

[Client responds, e.g., “I worked with another therapist before, and I learned how to set boundaries with my family.”]

Step 2: Identify Accomplishments

Therapist: “That’s an important skill. What else stands out from your work with that therapist or from your own efforts?”

[Provide ABLS after each reflection to anchor the progress.]

[Client responds, e.g., “I started journaling more, and I’ve been better about asking for help when I need it.”]

Step 3: Explore Imagery

Therapist: “Imagine these accomplishments as part of a foundation you’ve built. What do you see when you think about this foundation?”

[Client responds, e.g., “I see a strong, solid brick wall, with each brick representing something I’ve worked on.”]

[Provide ABLS to reinforce this imagery.]

Step 4: Connect to Emotions and Body Sensations

Therapist: “What emotions arise as you think about that foundation? Where do you notice those emotions in your body?”

[Client responds, e.g., “I feel a sense of pride, and there’s a heaviness lifting from my shoulders.”]

[Provide ABLS to anchor these sensations and emotions.]

Step 5: Create an Anchoring Gesture

Therapist: “What gesture or posture reflects this foundation of progress? Maybe standing tall, with your hands over your chest, or something else?”

[Client responds, e.g., “Standing tall with my arms crossed over my chest.”]

Therapist: “Perfect. Let’s pair that gesture with foot tapping to strengthen your connection to this progress.”

[Guide foot tapping while the client holds the gesture.]

Step 6: Name the Resource

Therapist: “Would you like to give this resource a name or title?”

[Client responds, e.g., “My Foundation.”]

Key Elements of the Progress Resource

1. **Reflection on Achievements:**
 - Help clients identify accomplishments, whether recent or from past therapy.
 - Use prompts if necessary to highlight progress.
2. **Sensory Exploration with ABLs:**
 - **Visual:** “What image comes to mind when you think about your progress?”
 - **Emotional and Physical:** “What emotions come up, and where do you feel them in your body?”
3. **Anchoring Gestures with ABLs:**
 - Guide clients to select a gesture or posture that symbolizes their progress.
 - Use foot tapping if the gesture prevents hand-based tapping.
4. **Naming the Resource:**
 - Encourage clients to name their resource (e.g., “My Progress Path,” “My Foundation”) to personalize and reinforce its meaning.

Nurturing Figure

Purpose: The Nurturing Figure embodies comfort, care, and emotional support. This resource addresses unmet emotional needs, fosters self-compassion, and provides clients with a profound sense of being cared for. It can take the form of a person, animal, or abstract presence, such as warm light or a soothing sensation.

Clinical Tips

- **Help Clients Who Struggle with Imagery:**
If a client has difficulty imagining a nurturing figure, ask about times they offered care to someone else, such as a child, a pet, or even themselves. This reframing can help clients connect to their capacity for nurturing and being nurtured.
- **Personalize the Experience:**
Encourage clients to draw from real-life figures or create entirely new ones. The goal is to evoke a strong sense of comfort and safety.

Therapist Script with Client Example

Step 1: Introduce the Nurturing Figure

Therapist: “Let’s create a Nurturing Figure who makes you feel cared for, understood, and supported. This could be someone you know, a pet, or even an imagined presence like light or warmth. Who or what comes to mind when you think about feeling cared for?”

[Client responds, e.g., “My grandmother—she always made me feel safe.”]

Step 2: Explore Visual Details

Therapist: “Let’s picture her in your mind. What does she look like? What’s her expression or posture?”

[Client responds, e.g., “She’s sitting in her favorite chair, wearing her apron, and smiling at me.”]

[Begin ABLs as the client describes their visualization.]

Step 3: Explore Auditory Details

Therapist: “What sounds do you notice when you imagine her? Does she speak to you or hum, or is it quiet?”

[Client responds, e.g., “She says, ‘I’m so proud of you.’”]

Therapist: “Take a moment to focus on her voice. What makes this Nurturing Figure so meaningful to you?”

[Client responds, e.g., "She always listened to me and made me feel like I was enough."]

[Provide ABLS to anchor auditory details and deepen the emotional connection.]

Step 4: Connect to Emotions and Physical Sensations

Therapist: "As you focus on your grandmother, what emotions come up? Where do you feel those emotions in your body?"

[Client responds, e.g., "I feel warmth in my chest and a little bit of relief in my stomach."]

[Provide ABLS to anchor these sensations and emotions.]

Step 5: Create an Anchoring Gesture

Therapist: "Now, think about what gesture or posture represents the feeling of being cared for by your grandmother. It could be placing your hands on your chest, wrapping your arms around yourself, or something else."

[Client responds, e.g., "I think wrapping my arms around myself, like I'm giving myself a hug."]

Therapist: "That's perfect. Let's pair that self-hug with foot tapping so we can reinforce this connection to your Nurturing Figure."

[Guide foot tapping while the client holds their gesture.]

Step 6: Name the Resource

Therapist: "Whenever you need comfort, you can use this gesture and tapping to reconnect with your grandmother's care. Would you like to give this resource a name or title?"

[Client responds, e.g., "Grandma's Hug."]

Key Elements of the Nurturing Figure

1. **Imagining the Nurturing Figure:**
 - Encourage the client to picture someone or something that evokes feelings of care and comfort.
 - Focus on **visual**, **auditory**, and **emotional** details to make the figure vivid.
2. **Sensory Exploration with ABLS:**
 - **Visual:** "What does the figure look like?" (Provide ABLS after visualization.)
 - **Auditory:** "What do you hear when you imagine this figure?" (Provide ABLS to anchor auditory details.)
 - **Emotional and Physical:** "What emotions come up, and where do you feel them in your body?" (Provide ABLS to anchor these sensations.)
3. **Anchoring Gestures with ABLS:**
 - Help clients identify a gesture or posture symbolizing the comfort provided by the Nurturing Figure (e.g., a self-hug, hands over the chest).
 - Use foot tapping if gestures limit hand-based tapping.
4. **Naming the Resource:**
 - Encourage clients to give the resource a meaningful name or title, such as "Grandma's Hug" or "The Caregiver."

Why It Matters: The Nurturing Figure resource provides clients with a reliable sense of care and emotional safety, addressing unmet needs and fostering resilience. This resource can be revisited whenever a client needs comfort, grounding, or encouragement, strengthening their capacity for self-compassion and healing.

Ideal Parent Resource

Purpose: The Ideal Parent Resource provides clients with an internalized figure that embodies the nurturing, loving, and protective qualities they needed but may not have experienced. This resource helps meet emotional needs, build a sense of security, and offer guidance. For some clients, the resource might reflect moments when they themselves have been loving or protective toward others, such as a child, a pet, or a family member. For others, it might be entirely imagined or based on real-life role models.

Clinical Tips

1. For Clients with Parental Trauma:

Clients who have difficulty conceptualizing an Ideal Parent due to their own parental history can reframe this exercise as imagining "someone who provides the kind of love and support you needed or wanted."

2. Encourage Self-Recognition:

If the client struggles, highlight moments when they have acted as a loving or protective figure to someone else, emphasizing their own capacity for these qualities.

Therapist Script with Client Example

Step 1: Introduce the Resource

Therapist: "Let's create an Ideal Parent—a figure that embodies the kind of love, care, and protection every child deserves. This might be someone you know, an imagined figure, or even you at your best as a caregiver. Who or what comes to mind for you?"

[Client responds, e.g., "I see myself holding my daughter when she was upset. I was calm and steady, and she felt comforted."]

Step 2: Explore Visual Details

Therapist: "What does this Ideal Parent look like? What's their expression or posture?"

[Client responds, e.g., "It's me sitting calmly, holding her while she cries."]

[Begin ABLS as the client visualizes the details.]

Step 3: Explore Auditory Details

Therapist: "Do you hear anything in this scene? Maybe words of comfort, soft tones, or silence?"

[Client responds, e.g., "I told her, 'I'm here for you. You're okay.'"]

Therapist: "Focus on those words and how they made her feel. Let's tap that in."

[Provide ABLS to reinforce the auditory experience.]

Step 4: Explore Tactile Details

Therapist: "What does it feel like physically in this moment? Do you feel touch, warmth, or something else?"

[Client responds, e.g., "Her little hands on my shoulders. They felt grounding and steady."]

Therapist: "Let's anchor that grounding and steadiness with tapping."

[Provide ABLS to reinforce the tactile sensations.]

Step 5: Connect to Emotions and Physical Sensations

Therapist: "What emotions arise as you connect with this image of your Ideal Parent? Where do you notice these emotions in your body?"

[Client responds, e.g., "I feel love in my chest and strength in my hands."]

Therapist: "That's powerful. Let's reinforce that love and strength with another round of tapping."

[Provide ABLS to deepen the emotional and bodily connection.]

Step 6: Create Present-Tense Statements for Internalization

Therapist: "Let's describe this Ideal Parent in the present tense, as if it's happening right now. For example, 'I am steady, loving, and protective.' What words would you use?"

[Client responds, e.g., "I am calm and caring. I give my family a sense of security."]

Therapist: "Those are beautiful statements. Let's tap those in to make them feel even more real."

[Provide ABLs to anchor the present-tense statements.]

Step 7: Anchor with a Gesture and Name the Resource

Therapist: "What gesture or posture reflects how this Ideal Parent makes you feel? It could be placing your hands on your chest, wrapping yourself in a hug, or something else."

[Client responds, e.g., "Placing my hands over my heart."]

Therapist: "That's perfect. Let's pair that with foot tapping to strengthen the connection."

Would you like to give this resource a name or title?"

[Client responds, e.g., "My Loving Self."]

Key Elements of the Ideal Parent Resource

1. **Imagining the Ideal Parent:**
 - Encourage the client to visualize someone or something that embodies nurturing, love, and protection.
 - Help the client draw from personal caregiving experiences, imagined figures, or real-life role models.
2. **Sensory Exploration with ABLs:**
 - **Visual:** "What does this Ideal Parent look like?" (Provide ABLs to anchor visualization.)
 - **Auditory:** "What do they say or sound like?" (Provide ABLs to reinforce auditory details.)
 - **Tactile:** "What does their touch or presence feel like?" (Provide ABLs to anchor tactile sensations.)
 - **Emotional and Physical:** "What emotions come up, and where do you feel them in your body?" (Provide ABLs to deepen these sensations.)
3. **Present-Tense Statements:**
 - Encourage clients to describe their Ideal Parent in the present tense (e.g., "I am loving, calm, and strong").
 - Reinforce these statements with ABLs to promote internalization.
4. **Anchoring Gestures with ABLs:**
 - Guide the client to choose a gesture or posture representing their Ideal Parent (e.g., hands over heart).
 - Use foot tapping if gestures limit hand-based tapping.
5. **Naming the Resource:**
 - Help the client create a meaningful name for the resource (e.g., "My Loving Self," "The Protector").

It Matters: The Ideal Parent Resource provides clients with a reliable, internalized sense of love, care, and security. It addresses emotional wounds by creating a nurturing internal figure that clients can access during difficult times. By building this resource, clients gain tools to foster self-compassion, resilience, and emotional stability.

Protector Figure Resource

Purpose: The Protector Figure represents strength, courage, and steadfast support. This resource allows clients to internalize a sense of protection, creating a foundation of safety and empowerment when confronting challenges. The Protector Figure can be inspired by someone the client knows, a protective animal, an imagined figure such as a guardian angel or superhero, or even a symbolic entity like a shield or flame.

Therapist Script with Client Example

Step 1: Introduce the Resource

Therapist: "Let's create a Protector Figure—someone or something that makes you feel strong, safe, and supported. It could be a person, an animal, an imagined figure like a guardian angel, or even yourself at your most powerful. What comes to mind for you?"

Client: "My dog, Max—he always made me feel protected."

Therapist: "That's a wonderful choice. Let's focus on Max. What does he look like? How is he standing or sitting?"

(The client taps on their thighs, uses a TheraTapper, or performs foot tapping while describing the visualization.)

Step 2: Explore Visual Details

Therapist: "Focus on Max's expression and posture. What do you notice about how he looks at you?"

Client: "He's standing tall and alert, with his ears perked up and his tail wagging."

Therapist: "Let's tap that in as you picture him standing strong and alert."

(Guide ABLs as the client enhances their image.)

Step 3: Explore Auditory Details

Therapist: "What sounds do you notice when you imagine Max? Does he bark, growl, or is it quiet?"

Client: "It's quiet, but I can hear his breathing—steady and strong."

Therapist: "Let's anchor that steady, strong breathing with some tapping."

(Provide ABLs to reinforce the auditory elements.)

Step 4: Connect to Emotional and Physical Sensations

Therapist: "What makes Max such a strong Protector Figure for you?"

Client: "He was always there for me, no matter what. I knew he'd never let anything bad happen to me."

Therapist: "That's a powerful memory. As you focus on Max, what emotions come up? Where do you feel those emotions in your body?"

Client: "I feel strong and steady, like my chest is expanding and my legs feel grounded."

Therapist: "Let's deepen that sense of strength and steadiness with another round of tapping."

(Provide ABLs to anchor these sensations and emotions.)

Step 5: Create Anchoring Gestures and Name the Resource

Therapist: "What gesture or posture reflects the strength and safety Max gives you? Maybe standing tall, placing your hands over your chest, or something else?"

Client: "Standing tall with my arms at my sides, ready for anything."

Therapist: "That's a great choice. Let's tap in that readiness while you hold your posture."

(Guide ABLs while the client adopts and anchors their chosen gesture.)

Therapist: "Whenever you need to feel strong and safe, you can use this posture to reconnect with Max. Would you like to give this resource a name or title?"

Client: "My Guardian Max."

Key Elements of the Protector Figure

1. **Imagining the Protector Figure:**
 - Encourage clients to visualize a figure or presence that represents protection and strength.
 - Allow flexibility—this could be a real person, animal, imagined figure, or symbolic entity.
2. **Sensory Exploration with ABLS:**
 - **Visual:** "What does your Protector Figure look like? How do they stand or move?" (Provide ABLS after visualizations.)
 - **Auditory:** "What sounds do you notice when you imagine them?" (Provide ABLS to anchor auditory details.)
 - **Emotional and Physical:** "What emotions come up, and where do you feel them in your body?" (Provide ABLS to deepen these feelings.)
3. **Anchoring Gestures with ABLS:**
 - Encourage clients to select a gesture or posture that symbolizes the strength and safety of their Protector Figure.
 - Use ABLS (e.g., self-tapping or foot tapping) to anchor the gesture or posture.
4. **Naming the Resource:**
 - Guide clients to create a meaningful name or title for their resource (e.g., "My Guardian Max," "The Shield," or "Strong Self").

Why It Matters: The Protector Figure Resource fosters an internal sense of safety and empowerment, enabling clients to draw on a well of strength when faced with challenges. By combining vivid imagery with ABLS, clients can anchor the qualities of protection and courage in both their minds and bodies, providing a reliable tool for resilience in therapy and daily life.

Wise Self Resource

Purpose: The Wise Self represents the client's accumulated knowledge, life lessons, and insights gained through experience, learning, and inspiration from role models or mentors. This resource helps clients connect to their aspirations, harness past guidance, and gain clarity about their future. By creating a vivid and anchored connection to the Wise Self, clients can access their inner wisdom in moments of uncertainty or challenge.

Therapist Script with Client Example

Step 1: Introduce the Resource

Therapist: "Let's imagine a part of you that holds all the wisdom you've gathered throughout your life—everything you've learned from books, courses, experiences, and the role models or mentors who have inspired you. This is your Wise Self. What does this version of you look like?"

Client: "I see myself older, sitting in a chair with a stack of books around me."

Therapist: "That's a great image. What is your posture like? What is your expression?"

(Therapist provides ABLS, such as tapping on the thighs or foot tapping, to anchor the visual details.)

Client: "My back is straight, and I look thoughtful, like I'm about to give advice."

Step 2: Explore Sensory Details

Therapist: "Are there any sounds in this moment? Maybe the rustle of pages, the turning of a book, or just the quiet of the room?"

Client: "Just silence, like a calm space where I can think."

Therapist: "Let's tap that in as you focus on this calm and quiet."

(Provide ABLS after the auditory detail to anchor the connection.)

Step 3: Deepen Emotional and Physical Connection

Therapist: "What makes this version of yourself so meaningful to you?"

Client: "It reminds me of how much I've learned and how much I still want to grow."

Therapist: "That's a powerful insight. Let's deepen that connection to your growth and learning with some tapping."

(Provide ABLS to reinforce the emotional connection to this response.)

Therapist: "As you connect with your Wise Self, pay attention to your emotions. What comes up for you, and where do you feel it in your body?"

Client: "Hope, in my chest, and a sense of calm in my stomach."

Therapist: "Let's anchor that hope and calmness with another set of tapping."

(Provide ABLS to reinforce these sensations.)

Step 4: Focus on Future Vision

Therapist: "Your Wise Self also imagines your future—your dreams and hopes. What does this part of you say or envision about your tomorrow?"

Client: "She tells me to keep dreaming big and trust the process."

Therapist: "Let's anchor that message of trust and dreaming big with some more tapping."

(Provide ABLS to solidify the connection to this future-oriented vision.)

Step 5: Create Anchoring Gestures and Name the Resource

Therapist: "What gesture or posture represents your Wise Self? Maybe sitting in a chair, resting your hands on your lap, or something else that feels calming and wise?"

Client: "Sitting calmly, with my hands open on my lap."

Therapist: "That's perfect. Let's pair that posture with foot tapping to anchor this connection to your Wise Self."

(Guide ABLS using foot tapping while the client adopts their chosen posture.)

Therapist: "Whenever you need to draw on your inner wisdom, you can use this posture and tapping. What would you like to call this resource?"

Client: "My Inner Guide."

Key Elements of the Wise Self

1. Integration of Wisdom:

- Acknowledge the client's accumulated knowledge from books, courses, experiences, and mentors.
- Highlight the Wise Self's dual focus on learning from the past and envisioning a hopeful future.

2. Sensory Exploration with ABLS:

- **Visual:** "What does your Wise Self look like? What's their expression or posture?"
- **Auditory:** "What sounds do you notice? Do they say anything to you?"
- **Emotional and Physical:** "What emotions arise, and where do you feel them in your body?"
- Use ABLS after each sensory, emotional, or physical detail to anchor the resource.

3. Gestures and Anchoring:

- Encourage a calm, reflective posture or gesture that embodies wisdom (e.g., open hands on lap).
- Use foot tapping for ABLS if the posture limits hand-based tapping.

4. Naming the Resource:

- Help the client create a meaningful name or title for their Wise Self (e.g., "My Inner Guide," "The Mentor," or "Wise Me").

Why It Matters: The Wise Self Resource empowers clients to connect with their inner guidance, reminding them of their capacity for growth and their aspirations for the future. By integrating past lessons and future goals, this resource serves as a reliable compass for navigating challenges and making decisions. Through the use of ABLS, clients can strengthen and access this resource whenever they need clarity or support.

Triumphant Self Resource

Purpose: The Triumphant Self reconnects clients with moments of personal victory and resilience. This resource reminds them of their ability to face challenges and persevere, no matter the scale of the accomplishment. Whether the triumph is completing a race, resolving a conflict, or overcoming a personal fear, it fosters a sense of pride and strength.

Therapist Script with Client Example

Step 1: Introduce the Resource

Therapist: "Let's explore a moment in your life when you accomplished something that felt challenging. It could be a big achievement or a small victory—whatever feels significant to you. What comes to mind?"

Client: "Finishing my first half marathon."

Therapist: "That's a great example! Picture yourself in that moment of triumph. What do you see?"

Step 2: Visual Details

Therapist: "Let's focus on that image. What do you notice around you? Are there colors, shapes, or specific details that stand out?"

Client: "I see myself crossing the finish line with my hands in the air. There's a big banner over the street, and the crowd is cheering."

Therapist: "That's a vivid image. Focus on those details as we tap that in."

(Therapist provides ABLS, such as thigh tapping or foot tapping, to anchor the visualization.)

Step 3: Auditory Details

Therapist: "Can you hear anything in this moment? Maybe the cheers of the crowd, your own breath, or the sound of your feet on the pavement?"

Client: "I hear clapping and people cheering my name."

Therapist: "Let's tap that in while you focus on those sounds."

(Therapist provides ABLS to reinforce auditory elements.)

Step 4: Emotional and Physical Connection

Therapist: "What makes this accomplishment so meaningful to you?"

Client: "I never thought I could run that far. I trained for months and didn't give up."

Therapist: "That determination and persistence are powerful. Let's deepen that connection with some tapping."

(Therapist provides ABLS to anchor the emotional significance of this memory.)

Therapist: "As you connect with this moment, what emotions come up? Where do you feel those emotions in your body?"

Client: "Pride and joy. I feel it in my chest—it's like I'm standing taller."

Therapist: "Let's anchor that pride and strength with another set of tapping."

(Therapist provides ABLS to solidify the emotional and somatic experience.)

Step 5: Anchoring with Gestures

Therapist: "What gesture or posture represents this feeling of triumph? For example, raising your arms as you did at the finish line."

Client: "Raising my arms in the air—it feels powerful."

Therapist: "Perfect. Let's pair that gesture with foot tapping to reinforce your connection to your Triumphant Self. Focus on the feeling of pride and power as we do this together."

(Therapist guides foot tapping while the client holds the gesture of raised arms.)

Therapist: "You can use this gesture and tapping anytime you want to reconnect with your Triumphant Self. What name or title would you like to give this resource?"

Client: "My Runner Self."

Key Elements of the Triumphant Self

1. Focus on a Real Accomplishment

- Help the client identify a specific moment of triumph, regardless of scale.
- Highlight the effort, challenges, and victory associated with the accomplishment.

2. Sensory Exploration with ABLS

- **Visual:** "What does the moment of triumph look like?" (Provide ABLS after visualizing.)
- **Auditory:** "What sounds are present in this moment?" (Provide ABLS after auditory details.)
- **Emotional and Physical:** "What emotions come up, and where are they felt in your body?" (Provide ABLS after exploring these sensations.)

3. Anchoring Gestures with ABLS

- Encourage a gesture that represents triumph (e.g., raising arms, standing tall).
- Use foot tapping if gestures limit hand-based tapping or TheraTapper use.

4. Naming the Resource

- Encourage the client to choose a meaningful name for the resource (e.g., "My Runner Self," "Victory Pose," "The Champion").

Why It Matters: The Triumphant Self resource is a powerful reminder of the client's resilience and capability. By reconnecting with these moments of success, clients can draw on their internal strength to face current and future challenges with confidence. Through ABLS, the resource is anchored in both the body and mind, making it readily accessible during difficult times.

Spiritual Entity Resource

Purpose: The Spiritual Entity resource provides clients with a connection to a figure or presence that offers comfort, strength, and guidance. This resource fosters hope, stability, and a sense of belonging to something greater than themselves. It can take the form of a religious figure, an ancestor, a symbolic presence, or an abstract representation of spiritual energy or strength.

Clinical Tip: For clients who are not spiritual or religious, suggest symbolic representations such as light, a tree, or a sense of universal connection. Normalize that this resource can be deeply personal and abstract.

Therapist Script with Client Example

Step 1: Introduce the Resource

Therapist: "Let's imagine a spiritual presence that brings you comfort, strength, or guidance. This could be a religious figure, someone you've loved and lost, or even a symbolic image. What comes to mind?"

Client: "I see a glowing figure—it feels like an angel."

Step 2: Visual Details

Therapist: "That's a beautiful image. Can you describe the details of this angel? What do they look like, and what kind of light surrounds them?"

Client: "They're surrounded by soft golden light. Their wings are folded, and their face is calm and peaceful."

Therapist: "What else stands out? Do you notice anything about their posture or expression?" (Therapist provides ABLS, such as tapping on the client's thighs, after each visual detail is described.)

Client: "They look steady, like nothing could shake them."

Step 3: Auditory Details

Therapist: "What sounds, if any, are part of this image? Do they speak to you, or is there silence?"

Client: "They say, 'You are safe.'"

Therapist: "Let's focus on those words. Notice how it feels to hear that reassurance as we do a set of taps."

(Therapist provides ABLS to anchor the auditory experience.)

Step 4: Emotional and Physical Experience

Therapist: "What makes this angel so meaningful to you?"

Client: "It feels like they are protecting me, and they're always there when I need them."

Therapist: "That's a powerful feeling. Let's deepen that connection with another set of taps." (Therapist provides ABLS to reinforce the emotional connection.)

Therapist: "As you focus on this presence, what emotions arise? Where do you notice those emotions in your body?"

Client: "Relief and safety. I feel a lightness in my chest and warmth in my hands."

Therapist: "Let's anchor those feelings of relief and warmth with another set of taps." (Therapist provides ABLS to deepen the physical sensations.)

Step 5: Anchoring with Gestures

Therapist: "Now think about what gesture or posture captures the feeling of connection to this angel. Maybe placing your hands over your heart, sitting still with your palms open, or something else."

Client: "Placing my hands over my heart."

Therapist: "That's perfect. Let's pair that gesture with foot tapping to strengthen your connection to this spiritual entity."

(Therapist guides foot tapping while the client holds their chosen gesture.)

Therapist: "Whenever you want to reconnect with this angel, you can use this gesture and tapping. Would you like to give this presence a name or title?"

Client: "My Guardian Angel."

Key Elements of the Spiritual Entity Resource

1. Imagining the Entity

- Help the client identify a figure or presence that offers comfort, guidance, or hope.
- Allow for symbolic representations like light, energy, or natural elements.
- Encourage vivid sensory descriptions to bring the entity to life.

2. Sensory Exploration with ABLS

- **Visual:** "What does the entity look like?" (Provide ABLS after the client describes their imagery.)
- **Auditory:** "Do they speak to you? What do they say, or is there silence?" (Provide ABLS to anchor auditory details.)
- **Emotional and Physical:** "What emotions arise, and where do you feel them in your body?" (Provide ABLS to deepen emotional and physical sensations.)

3. Anchoring Gestures with ABLS

- Encourage the client to choose a gesture or posture that represents their connection to the spiritual entity (e.g., hands over the heart, open palms).
- Use foot tapping if gestures prevent hand-based tapping.

4. Naming the Resource

- Invite the client to name their resource, such as "My Guardian Angel," "The Protector," or "Golden Light."

Why It Matters: The Spiritual Entity resource fosters a sense of protection, belonging, and guidance that can anchor clients during times of distress or uncertainty. By internalizing this presence and integrating it with ABLS, clients can reconnect with their resource whenever needed, enhancing their resilience and emotional stability.

Future Self Resource

Purpose: The Future Self resource connects clients to their vision of who they hope to become—a version of themselves living in alignment with their goals, values, and dreams. This exercise fosters hope, promotes action, and instills a sense of purpose and direction.

Therapist Script with Client Example

Step 1: Introduce the Resource

Therapist: "Let's imagine a version of yourself in the future—someone who has achieved the goals and dreams you hold today. This is your Future Self, living the life you want. What do you see?"

Client: "I see myself standing in a sunlit room, smiling. I'm confident and happy."

Step 2: Visual Details

Therapist: "Take a moment to focus on that image. What's your posture? How are you holding yourself?"

Client: "My shoulders are back, and I look relaxed but strong."

Therapist: "That's a powerful image. Let's anchor it with some tapping."

(Therapist provides ABLS, such as tapping on the thighs or guiding foot tapping, while the client holds the image.)

Therapist: "What's around you in this future? Are there any objects, people, or other details?"

Client: "There's a desk with a journal, and I'm in a cozy, peaceful home."

Therapist: "Let's tap that in as you focus on this peaceful space."

(Therapist provides ABLS after the client visualizes the setting.)

Step 3: Auditory Details

Therapist: "Do you hear anything in this scene? Maybe voices, music, or just the natural sounds around you?"

Client: "It's quiet, but I can hear birds chirping outside the window."

Therapist: "Let's anchor that calm and connection to nature with another set of tapping."

(Therapist provides ABLS to deepen the auditory connection.)

Step 4: Emotional and Physical Connection

Therapist: "What makes this Future Self so meaningful to you?"

Client: "It shows me that I can create the life I want—that I'm capable of getting there."

Therapist: "That's an empowering realization. Let's strengthen that belief with some tapping."

(Therapist provides ABLS to deepen the emotional connection.)

Therapist: "As you connect with this version of yourself, what emotions arise? Where do you feel them in your body?"

Client: "Excitement and pride. I feel a lightness in my chest and a buzz of energy in my hands."

Therapist: "Let's anchor those feelings with another set of tapping."

(Therapist provides ABLS after the client identifies their emotions and bodily sensations.)

Step 5: Anchoring with Gestures

Therapist: "What gesture or movement captures the energy of your Future Self? Maybe standing tall, placing a hand over your heart, or something else?"

Client: "Standing tall with my hands on my hips, like I'm ready for anything."

Therapist: "That's a great choice. Let's pair that gesture with foot tapping so you can easily reconnect with your Future Self whenever you need to."

(Therapist guides the client through foot tapping while they hold the chosen posture.)

Therapist: "What name or title would you like to give this resource?"

Client: "My Best Me."

Key Elements of the Future Self

1. Visualization

- Encourage clients to imagine their Future Self in rich detail.
- Focus on the environment, posture, and expressions to make the vision vivid.

2. Sensory Exploration with ABLS

- **Visual:** "What does the Future Self look like?" (Provide ABLS after visualizing.)
- **Auditory:** "What sounds do you hear in this vision?" (Provide ABLS to reinforce auditory elements.)
- **Emotional and Physical:** "What emotions come up, and where do you feel them in your body?" (Provide ABLS after exploring these sensations.)

3. Gestures and Anchoring

- Encourage gestures or postures that embody the energy and confidence of the Future Self (e.g., standing tall, hands on hips).
- Use foot tapping for ABLS if the gesture limits hand use.

4. Naming the Resource

- Help the client give their resource a meaningful name (e.g., "My Best Me," "Confident Self," "Future Vision").

Why It Matters: The Future Self resource instills hope and motivation by helping clients visualize their goals as achievable and within reach. By using ABLS and anchoring gestures, clients can reconnect with this vision whenever they need a reminder of their aspirations and potential. This resource bridges the gap between where they are and where they want to be, fostering both action and resilience.

Ideal Resource

Purpose: The Ideal Therapist resource embodies the client's perception of a supportive, compassionate, and skilled therapist. By internalizing this figure, clients gain access to guidance, reassurance, and clarity when navigating challenges outside of therapy. It is especially useful for fostering self-regulation and problem-solving independence

Clinical Tip: Normalize the concept by explaining that the Ideal Therapist is not a replacement for the real therapist but an internal guide clients can access when support is unavailable.

Therapist Script with Client Example

Step 1: Introduce the Resource

Therapist: "Let's create an internal version of your Ideal Therapist—someone who embodies support, understanding, and wisdom. This could be based on me, another therapist you've worked with, or someone entirely imagined. Who or what comes to mind?"

Client: "I think it's a combination of you and my first therapist—someone who really listened and gave me practical tools."

Step 2: Visual Details

Therapist: "That's a great starting point. Let's picture this Ideal Therapist now. What do they look like? How are they sitting or standing?"

Client: "They're sitting across from me in a chair, with a calm and open posture."

Therapist: "What's their expression like? Are they smiling or just looking steady and attentive?"

(Therapist provides ABLS, such as tapping on the thighs, after the client describes the visualization.)

Client: "They're smiling gently, like they're really listening."

Step 3: Auditory Details

Therapist: "What do you hear in this image? Do they say anything to you, or is it more about their presence?"

Client: "They're saying, 'You've got this. Let's take it one step at a time.'"

Therapist: "Let's focus on those words and the calm tone of their voice. I'm going to guide you through a set of taps to anchor this."

(Therapist provides ABLS to reinforce auditory details.)

Step 4: Emotional and Physical Experience

Therapist: "What makes this Ideal Therapist so meaningful or helpful to you?"

Client: "They make me feel like I'm not alone, and they help me figure things out without judging me."

Therapist: "That's a powerful feeling. Let's tap that in."

(Therapist provides ABLS to deepen the emotional connection to this resource.)

Therapist: "As you focus on this Ideal Therapist, what emotions come up for you? Where do you notice those emotions in your body?"

Client: "I feel calm and hopeful. My chest feels lighter, and my shoulders are less tense."

Therapist: "Let's anchor those sensations and emotions with another set of taps."

(Therapist provides ABLS after the client identifies their emotions and bodily sensations.)

Step 5: Anchoring with Gestures

Therapist: "Now, think about what gesture or posture matches the feeling of being supported by your Ideal Therapist. Maybe it's sitting calmly, placing your hands on your lap, or something else."

Client: "Sitting with my hands relaxed on my lap."

Therapist: "That's perfect. Let's pair that posture with foot tapping to reinforce this connection. Whenever you need guidance, you can imagine this Ideal Therapist sitting with you. What name or title would you like to give this resource?"

Client: "My Inner Guide."

Key Elements of the Ideal Therapist

1. Imagining the Ideal Therapist

- Encourage the client to visualize a figure who embodies support, wisdom, and nonjudgmental guidance.
- Help them draw inspiration from real therapists, mentors, or imagined figures.

2. Sensory Exploration with ABLS

- **Visual:** "What does your Ideal Therapist look like?" (Provide ABLS after visualization.)
- **Auditory:** "Do they say anything to you? What words or tone do they use?" (Provide ABLS to anchor auditory details.)
- **Emotional and Physical:** "What emotions arise, and where do you feel them in your body?" (Provide ABLS to anchor these sensations.)

3. Anchoring Gestures with ABLS

- Encourage a calming posture or gesture that reflects the support of the Ideal Therapist (e.g., sitting calmly, hands on lap).
- Use foot tapping if gestures prevent hand-based tapping.

4. Naming the Resource

- Ask the client to name their Ideal Therapist (e.g., "My Inner Guide," "The Listener," or "Wise Mentor").

Why It Matters: The Ideal Therapist resource provides clients with a sense of constant support and encouragement, even outside of therapy sessions. By internalizing this figure, clients build resilience, self-reliance, and the ability to approach challenges with clarity and confidence. Incorporating ABLS ensures a deeper integration of this resource, making it readily accessible when needed

EMDR Tools & Technology

Tactile Stimulators

EMDR tappers (aka pulsators or buzzers) are devices that were invented and developed to provide alternating bilateral tactile stimulation. All are easy to use and a relatively inexpensive.

Bi-Tapp: Innovative EMDR Tappers

Bi-Tapp is a new and innovative type of EMDR tappers that uses gentle tapping instead of buzzing. Bi-Tapp tappers are synchronized via a mobile phone app, which allows therapists to control the tapping speed and intensity remotely. This makes Bi-Tapp ideal for both in-person and teletherapy sessions. Bi-Tapp is also being used in psychedelic-assisted EMDR therapy, which is a new and emerging treatment for trauma and other mental health conditions. Since the Bi-Tapps are wearable, they can be used to provide bilateral stimulation during psychedelic-assisted EMDR therapy sessions, when clients lie down with their eyes closed for extended periods of time.

Bi-Tapp virtual EMDR Tappers

<https://bi-tapp.com/product/bi-tapp-kit-shop/>

Bilateralstimulation.io Buzzers:

Reliable Bilateral Stimulation for Virtual EMDR Sessions Enhance your virtual EMDR therapy with Bilateralstimulation.io's innovative USB tappers. Developed during the COVID-19 pandemic, these buzzers seamlessly integrate with the virtual EMDR platform, offering effortless bilateral stimulation for remote sessions. Easy to set up and use, these tappers now come with a convenient carrying pouch and replacement cable.

<https://www.bilateralstimulation.io/tactile>

TheraTapper Pulsers

Therapappers are some of the most trusted tactile bilateral stimulation (BLS) devices for EMDR therapy. BLS is a key component of EMDR therapy, and it involves stimulating both sides of the body in an alternating fashion. This can be done using a variety of different devices, such as light bars, buzzers, and tappers. Therapappers are a type of tactile BLS device, which means that they use physical stimulation to activate both sides of the body. Therapappers are wired and battery-operated, and they are very easy to use. Simply place them in your palms or pockets, and they will start to vibrate. You can then adjust the intensity of the vibration to suit your needs. Therapappers are known for their high quality, reliability, and cost-effectiveness. They are also very durable and can last for years.

<https://theratapperinc.com/>

Touchpoints

TouchPoints are wearable tappers that can be clipped to socks, worn as wristbands, put in pockets, or simply held. They are used by EMDR therapists and the general population for stress reduction. TouchPoints use gentle vibrations to stimulate the body's natural stress response, helping to calm the mind and body. They are backed by scientific research and have been shown to be effective in reducing stress, anxiety, and other mental health conditions. TouchPoints are also a great way to improve focus, sleep, and overall performance. They are easy to use and can be used anywhere, anytime.

<https://thetouchpointsolution.com/>

EMDR Kit Pulsators

EMDR Kit's Bluetooth-operated EMDR pulsators are wireless, they look good and are operated via a free EMDR Kit app that you can use on your tablet or phone. EMDR Kit has two versions of their tappers – with or without headphones. The pulsators come with a docking station and a charger.

<https://www.emdrkit.com/en/product/pulsators-headphone-wireless-set-2024/>

(Environments) Virtual Sites for Remote EMDR

Bilateralstimulation.io

This tool is both free and user-friendly, ensuring HIPAA compliance while delivering online BLS training. It supports visual and auditory BLS, and with the addition of remote BLS buzzers, tactile BLS can be offered remotely. Alongside the free version, [bilateralstimulation.io](https://www.bilateralstimulation.io) provides a pro plan at \$15 per month, granting access to premium features.

<https://www.bilateralstimulation.io/help#tutorial>

<https://www.bilateralbase.com/>

RemotEMDR

remotEMDR brings you a cutting-edge, comprehensive solution for online EMDR therapy. The feature-rich platform enables you to provide your clients with the highest level of care, both online and in in-person sessions. remotEMDR brings together a HIPAA-compliant video chat with therapist-controlled bilateral stimuli, creating an invaluable resource for online EMDR therapy.

<https://www.remotemdr.com/>

EMDR Online Tools

EMDR Online Tools is a Dutch company that offers virtual EMDR tools for therapists worldwide. The platform offers solutions designed for EMDR therapists, aiming to streamline EMDR processing and progress tracking in virtual settings.

<https://emdronlinetools.com/>

EMDR Live

EMDR Live is online EMDR tool was made with love and is **free** to use - please feel free to share it with others. Connecting Clients and Therapists for live EMDR sessions.

<https://emdrlive.com/>

ActiveEMDR

Active EMDR offers a **free** bilateral stimulation (BLS) tool for EMDR therapists. This web-based application aims to replace your EMDR equipment. Active EMDR integrates with popular video-conferencing solutions and runs on your browser, so you don't have to download any software.

<https://activeemdr.com/>

Cloud EMDR

Cloud EMDR is a tool for Online EMDR Therapy. Two versions : and (a little less free) With our basic version (free), you can do a video call with Cloud EMDR by sharing your screen.~a few downsides: the animation isn't always smooth for the client and they can get distracted by seeing the controls.CloudEMDR (pro), you can do Remote Sessions: You send the client a link that they can go to and then you can control everything they see.

<https://docs.cloudemdr.com/faq/pro.html>

EMDR Bilateral Stimulator

Online tool for bilateral dual-attention stimulation.This tool is **free** to use for both client and therapist that provides visual and auditory bilateral stimulation. Therapists are required to register. This allows sessions to be saved so that clients can use the same link every session.

<https://emdrstimulator.com/>

Moved

Discover how the platform uses AI, data and algorithms to optimize treatment results. Clients will notice the remarkable, efficient outcomes facilitated by WeMind, specializing in optimal Dual Attention Stimulation and Memory Enhancement. More happy clients, with better results.

<https://moovd.nl/en/request-a-demo/?via=start>

EMDR Remote

EMDR Remote offers a reliable HIPAA-compliant solution for working virtually with your EMDR clients. EMDR therapists can easily change settings such as color, sound, volume, size, speed, light behavior, video stream display, and much, much more.

<https://www.emdrremote.com/>

Bilateral Base

Bilateral Base is a web-based, HIPAA-compliant application that offers a free plan (5 hours a month) and some paid plans.. The app combines video features with controls over sound and visual BLS. In the near future, there will be an option to combine tactile BLS with the app

**Recommended Readings
& Seminar References
2026**

Recommended Readings

EMDR General

- Eye Movement Desensitization and Reprocessing (EMDR): Basic Principles, Protocols, and Procedures, Francine Shapiro, Guilford, 1995
- Getting Past Your Past: Take Control of Your Life with Self-Help Techniques from EMDR Therapy, Francine Shapiro, Rodale Press, 2013
- EMDR Toolbox: Theory and Treatment of Complex PTSD and Dissociation~James Knipe (2015)
- EMDR Solutions I: Pathways to Healing ~Robin Shapiro (2005)
- EMDR Solutions II: for Depression, Eating Disorders, Performance, and More~Robin Shapiro & Celia Grand
- **A Therapist's Guide to EMDR: Tools and Techniques for Successful Treatment, Laurel Parnell 2006 W. W. Norton & Company**

EMDR & Addictions

- The Feeling-State Theory and Protocols for Behavioral and Substance Addictions: A Breakthrough in the Treatment of Addictions, Compulsions, Obsessions, Codependence, and Anger ~R. Miller, 2016
- Treating Addictions With EMDR Therapy and the Stages of Change~Nancy J. Abel, John M. O'Brien, 2014

EMDR & Pain

The New Change Your Brain, Change Your Pain: Based on EMDR ~Marc Grant (2016)

EMDR & Children

- EMDR and the Art of Psychotherapy with Children, Second Edition: Infants to Adolescents 2nd Ed. ~Robbie Adler-Tapia PhD & Carolyn Settle, 2017
- EMDR and the Art of Psychotherapy with Children, 2nd Ed (**Manual**): Infants to Adolescents **Treatment Manual** 2nd Edition ~Robbie Adler-Tapia & Carolyn Settle, 2017
- Child Trauma Handbook A Guide For Helping Trauma-Exposed Children and Adolescents by Ricky Greenwald Haworth, 2005
- Through the Eyes of a Child (Norton Professional Books) Robert H. Tinker and S.Wilsons
- Efficacy of EMDR in children: A meta-analysis <http://www.emdrkindenadolescent.nl/foldersEfficacy%20of%20EMDR%20in%20children%20A%20meta-analysis1.pdf>
- **EMDR Therapy and Adjunct Approaches with Children: Complex Trauma, Attachment, and Dissociation 1st Ed. Ana Gomez, 2013**

General Trauma Books

- Trauma Competency: A Clinician's Guide. Curran, 2009
- 101 Trauma-Informed Interventions, Curran, 2013
- Healing Trauma: Attachment, Mind, Body, and Brain by Daniel J. Siegel, 2003
- Invisible Heroes: Survivors of Trauma and How They Heal Bantam, Belleruth Naparstek, 2005
- Trauma and the Body: A Sensorimotor Approach to Psychotherapy, P. Ogden, 2006

- The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication, and Self-regulation (Norton Series on Interpersonal Neurobiology) S.W. Porges, 2011
- Affect Regulation and the Repair of the Self, Schore (Norton Series on Interpersonal Neurobiology)
- Waking the Tiger: Healing Trauma by P. Levine, 1997
- In an Unspoken Voice: How the Body Releases Trauma and Restores Goodness ~Levine, 2010
- Trauma and Memory: Brain and Body in a Search for the Living Past: A Practical Guide for Understanding and Working with Traumatic Memory ~P. Levine, 2015
- Treating Complex Traumatic Stress Disorders (Adults): Scientific Foundations and Therapeutic Models. Courtois, C. & Ford, J. The Guilford Press; 2013
- **Trauma and Recovery: The Aftermath of Violence--From Domestic Abuse to Political Terror ~J. Herman, 2015**
- **The Body Keeps the Score: Brain, Mind and Body in the Healing of Trauma, van der Kolk, Penguin Books, 2014**

Trauma & Dissociation

- Brand, B. L., et al. (2016). Guidelines for treating dissociative identity disorder in adults. *Journal of Trauma & Dissociation*.
- Brand, B. L., Schielke, H., Schiavone, F., & Lanius, R. A. (2022). *Finding Solid Ground: Overcoming Obstacles in Trauma Treatment*. This book offers evidence-informed strategies for stabilizing and treating complex trauma and dissociation.
- Schielke, H., Brand, B. L., & Lanius, R. A. (2022). *The Finding Solid Ground Program Workbook: Overcoming Obstacles in Trauma Recovery*. A companion workbook providing practical exercises for trauma recovery.
- Brand, B. L. (2023). *The Concise Guide to the Assessment and Treatment of Trauma-Related Dissociation*. A comprehensive guide on assessing and treating trauma-related dissociation.
- Fisher, J. (2017). *Healing the Fragmented Selves of Trauma Survivors: Overcoming Internal Self-Alienation*. This book explores therapeutic techniques for integrating fragmented self-states in trauma survivors.
- **Neurobiology and Treatment of Traumatic Dissociation: Towards an Embodied Self, Lanius, Paulsen & Corrigan, Singer Publishing, 2014**

Highly Sensitive Nervous Systems

- The Highly Sensitive Child: Helping Our Children Thrive When the World Overwhelms Them E. Aron
- **The Highly Sensitive Person. E. Aron, Urban Books**

Recommended CDs, DVDs & Online Programs

- EMDR & Beyond: The Trauma Power Therapies. Premier Publishing & Media, 2012
- Attachment-Focussed EMDR, Parnell PESI, 2017
- Healing Trauma: A Pioneering Program for Restoring the Wisdom of Your Body, Levine, 2012
- Sexual Healing: Transforming the Sacred Wound, Levine, Sounds True, 2002
- **EMDR Step By Step Plus, Curran PESI, 2020**

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Notes

SEMINAR SLIDES



SPEAKER BIO

Linda A. Curran, BCPC, LPC, CAADC, CCDPD
is a veteran clinician, best-selling author, international speaker, and film producer. With over two decades in the trenches specializing in complex PTSD, eating disorders, and attachment-related trauma, she serves as President of Integrative Trauma Treatment, LLC in Wilmington, Delaware. Having trained thousands of mental health professionals across the country, she blends Gestalt irreverence with EMDR precision to deconstruct rigid protocols—reminding clinicians that healing isn't one-size-fits-all. As the author of *Trauma Competency: A Clinician's Guide* and *101 Trauma-Informed Interventions*, and the creator of *The Master Clinician Series*, she continues to advocate fiercely for accessible, coherent, and integrative trauma treatment that prioritizes presence over protocol.

Linda A. Curran,
BCPC, LPC, CAADC, CCDPD

Introductions

Please Include:

- ❖ **Your name**
- ❖ **Where you live and/or work**
- ❖ **How long have you been a therapist?**
- ❖ **Are you seeing clients/patients: in person, virtual, or a hybrid of both?**
- ❖ **With regard to the trauma processing modality, EMDR, would you say that you are: a believer, a skeptic, or somewhere in between?**

The American Psychological Association (APA) now requires all presenters to add this slide to the beginning of your presentation.

Materials that are included in this course may include interventions and modalities that are beyond the authorized practice of mental health professionals.

As a licensed professional, you are responsible for reviewing the scope of practice, including activities that are defined in law as beyond the boundaries of practice in accordance with & in compliance with your profession's standards.

Scope & Limitations

EMDR Clinical Mastery Certification Bootcamp · 42 Hours

SCOPE
This 42-hour bootcamp trains licensed clinicians in the 8-phase and modified EMDR protocols, imaginal resourcing, and supervised reprocessing of traumatic memories.

PREREQUISITE
Assumes working knowledge of and clinical experience with complex trauma. This course does not provide foundational trauma training.

NOT COVERED

- Specialized EMDR adaptations (dissociative disorders, children, addictions, couples, military)
- In-depth training in Sensorimotor Psychotherapy, Internal Family Systems, or Somatic Experiencing
- Ongoing post-training supervision

LIMITATIONS & RISKS

- EMDR is evidence-based, but theoretical and neurophysiological models remain under ongoing scientific discussion.
- Reprocessing carries clinical risk; relative contraindications will be reviewed. Improper or premature application may result in destabilization or retraumatization.
- Experiential exercises may evoke strong emotional responses ~self-care is encouraged.

PROFESSIONAL RESPONSIBILITY
Participants must practice within the scope of their license, training, and competence and adhere to their professional ethical guidelines.

This disclaimer will also be announced verbally at the start of the webinar.

Lessons Learned 9/11

From Critical Incident Stress Debriefing (CISD) to Psychological First Aid

FILM CLIP

Psychological First Aid

Cavalcade Productions
www.cavalcadeproductions.com

TRAUMA 101

WHAT IS TRAUMA?

ACCORDING TO PETER LEVINE:

"Trauma is perhaps the most avoided, ignored, belittled, denied, misunderstood, and untreated cause of human suffering...."

WHAT IS TRAUMA?

*"...Although it is the source of tremendous distress and dysfunction, it is not an ailment or a **disease**, but the byproduct of an instinctively instigated, altered state of consciousness. ... We enter this altered state - let us call it survival mode- when we **perceive*** that our lives are being threatened...."*

WHAT IS TRAUMA?

*"If we are overwhelmed by the threat and are unable to successfully defend ourselves, we can become stuck in survival mode.... This highly aroused state is designed solely to enable **short-term* defensive actions**; but left untreated over time, it begins to form the symptoms of trauma. These symptoms can invade every aspect of our lives...."*

WHAT IS TRAUMA?

"Trauma is a basic rupture- loss of connection - to ourselves, our families, and the world. The loss, although enormous, is difficult to appreciate because it happens gradually. We adjust to these slight changes, sometimes without taking notice of them at all...."

WHAT IS TRAUMA?

"Contrary to the view of psychiatric medicine- that trauma is basically untreatable and only marginally controllable by drugs, when treated thoroughly healing can lead not only to symptom reduction, but long-term transformation."

FILM CLIP

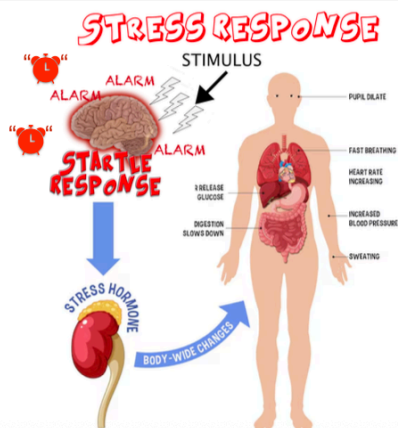
**Body-Oriented Trauma Therapy I:
Clinical Perspectives (2008)**

Cavalcade Productions

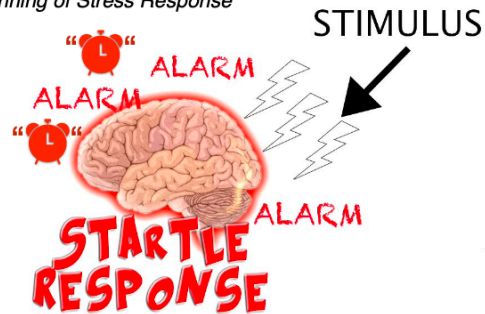
www.cavalcadeproductions.com

Biological Nature of Trauma

**Group Startle Exercise
F/B 4-7-8 Reset Breath**



The Startle Response is the
Beginning of Stress Response



Biological Nature of Trauma

IN HIS WORK, *HEALING TRAUMA*, LEVINE WRITES:

"HUMAN RESPONSES TO THREAT ARE PRIMARILY INSTINCTIVE AND BIOLOGICAL, AND SECONDARILY PSYCHOLOGICAL AND COGNITIVE. THEY COMPRISE THREE INNATE ACTION PLANS: FIGHT, FLIGHT, AND FREEZE."

THESE THREE RESPONSES ARE COMMON TO ALL MAMMALS....

"...WHEN WE SENSE THREAT, OUR BODIES AND MINDS ENTER THE FIRST STAGE OF WHAT IS CALLED AN 'AROUSAL CYCLE'. OUR MUSCLES TENSE, AND WE BEGIN TO SEARCH FOR THE SOURCE OF POSSIBLE DANGER."

Biological Nature of Trauma

"...IF WE LOCATE THIS SOURCE AND PERCEIVE IT TO BE A REAL THREAT, THEN WE ENTER THE SECOND STAGE."

MOBILIZED, OUR BODIES AND MINDS BEGIN TO PRODUCE ADRENALINE AND CORTISOL, THE TWO PRIMARY CHEMICALS THAT ENERGIZE US TO FIGHT OR FLEE."

Biological Nature of Trauma

"...IN THE THIRD STAGE: WE DISCHARGE THIS ENERGY BY COMPLETING THE APPROPRIATE DEFENSIVE ACTIONS (NAMELY, FIGHTING OR FLEEING)."

Biological Nature of Trauma

"...THE FOURTH AND FINAL STAGE ENSUES WHEN THE NERVOUS SYSTEM, NO LONGER AROUSED, RETURNS TO A STATE OF EQUILIBRIUM."

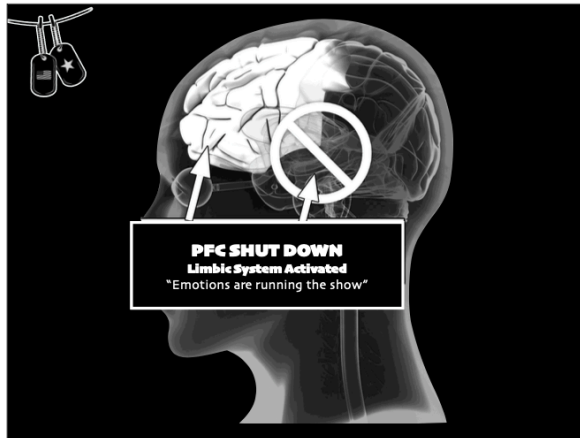
Biological Nature of Trauma

"IF WE ARE OVERWHELMED BY A THREAT AND ARE UNABLE TO FIGHT OR FLEE, WE INSTINCTIVELY EMPLOY THE THIRD ACTION PLAN, THE 'FREEZE RESPONSE' (ALSO KNOWN AS THE 'IMMOBILITY RESPONSE' OR 'PLAYIN' POSSUM')"



FILM CLIP

**Sympathetic
Freeze Response**



Classic PTSD

BRAIN STRUCTURES

- Anterior Cingulate Cortex
- Medial Prefrontal Cortex
- Amygdala
- Right Anterior Insula

PFC Shut Down
Limbic System Activated

Anterior Cingulate Cortex: hypo-activation; emotion regulation difficulties and reduced cognitive control

Medial Prefrontal Cortex: decreased activity and reduced structural integrity impaired leads to fear extinction, emotion regulation, & executive control over trauma-related responses

Amygdala: Exhibits hyperactivity & hypervigilance, with exaggerated threat detection and fear responses

Right Anterior Insula: heightened activation, reflecting increased interoceptive awareness and bodily sensations associated with fear and arousal states

SINGLE INCIDENT TRAUMA

Biological Nature of Trauma

“IN THE WILD, THIS DEFENSIVE MANEUVER (FREEZE RESPONSE) SERVES TWO PURPOSES:

- * *It may fool the attacker into losing interest, allowing us a chance to escape.*
- * *Most predators don’t eat dead things.*

Biological Nature of Trauma

HERE’S THE PROBLEM WITH THE SYMPATHETIC FREEZE RESPONSE (NOT THE DORSAL VAGAL RESPONSE):

EVEN THOUGH WE ARE IMMOBILIZED, THE NERVOUS SYSTEM IS STILL HIGHLY AROUSED. SINCE WE HAVE BEEN UNABLE TO DISCHARGE ANY OF THE FIGHT-OR-FLIGHT ENERGY THAT OUR BODY HAS MOBILIZED, WE ARE LEFT IN A STATE LIKE THAT OF A CAR WHOSE ACCELERATOR AND BRAKES ARE BEING FLOORED AT THE SAME TIME.

Biological Nature of Trauma

ANIMALS IN THE WILD WHO SURVIVE AN ATTACK BY USING THE FREEZING RESPONSE SIMPLY ALLOW FOR THE BIOLOGICAL DISCHARGE OF EXCESS ENERGY AND COMPLETION OF THE AROUSAL CYCLE.

- *They shake*
- *They rattle*
- *They roll around*
- *They tremble*

Biological Nature of Trauma

INSTINCTIVELY, ANIMALS TREMBLE IN A WAY THAT RESTORES SPONTANEOUS BREATHING AND ALLOWS THE NERVOUS SYSTEM TO REGAIN ITS BALANCE.

Biological Nature of Trauma

This is difficult for human beings for two reasons:

1. *The intensity of survival energy frightens us*
2. *We are not comfortable yielding our conscious control to involuntary (unconscious) sensations.*

Biological Nature of Trauma

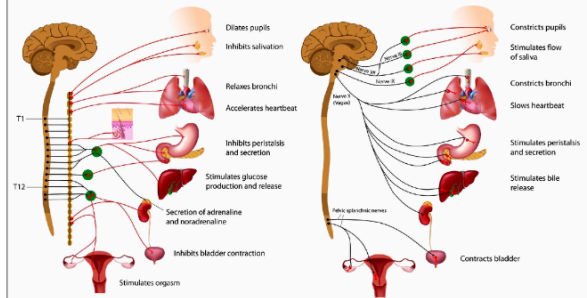
It is impossible to complete the arousal cycle if one can't move!

REVIEW ANS: SYMPATHETIC & PARASYMPATHETIC RESPONSES

Autonomic Nervous System

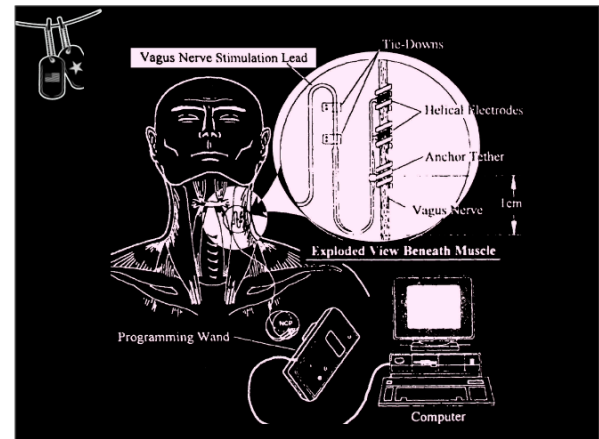
SYMPATHETIC DIVISION

PARASYMPATHETIC DIVISION



The Vagus~What Nerve!

Captain of the parasympathetic nervous system



The Polyvagal Theory

Stephen Porges, PhD

Tend/Befriend

Fight/Flight/Freeze

Collapse

Safety
Social Engagement
Ventral Vagal
Parasympathetic

Danger
Mobilization
Sympathetic

Life Threat
Immobilization
Dorsal Vagal
Parasympathetic

Optimal Physiological arousal
Socially Engaged (eye contact,
vocalization, facial expressivity)

Hyperarousal (increased HR, BP, etc)
Freeze is an activated state-hyper-
awareness, increased muscle tone
Possibly dissociated rage

Hypoarousal (decreased HR, BP, etc.)
Collapse-Loss of muscle tone,
Decreased conscious awareness

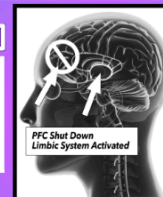
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Parasympathetic Freeze Response

PTSD DISSOCIATIVE TYPE

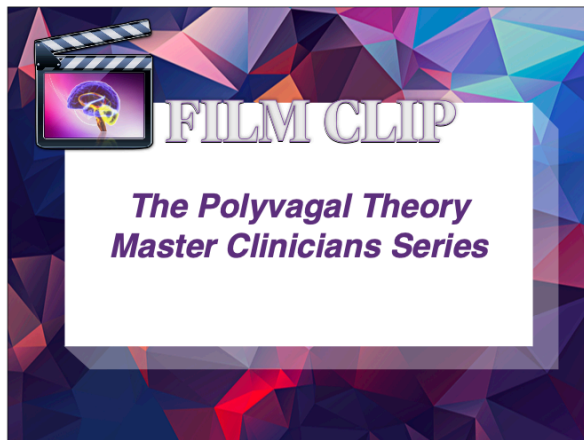
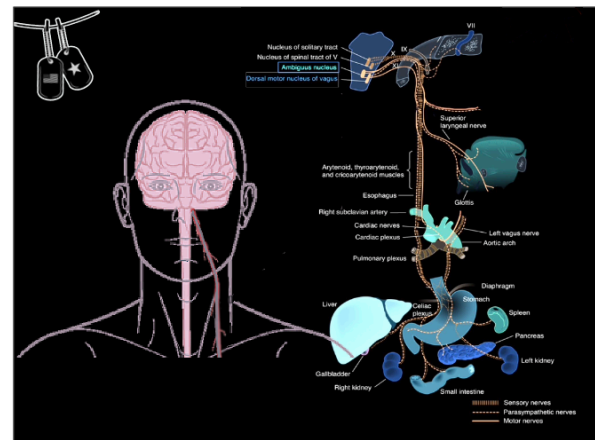
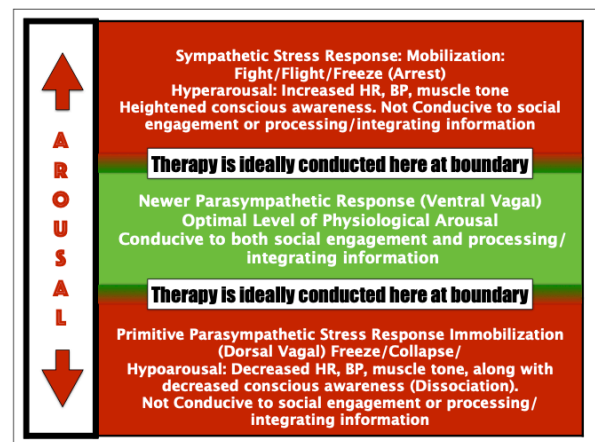
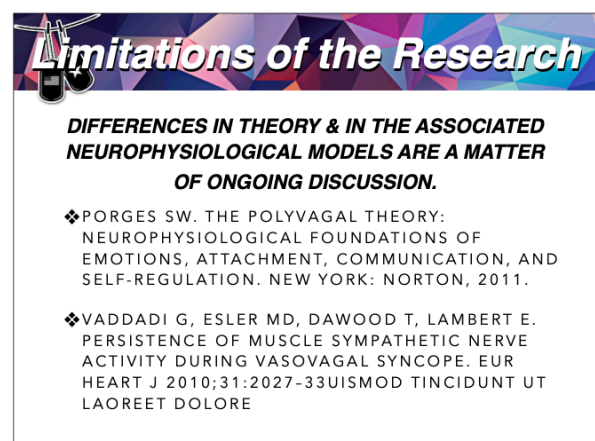
BRAIN STRUCTURES

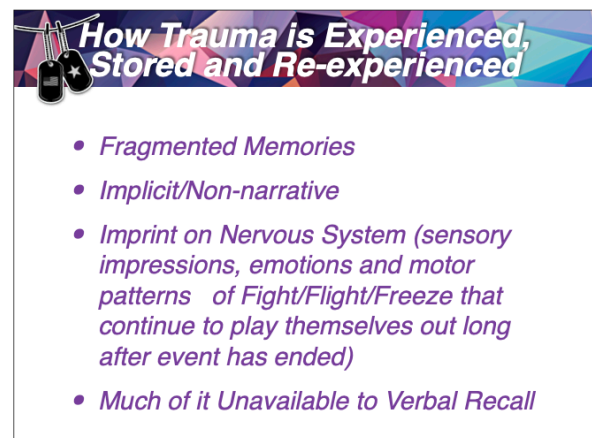
- Anterior Cingulate Cortex
- Medial Prefrontal Cortex
- Amygdala
- Right Anterior Insula



- Anterior Cingulate Cortex: hypo activation: emotion regulation difficulties and reduced cognitive control
- Medial Prefrontal Cortex: decreased activity and reduced structural integrity impaired leads to fear extinction, emotion regulation, & executive control over trauma-related responses
- Amygdala: Exhibits hyperactivity & hypervigilance, with exaggerated threat detection and fear responses
- Right Anterior Insula: heightened activation, reflecting increased interoceptive awareness and bodily sensations associated with fear and arousal states

PFC ACTIVATED
LIMBIC SYSTEM
SHUT DOWN







Biological Nature of Trauma

Simple post-traumatic stress disorder (PTSD) develops after a terrifying ordeal that involved physical harm or the threat of physical harm.

The person who develops PTSD may have been the one who was harmed, the harm may have happened to a loved one, or the person may have witnessed a harmful event that happened to loved ones or strangers.

(National Institute of Mental Health (NIMH))



Biological Nature of Trauma

- ❖ A trauma survivor can exhibit any or all of the symptoms described in the next sections, regardless of the cause of trauma.
- ❖ The important information, that connects the symptoms to the original trauma, is imprinted on the nervous system.



Biological Nature of Trauma

AN EVENT: Something highly stressful happens that exceeds the person's capacity, i.e. his/her internal and/or external resources were overwhelmed (inadequate for the situation).



Specific Trauma Symptoms & Their Order of Appearance

First Set

State Changes



Specific Trauma Symptoms & Their Order of Appearance

Physical Symptoms

- ☐ Hypervigilance (being on guard all the time)
- ☐ Extreme sensitivity to light and sound
- ☐ Hyperactivity, restlessness, agitation
- ☐ Exaggerated emotional and startle reactions
- ☐ Difficulty sleeping
- ☐ Hyperarousal (increased heart rate, difficulty breathing, cold sweats, tingling, muscular tension)



Specific Trauma Symptoms & Their Order of Appearance

Psychological Symptoms

- ☐ Intrusive imagery or flashbacks
- ☐ Nightmares and night terrors
- ☐ Affect dysregulation: abrupt mood swings (rage reactions, temper tantrums, shame)
- ☐ Reduced ability to deal with stress
- ☐ Racing thoughts and worry



Specific Trauma Symptoms & Their Order of Appearance

Second Set

Trait Changes



Specific Trauma Symptoms & Their Order of Appearance

Physical Symptoms

- ☐ Panic Attacks
- ☐ Agitation
- ☐ Anxiety
- ☐ Avoiding certain circumstances that remind us of previous traumas ability to deal with stress
- ☐ Exaggerated or diminished sexual activity*



Specific Trauma Symptoms & Their Order of Appearance

Psychological Symptoms

- ☐ Abrupt mood swings
- ☐ Dissociation: mental blankness or spaciness
- ☐ Frequent anger or crying
- ☐ Attraction to dangerous situations
- ☐ Amnesia and forgetfulness
- ☐ Fear of dying or having a shortened life
- ☐ Feelings of helplessness and immobility



Specific Trauma Symptoms & Their Order of Appearance

Relational Symptoms

- ☐ Avoidance
- ☐ Isolation



Specific Trauma Symptoms & Their Order of Appearance

Final Set

Physical Changes

Medical Issues



Specific Trauma Symptoms & Their Order of Appearance

Physical Symptoms

- ☐ Headaches
- ☐ Chronic fatigue, very low physical energy
- ☐ Immune system and certain endocrine problems
- ☐ Thyroid dysfunction
- ☐ Psychosomatic illnesses
- ☐ Neck and back problems
- ☐ Asthma
- ☐ Irritable bowel syndrome
- ☐ Spastic colon
- ☐ Severe PMS
- ☐ Eating disorders



FILM CLIP

Robert Scaer, MD

Master Clinician Series: TraumaTreatment



Specific Trauma Symptoms & Their Order of Appearance

Psychological Symptoms

- ☐ Excessive shyness
- ☐ Diminished emotional responses
- ☐ Depression
- ☐ Feelings of impending doom



Specific Trauma Symptoms & Their Order of Appearance

Spiritual Symptoms

- ☐ Feeling like the living dead: detached, alienated and isolated
- ☐ Disconnection from the mysteries of self and world



Simple PTSD

Duration

IF LASTS < ONE MONTH =
ACUTE STRESS DISORDER

IF LASTS > SIX MONTHS =
CHRONIC PTSD (NOT COMPLEX)

(National Institute of Mental Health (NIMH))



PTSD DISSOCIATIVE TYPE

“...we will present evidence in favor of a dissociative subtype of PTSD, with clinical and neurobiological features that can be distinguished from non-dissociative PTSD. The dissociative subtype is characterized by frequent over-modulation of affect, while the more common under-modulated type involves the predominance of the more commonly studied reexperiencing and hyperarousal symptoms. These findings have important implications for treatment of PTSD, including the need to assess patients with PTSD for dissociative symptoms and to incorporate the treatment of dissociative symptoms into stage-oriented trauma treatment

PTSD DISSOCIATIVE TYPE

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

- **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
- **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

Brain Networks in Classic PTSD vs. PTSD- Dissociative

Ruth Lanius's research distinguishes between two distinct subtypes of emotional regulation: **undermodulation** (re-experiencing PTSD), characterized by low vmPFC control and high amygdala activity and **overmodulation** (dissociative PTSD), characterized by high medial prefrontal cortex (vmPFC) control and inhibited emotions

- **Undermodulation (re-experiencing PTSD),** characterized by low vmPFC control and high amygdala activity
- **Overmodulation (dissociative PTSD),** characterized by high medial prefrontal cortex (vmPFC) control and inhibited emotions

Lanius RA, Vermetten E, Loewenstein AL, Dwyer B, Schmitz G, Bremner JD, and Sengco G. (2010). Emotion Modulation in PTSD: Clinical and Neurobiological Evidence for a Dissociative Subtype. *Arch Psychiatry* 2010; June, 167(6): 640-647. doi:10.1093/archpsp/psq008
Lanius RA, Frewen PA, Tannock M, Jolly A, & McKinnon MC. (2010). Restoring large-scale brain networks in PTSD and related disorders: A proposal for neuroscientifically-informed treatment interventions. *European Journal of Psychopathology* 4:1-17. doi: 10.1007/s10329-010-0101-0

PTSD DISSOCIATIVE TYPE

BRAIN STRUCTURES

- Anterior Cingulate Cortex ↓
- Medial Prefrontal Cortex ↓
- Amygdala ↑
- Right Anterior Insula ↑

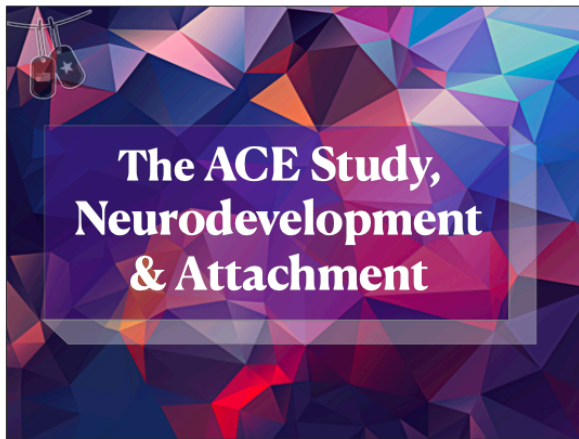
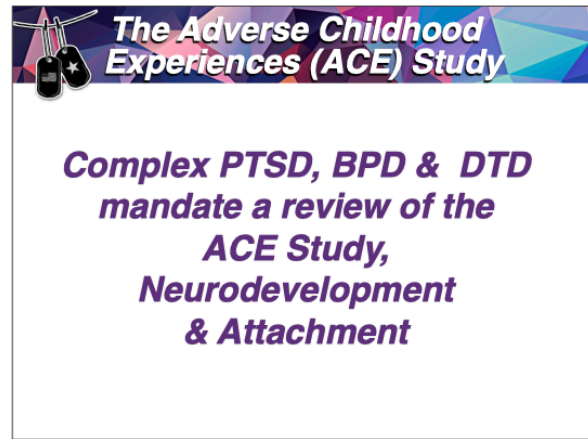
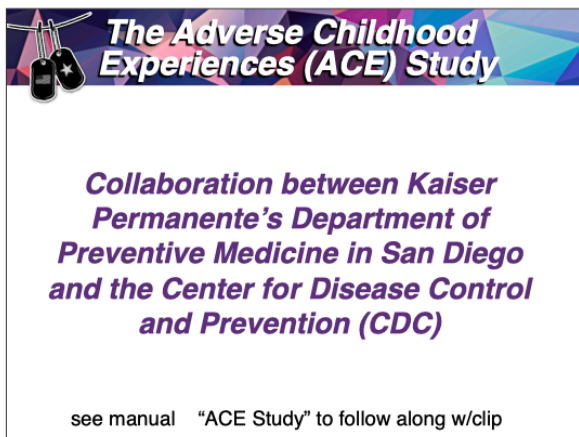
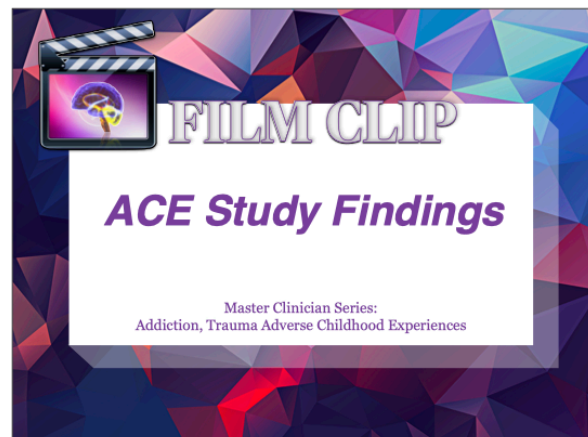
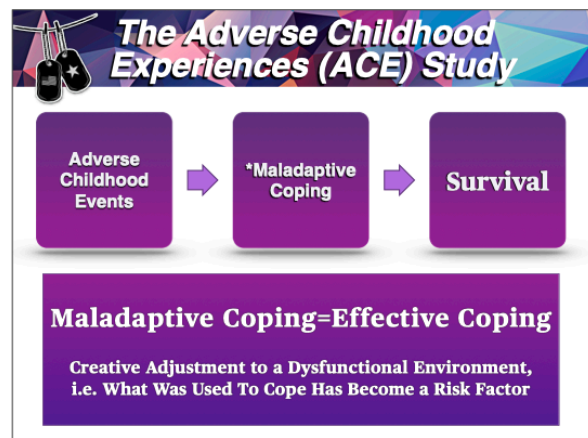
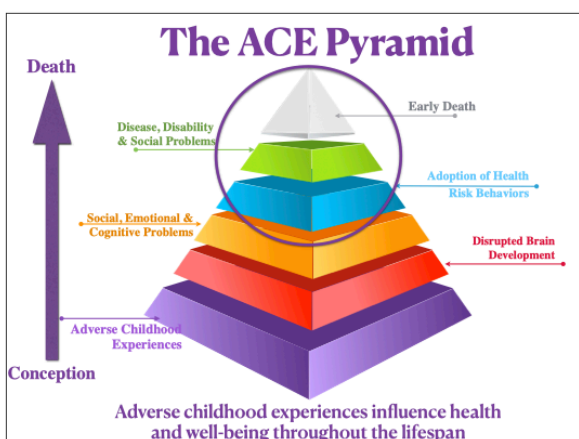
Anterior Cingulate Cortex: hypo-activation: emotion regulation difficulties and reduced cognitive control

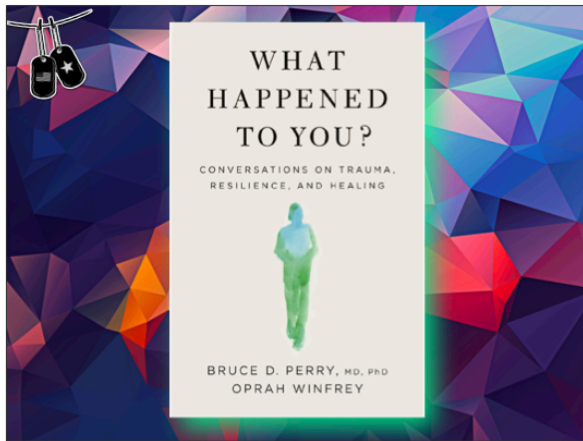
Medial Prefrontal Cortex: decreased activity and reduced structural integrity impaired leads to fear extinction, emotion regulation, & executive control over trauma-related responses

Amygdala: Exhibits hyperactivity & hyper vigilance, with exaggerated threat detection and fear responses

Right Anterior Insula: heightened activation, reflecting increased interoceptive awareness and bodily sensations associated with fear and arousal states

Distinguishing Features: PTSD vs PTSD (Dissociative Subtype)		
Features	PTSD (Classic Reexperiencing)	PTSD (Dissociative Subtype)
Reaction to Exposure of Traumatic Material	<ul style="list-style-type: none"> • Fear/Terror/Anxiety • Increased physiological arousal • Suppression of ANS response • Normal HR and GSC 	<ul style="list-style-type: none"> • Dissociation Numbing • Suppression of ANS response • Normal HR and GSC
Epidemiology	Generally associated with a single incident trauma in adulthood	Generally associated with months to years of trauma in adulthood OR developmental trauma
Levels of Structural Dissociation of Personality	Primary	Secondary
# of Apparently Normal Personalities	1	1
# of Emotional Personalities (EP)	1	2 or more
Phenomenology	Reexperiencing	Dissociation Reexperiencing
Concept	Emotional Undermodulation	Emotional Overmodulation
Brain Imaging	Anterior Cingulate Cortex Medial Prefrontal Cortex Amygdala Right Anterior Insula	Anterior Cingulate Cortex Medial Prefrontal Cortex Amygdala Right Anterior Insula



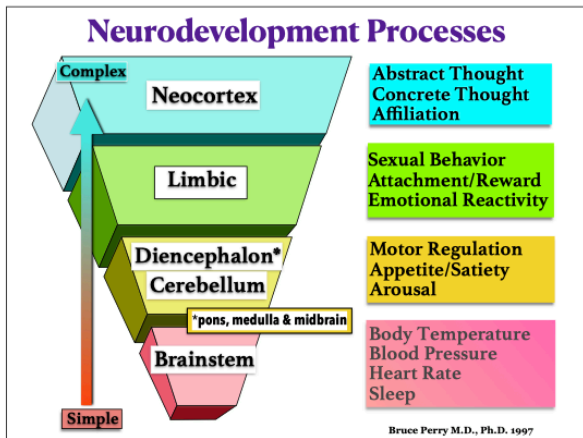
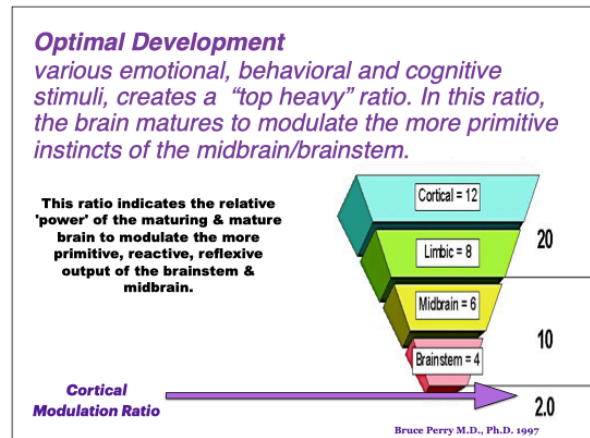
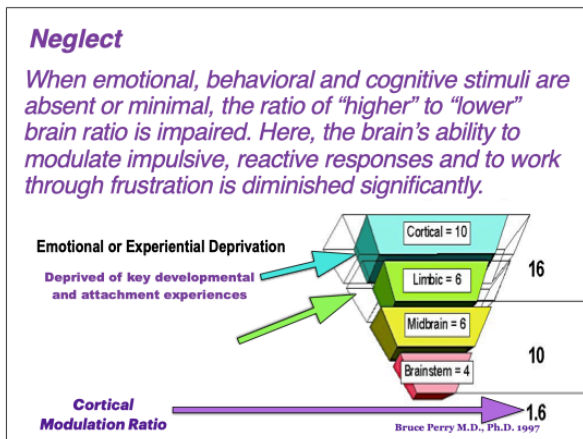
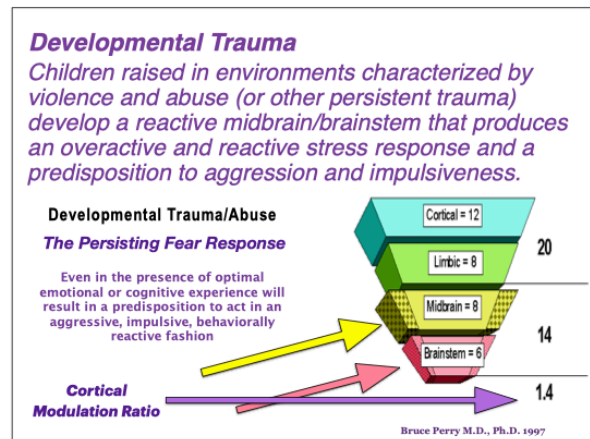
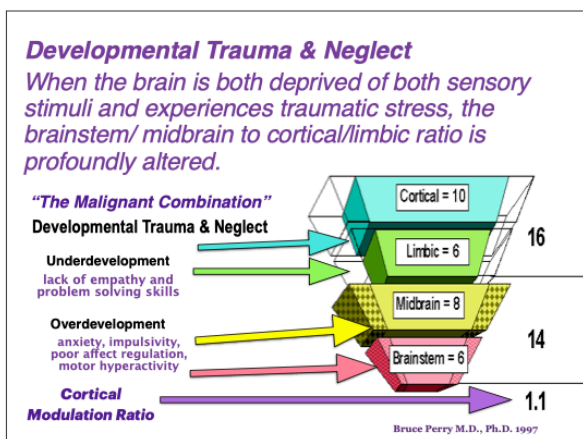


NEURODEVELOPMENT

BRUCE PERRY, MD, PH.D

PRINCIPLES OF NEURODEVELOPMENT

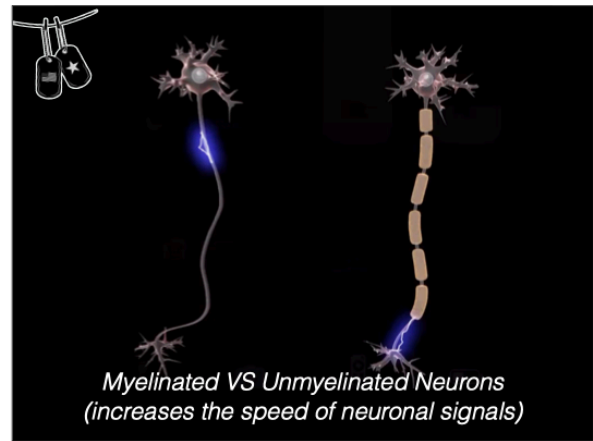
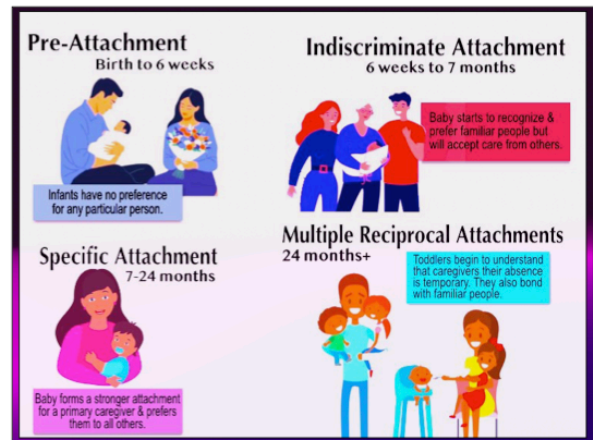
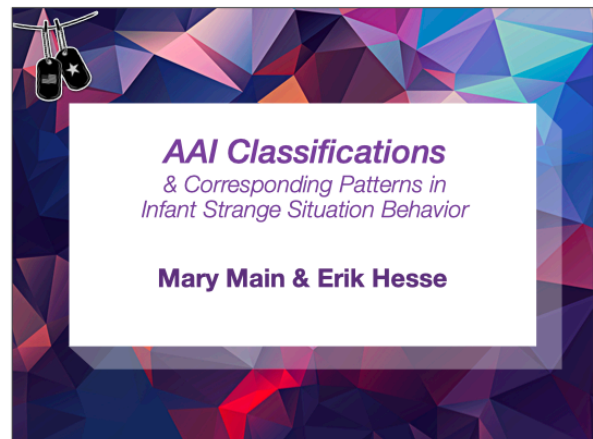
- The brain is underdeveloped at birth
- The brain organizes from the “bottom” up—brainstem to cortex and from the inside out
- Organization and functional capacity of neural systems is sequential
- Experiences do not have equal influence throughout development (sensitive periods)

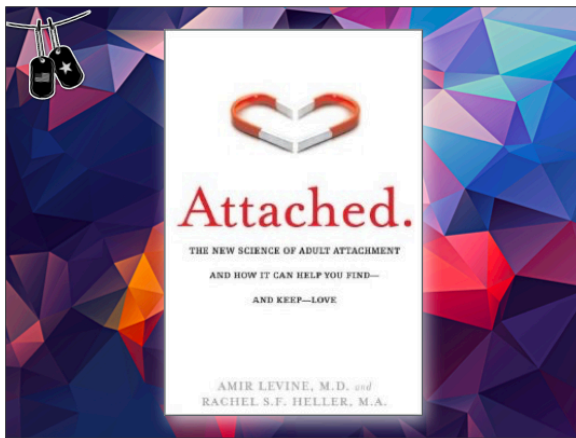
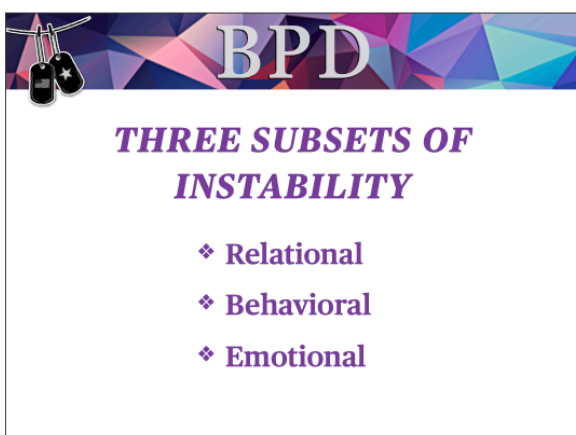


FILM CLIP

Developmental Trauma Disorder

Bessel van der Kolk, MD
Master Clinician Series








Single-Incident PTSD

Stable baseline exists

Knows what "Normal" feels like

Clear before & after trauma

Complex PTSD

**No baseline-developed in chaos-
"marinated in trauma"**

"Normal" = Survival Mode

There is no "before trauma"




PTSD (single incident)

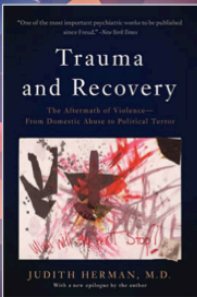
- Sense of Threat
- Persistent Avoidance of Stimuli Associated with the Traumatic Event
- Recurrent Involuntary & Intrusive Distressing Memories of the Traumatic Event
- Exposure to Actual or Threat of Death, Serious Injury or Sexual Violence

C-PTSD

- Interpersonal Disturbances
- Negative Self Concept
- Affect Dysregulation Sense of Threat
- Persistent Avoidance of Stimuli Associated with the Traumatic Event/s
- Recurrent Involuntary and Intrusive Distressing Memories of the Traumatic Event
- Exposure to Actual or Threat of Death, Serious Injury or Sexual Violence



Complex PTSD



Seminal Work in Complex PTSD

TRI-PHASIC MODEL

Judith Hermann, 1992

THE THREE STAGES OF TRAUMA RECOVERY

Stage 1 Safety & Stabilization	Stage 2: Remembrance & Mourning	Stage 3 Reconnection & Integration
<ul style="list-style-type: none"> •Goal: Establish physical, emotional, and environmental safety, stabilization, and self-regulation skills. •Key Focus: Addressing ongoing dangers, such as abusive relationships, and managing symptoms like addiction or dissociation. •Significance: This foundation ensures that processing trauma in later stages does not overwhelm (or "flood") the client. 	<ul style="list-style-type: none"> •Goal: To process, integrate, and mourn the traumatic events. •Key Focus: Telling the story of the trauma, identifying sensations, and creating a new narrative to give the memories a place in the past. •Techniques: Often involves therapy techniques like CBT, EMDR, or Trauma-Focused Cognitive Behavioral Therapy to transform traumatic memory into a coherent narrative 	<ul style="list-style-type: none"> •Goal: Redefining oneself, engaging in life, and moving forward. •Key Focus: Reconnecting with others, finding new meaning in life, and, if desired, using the experience to help others or pursue a "mission". •Significance: This stage helps survivors turn the traumatic experience into a new, integrated part of their life story rather than a consuming force.



Complex PTSD

According to Judith Hermann,
"Even the diagnosis of "post-traumatic stress disorder," as it is presently defined, does not fit The existing diagnostic criteria for this disorder are derived mainly from survivors of circumscribed traumatic events. They are based on the prototypes of combat, disaster, and rape

SEMINAL WORK IN COMPLEX PTSD, 1992




Complex PTSD

"In survivors of prolonged, repeated trauma, the symptom picture is often far more complex. Survivors of prolonged abuse develop characteristic personality changes, including deformations of relatedness and identity...."

SEMINAL WORK IN COMPLEX PTSD




Complex PTSD

"Survivors of abuse in childhood develop similar problems with relationships and identity; in addition, they are particularly vulnerable to repeated harm, both self inflicted and at the hands of others...."

SEMINAL WORK IN COMPLEX PTSD, 1992




Complex PTSD

"The current formulation of post traumatic stress disorder fails to capture either the protean symptomatic manifestations of prolonged, repeated trauma or the profound deformations of personality that occur in captivity. . ."

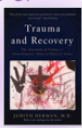
SEMINAL WORK IN COMPLEX PTSD, 1992



Complex PTSD

"The responses to trauma are best understood as a spectrum of conditions rather than as a single disorder. They range from a brief stress reaction that gets better by itself and never qualifies for a diagnosis, to classic or simple post-traumatic stress disorder, to the complex syndrome of prolonged, repeated trauma..."

SEMINAL WORK IN COMPLEX PTSD, 1992



Complex PTSD

"The syndrome that follows upon prolonged repeated trauma needs its own name. I propose to call it 'complex posttraumatic stress disorder'."

Criteria to Follow

SEMINAL WORK IN COMPLEX PTSD, 1992



Complex PTSD

1. A history of subjection to totalitarian control over a prolonged period (months to years). Examples include hostages, prisoners of war, concentration-camp survivors, and survivors of some religious cults.

Examples also include those subjected to totalitarian systems in sexual and domestic life, including survivors of domestic battering, childhood physical or sexual abuse, and organized sexual exploitation.

SEMINAL WORK IN COMPLEX PTSD, 1992



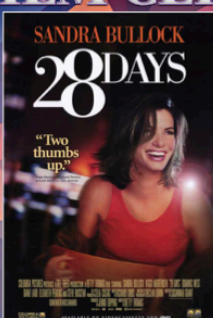
Complex PTSD

- ❖ Persistent dysphoria
- ❖ Chronic suicidal preoccupation
- ❖ Self-injury
- ❖ Explosive or extremely inhibited anger (may alternate)
- ❖ Compulsive or extremely inhibited sexuality (may alternate)

SEMINAL WORK IN COMPLEX PTSD, 1992



FILM CLIP



SANDRA BULLOCK
28 DAYS
"Two thumbs up"

FILM CLIP

BACK FROM THE EDGE
Living with and Recovering from
BORDERLINE PERSONALITY DISORDER

Resource Center at New York-Presbyterian Hospital
www.nyp.org/bpdresourcecenter

The Columbia Protocol

Unique Suicide Risk Assessment Tool

The Columbia Protocol

<https://cssrs.columbia.edu/>

The Columbia Protocol



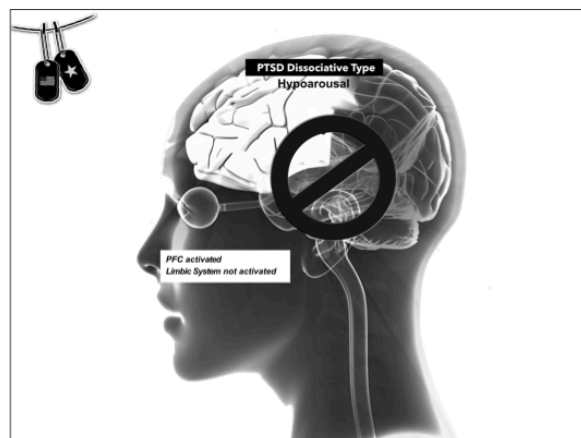
<https://cssrs.columbia.edu/>

Complex PTSD

3. Alterations in consciousness, including:

- ❖ Amnesia or hypermnesia for traumatic events
- ❖ *Transient dissociative episodes*
- ❖ Depersonalization/derealization
- ❖ Reliving experiences, either in the form of intrusive post-traumatic stress disorder symptoms or in the form of ruminative preoccupation

SEMINAL WORK IN COMPLEX PTSD, 1992

FILM CLIP



precious
the longest journey begins with a single step

TRIGGERING

(Physical and Sexual Abuse)

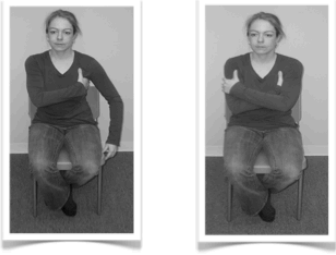
Complex PTSD

- ❖ Take some time to settle into your body and the chair.
- ❖ Put your right hand under the left armpit by the heart.
- ❖ Then place the left hand over the right heart upper arm and shoulder.
- ❖ Maintain this position, and feel how you are gently holding all your being.

TRAUMA COMPETENCY PP 168-171

Complex PTSD

Pose Sequence



Containment/Settling

Complex PTSD

The Fear Tap

Locate the notch on the back side of your hand, just behind the knuckles, between your ring finger and little finger.

Tap this area with two or three fingers from your other hand for up to a minute, breathing in through your nose and out through your mouth. Switch hands and repeat the process.

TRAUMA COMPETENCY PP 168-171

Complex PTSD



Triple Warmer Tap for Fear

Containment/Settling The Fear Tap

TRAUMA COMPETENCY PP 168-171

Complex PTSD

First, sit or lie down and then focus on a stress you already feel or on a stressful thought, memory, or situation.

Next, place the palm of one hand on your forehead and the palm of the other hand on the back of your head.

On the inhalation, raise your head up.

On the exhalation tuck your chin to your chest.

TRAUMA COMPETENCY PP 168-171



Complex PTSD

Neurovascular Hold



TRAUMA COMPETENCY PP 168-171



Complex PTSD

Neurovascular points are specific spots on the head that activate blood flow. Thinking about a particular stressor while touching the neurovascular points will suspend the stress reaction by preventing the blood from leaving the forebrain.

TRAUMA COMPETENCY PP 168-171



Complex PTSD

By interrupting a key component of the fight-or flight response, the Neurovascular Hold allows us to think more clearly and cope more effectively with life stress.

TRAUMA COMPETENCY PP 168-171



Complex PTSD

Pose Sequence

Next, place the left hand on the heart and the right hand on the forehead. Allow energy to flow freely between these two points and throughout your body.

Placing the right hand on the belly, again allow the energy to flow freely.

TRAUMA COMPETENCY PP 168-171



Complex PTSD

Pose Sequence



Containment/Settling

TRAUMA COMPETENCY PP 168-171

Dissociation

A psychological process used to describe the disconnection or lack of connection between things usually associated with each other.

Dissociation

Dissociated experiences are not integrated into the usual sense of self, resulting in discontinuities in conscious awareness...In severe forms, disconnection occurs in the usually integrated functions of consciousness, memory, identity, or perception.

Dissociation

...There are five main ways in which the dissociation of psychological processes changes the way a person experiences living:

depersonalization, derealization, amnesia, identity confusion, and identity alteration.

...presence of a dissociative disorder is suggested by the robust presence of any of the five features.

The Theory Of Structural Dissociation

*Kathy Steele's Insight:
When internal systems conflict,
there's a tug-of-war ~
something has to give. That's
when dissociation emerges.*

The Theory Of Structural Dissociation

*"Defines dissociation as a failure in
personality integration, wherein trauma
leads to compartmentalization into distinct
part with 'two primary types of parts':*

- the Apparently Normal Part (ANP) which has
partial or full amnesia for trauma-related
material and manages day-to-day tasks*
- the Emotional Part (EP), which identifies
intensely with the traumatic experience and is
oriented toward survival' "*

Theory Of Structural Dissociation



(Steele, van der Hart & Nijenhuis, 2005; Nijenhuis & Van der Hart, 2011)

Theory Of Structural Dissociation

*"The EP is dedicated to the
survival of 'predatory' threat*

*The ANP is dedicated to
managing daily life and to
survival of the species"*

(Steele, van der Hart & Nijenhuis, 2005; Nijenhuis & Van der Hart, 2011)

Theory Of Structural Dissociation

Categorizes Dissociation into 3 Levels

- Primary (PTSD-related)
- Secondary (linked to BPD & DDNOS)
- Tertiary (linked to DID)

(Steele, van der Hart & Nijenhuis, 2005; Nijenhuis & Van der Hart, 2011)

The Fundamental Conflict

(Van der Hart, Nijenhuis, & Steele, 2006)



*Stop thinking of dissociation as pathology;
it's adaptive genius*

(Steele, van der Hart & Nijenhuis, 2005; Nijenhuis & Van der Hart, 2011)

The Five Types You Need to Recognize

Key insight:
Clients often experience multiple types simultaneously

- 1 **Depersonalization** "I felt like I was watching myself from outside my body"
- 2 **Derealization** "Everything felt fake, like a badly edited movie"
- 3 **Identity Disturbance** "I don't know why I did that—it's not like me"
- 4 **Identity Alteration** Complete personality shifts without conscious control
- 5 **Dissociative Amnesia** "I lost hours" or "I can't remember how I got here"

Bethany Brand's (2024)
For accurate DID diagnosis, clients likely experience all five types of dissociation.

"Do you ever hear voices?"

Ruth Lanius's key diagnostic question

- 70%+ of DID clients hear voices (Lanius et al., 2014)
- They don't tell you because they fear being labeled psychotic
- Internal voices vs. external voices = critical difference

DID vs. Schizophrenia

DID
Voices are internal, often child-like,
part of internal system

Schizophrenia
Voices are external, commanding,
often persecutory

*Ask the question.
You can't treat what you don't assess*

Another key diagnostic question

"Do you ever feel like you have different parts of yourself that handle different situations?"

Clinical Red Flags for Dissociation

Some Obvious Signs:

Childhood trauma history	World feels "unreal" or "foggy"
Acts contrary to stated values without awareness	Others report dramatic personality changes
Frequent "lost time" experiences	Freeze responses that seem to come from nowhere
Watching themselves from outside their body	Hearing multiple internal voices (especially child voices)

⚠️ If you see 3+ of these, you're dealing with dissociation

What to Assess

- Age of first trauma (earlier = more complex)
- Number of different trauma type
- Relationship to perpetrator (caregiver = worse prognosis)
- Dissociative episodes during trauma
- Current dissociative symptoms

The Core Argument

Dissociation is the most commonly missed variable in complex trauma treatment

It is missed not because clinicians fail to care — but because dissociation is by nature self-concealing. Proceeding without a clear assessment of dissociative organization is the most common reason complex trauma treatment fails.

MISSED

The articulate, motivated client operating entirely from the ANP while EPs remain invisible

MISREAD

The flat, disconnected client in chronic hypoarousal ~ misread as resistant or unengaged

DESTABILIZED

The client who decompensates in processing because dissociation level was never established

Dissociation Is a Spectrum

A client's position on the spectrum determines everything that follows.

PRIMARY	SECONDARY	TERTIARY
Simple PTSD	C-PTSD / BPD	DID
1 ANP / 1 EP Subtle dissociation Processing possible with preparation	1 ANP / Multiple EPs Significant dissociation Extended stabilization required	Multiple ANPs / Multiple EPs Severe fragmentation Specialist framework essential

Dissociation level — not symptom severity, not client motivation, not time in treatment — is the primary determinant of treatment sequencing.

Three-Tier Dissociation Assessment Framework

Pre-Session Screening Battery

- 1
 - ITQ — ICD-11 PTSD & C-PTSD diagnosis; DSO cluster identification
 - DES-II — Dissociation load; the first clinical gate
 - AAI — Attachment pattern; narrative coherence; internal working model
 - Sensitivity Questionnaire — Nervous system profile; pacing indicator

Formal Diagnostic Evaluation (DES-II > 30)

- 2
 - DDIS — Dissociative Disorders Interview Schedule; formal diagnosis
 - MID — Multidimensional Inventory of Dissociation; dimensional profile
 - Establishes level of structural dissociation before any processing begins
 - Clinical & ethical requirement — not optional based on alliance strength

In-Session Monitoring & Management

- 3
 - Dual awareness check / Grounding inventory / Parts check-in
 - Somatic tracking / Window of tolerance / Presence & absence tracking
 - Containment capacity check at session close
 - BHS & CIPOS — real-time detection and stabilization tools

The Battery: What Each Instrument Reveals

DES-II	ITQ	AAI	SQ
Dissociation load Dissociative Experiences Scale II	ICD-11 PTSD & C-PTSD International Trauma Questionnaire	Attachment Pattern & Narrative Coherence Adult Attachment Interview	Nervous System Sensitivity Sensitivity Questionnaire
<ul style="list-style-type: none"> • Score < 20: normal range • Score 20-30: elevated — monitor closely • Score 30+: Tier 2 required — no processing until level established 	<ul style="list-style-type: none"> • PTSD vs. C-PTSD diagnosis before session one • DSO clusters: affective dysregulation, negative self-concept, relational disturbance • Symptom cluster dominance → where to begin treatment 	<ul style="list-style-type: none"> • Internal working model entering the therapeutic relationship • Likely transference terrain before it arrives • Which intervention set to open with 	<ul style="list-style-type: none"> • Pacing indicator — how fast to move • Modality selection — direction of somatic approach • Key variable in C-PTSD vs. BPD differential

Four instruments. Four constructs.
One clinical picture ~ before the first session begins.

If DES-II > 30 Diagnostic Instrument Required

IF	THEN	OR
DES-II Dissociation Load Dissociative Experiences Scale II <ul style="list-style-type: none"> • Score < 20: normal range • Score 20-30: elevated ~ monitor closely • Score 30+: Tier 2 required ~ no processing until level established 	DDIS Dissociative Disorders Interview Schedule www.rossinst.com/ddis	MID Multidimensional Inventory of Dissociation www.mid-assessment.com

Assessment Results Direct Treatment

Dissociation Level Directs → Treatment Sequencing	Primary → Processing Possible With Preparation Secondary → Extended Stabilization Tertiary → Years of Phase 1 Work
Attachment Pattern Directs → Relational Stance & Intervention Sequence	Avoidant → Slow, Indirect, Somatic/Cognitive Entry Anxious → Build Capacity To Receive Care Disorganized → Pacing Is Everything; Fear & Intimacy
Nervous System Sensitivity Directs → Pacing & Modality Direction	High Sensitivity + Overwhelmed → Titrate Downward Dissociated + Numb → Introduce Somatic Upward Same Tool, Opposite Direction.
DOS Cluster Profile Directs → Treatment Target Priority	Affect Dysregulation → Regulation Skills First Negative Self-Concept → Shame-Informed Approach Relational Disturbance → Therapeutic Relationship IS the Treatment

Different profiles require fundamentally different clinical approaches

Working with Dissociation as Threat Response

The lowered threshold effect:

The more dissociation proves adaptive, the lower the threshold becomes for triggering it.

Dissociation + Freeze Response Combination

Trigger	Protector Response	Client Experience
Hurt/exiled part begins to surface	Freeze reaction to anticipated shame	Appears to freeze "out of nowhere"

Always address protector parts before exiled parts

In-Session Monitoring: Assessment & Intervention

Every method is simultaneously a clinical read and a clinical act

Dual Awareness Check Can the client hold present moment and trauma content simultaneously? Absence = contraindication to processing.	Grounding Inventory Eyes open/closed, feet on floor, name/date/location. Orients to sensory present-moment reality.	Parts Check-In Who is present? Who just showed up? Any part opposed to planned work? Essential for 2 nd and 3 rd dissociation.	Somatic Tracking Where is activation? Where is numbness? Where is nothing at all? Maps the body's dissociative landscape.
Window of Tolerance Hyperarousal / Optimal / Hypoarousal ~ moment to moment. Determines whether clinical work can proceed.	Presence & Absence Eye contact, voice quality, breathing, postural shift, response latency. The clinician's continuous read.	Containment Check At session close: can the client put material away? Inability = containment work is the priority.	

Within this framework: BHS (Back of the Head Scale) & CIPOS ~ real-time somatic detection and present-orientation stabilization tools (Knipe)

BHS

Back of the Head Scale (Knipe, 2003, 2018)

Real-time dissociation monitoring

The Back of the Head Scale (BHS)

is a clinical tool used to assess a client's subjective sense of presence, particularly useful for identifying when a client may be shifting into a dissociative state during a session. The scale leverages the concept of "where the client feels located" in their head as a marker for assessing how present and engaged they are.

BHS

Back of the Head Scale (Knipe, 2003, 2018)

Mechanics of the BHS

The BHS asks clients to gauge their awareness along a continuum of locations in their head- from the back of the head (indicating detachment or disengagement) to the front (indicating full presence). A client's ability to report feeling located closer to the front of their head suggests greater engagement with the here and now, while a sensation toward the back may reflect increased dissociation or detachment from present experience.

BHS

Back of the Head Scale (Knipe, 2003, 2018)

Clinical Significance

The BHS can help therapists make in-the-moment decisions to prevent clients from becoming overwhelmed. It also promotes the client's awareness of their own dissociative responses, encouraging self-monitoring and gradual mastery over their dissociative tendencies.

CIPOS

Constant Installation of Present Orientation & Safety
(Knipe, 2003, 2018)

In-session grounding & stabilization

CIPOS is a technique developed to help clients maintain a sense of safety and grounding, particularly during trauma processing. CIPOS integrates various grounding and orientation strategies to keep the client connected to the present moment, reducing the likelihood of dissociation.

CIPOS

(Knipe, 2003, 2018)

Core Principles of CIPOS

The CIPOS approach emphasizes the use of body-based grounding techniques, such as ABLS, to continuously anchor the client in the present. Techniques like tapping, foot-to-ground awareness, and focusing on physical sensations serve to remind the client of their physical presence and safety in the therapy environment. By continually returning to these physical cues, clients are better able to manage overwhelming emotions that arise during sessions.

CIPOS

(Knipe, 2003, 2018)

Benefits for Highly Dissociative Clients

For clients with a high dissociative threshold, CIPOS provides a framework to safely engage with trauma processing while maintaining stability. By promoting a constant sense of orientation to the present, CIPOS reduces the risk of the client becoming lost in traumatic memories or entering a dissociative shutdown. This technique fosters client autonomy as well, equipping them with practical skills for grounding that they can use independently between sessions (Knipe, 2015; Porges, 2011).

Practical Intervention

Ruth Lanius' recommendation for dissociative amnesia:

The Technique:

- Set manageable alarms (30 minutes to 3 hours)
- Have client write down experiences during each interval
- Review previous entries to reduce "lost time"
- Maintain present-moment grounding

Practical Intervention

Ruth Lanius' recommendation for dissociative amnesia:

Why it works:

- Creates external memory aid
- Reduces anxiety about "losing time"
- Builds awareness of dissociative patterns
- Provides concrete evidence of continuity

Simple, practical, and clients can implement immediately

The Problem with EMDR

It assumes an integrated client

Reality Check:

- ❖ Complex trauma clients aren't integrated
- ❖ They have divided internal structures
- ❖ Your "resistant" client isn't resistant; they're structurally divided.
- ❖ Grad school didn't prepare us for this

Bottom line: You need different tools for different internal structures

Common EMDR Mistakes with Dissociative Clients

Starting memory processing too early	Ignoring ANP's fear of EP	Trying to eliminate parts
1	2	3
Result: <ul style="list-style-type: none"> • Flooding, • Hospitalization • Increased dissociation 	Result: <ul style="list-style-type: none"> • Missed appointments • "Resistance" 	Result: <ul style="list-style-type: none"> • Internal warfare • Worsening symptoms
FIX: MORE PHASE 1 PREPARATION WORK	FIX: ADDRESS ANP CONCERNS FIRST	FIX: ADDRESS ANP CONCERNS FIRST

Preparation for Secondary Dissociation

Standard EMDR preparation assumes integration

For Complex PTSD, you need:

Parts Mapping <i>Identify different self-states</i>	Internal Communication <i>Teach parts to talk</i>
Grounding Techniques <i>Bring ANP back when EP takes over</i>	Window of Tolerance Work <i>Expand capacity for activation</i>

Rushing this and creates more dissociation

Complex PTSD

4. Alterations in self-perception, including:

- ❖ Sense of helplessness or paralysis of initiative
- ❖ Shame, guilt, and self-blame
- ❖ Sense of defilement or stigma
- ❖ Sense of complete difference from others (may include sense of specialness, utter aloneness, belief no other person can understand, or non-human identity)

SEMINAL WORK IN COMPLEX PTSD



Complex PTSD

5. Alterations in perception of perpetrator, including:

- ❖ Preoccupation with relationship with perpetrator (includes preoccupation with revenge)
- ❖ Unrealistic attribution of total power to perpetrator (caution: victim's assessment of power realities may be more realistic than clinician's)
- ❖ Idealization or **paradoxical gratitude**
- ❖ Sense of special or supernatural relationship
- ❖ Acceptance of belief system or rationalizations of perpetrator

SEMINAL WORK IN COMPLEX PTSD



Complex PTSD

6. Alterations in relations with others, including:

- ❖ Isolation and withdrawal
- ❖ Disruption in intimate relationships
- ❖ Repeated search for rescuer (may alternate with isolation and withdrawal)
- ❖ Persistent distrust
- ❖ Repeated failures of self-protection

SEMINAL WORK IN COMPLEX PTSD



Complex PTSD

7. Alterations in systems of meaning:

- ❖ Loss of sustaining faith
- ❖ Sense of hopelessness and despair

SEMINAL WORK IN COMPLEX PTSD



Complex PTSD

Naming the syndrome of complex post-traumatic stress disorder represents an essential step toward granting those who have endured prolonged exploitation a measure of the recognition they deserve.

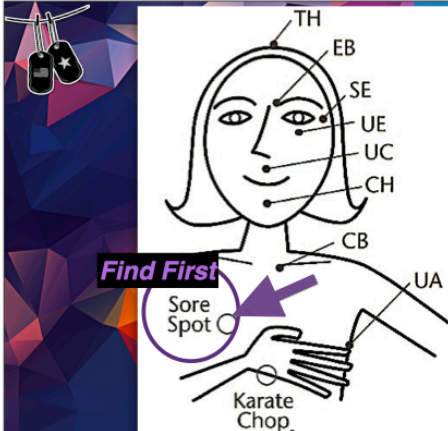
It is an attempt to find a language that is at once faithful to the traditions of accurate psychological observation and to the moral demands of traumatized people. It is an attempt to learn from survivors, who understand, more profoundly than any investigator, the effects of captivity."

"TRAUMA AND RECOVERY, HERMAN, 1992



TREATMENT WHAT WORKS?

Let's talk about drugs



FILM CLIP



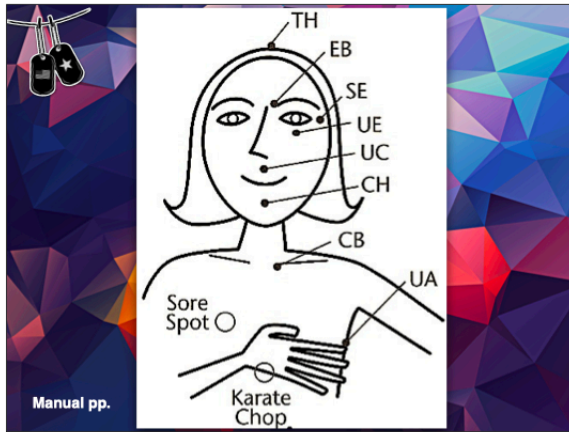
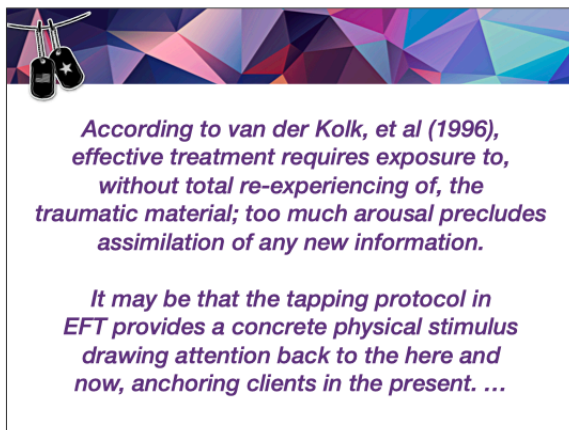
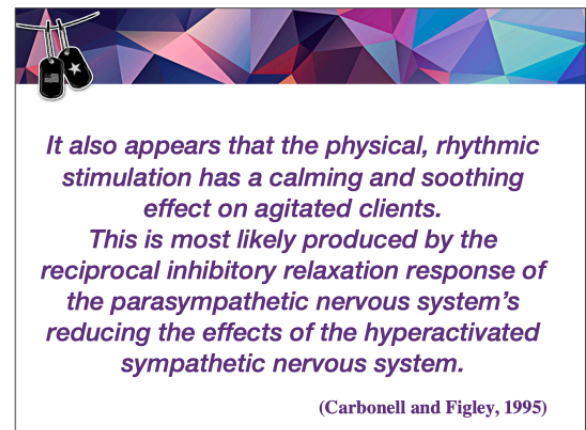
TRIGGERING

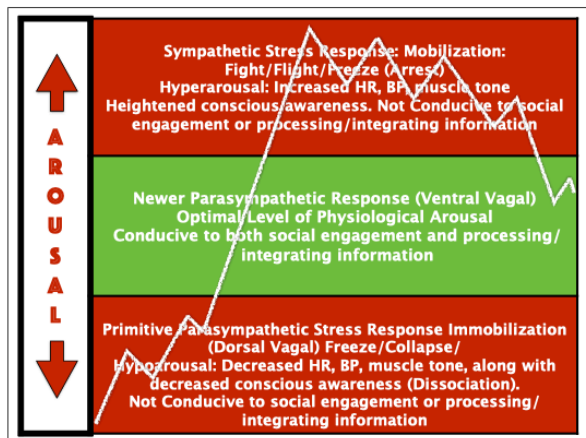
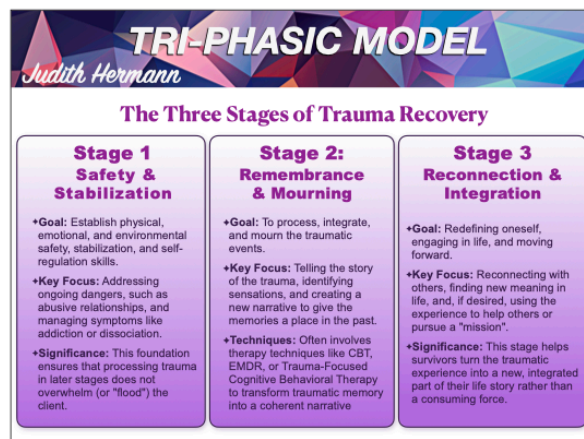
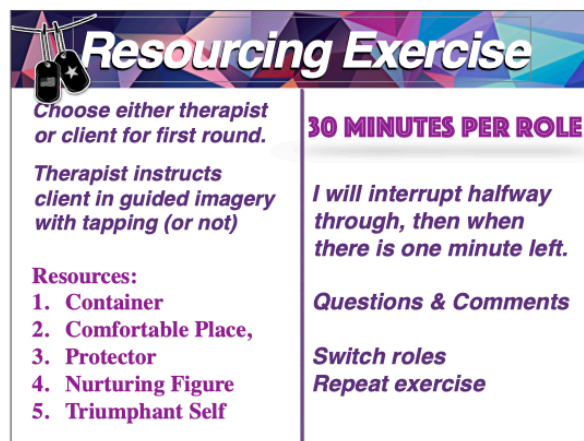
(Physical and Sexual Abuse)

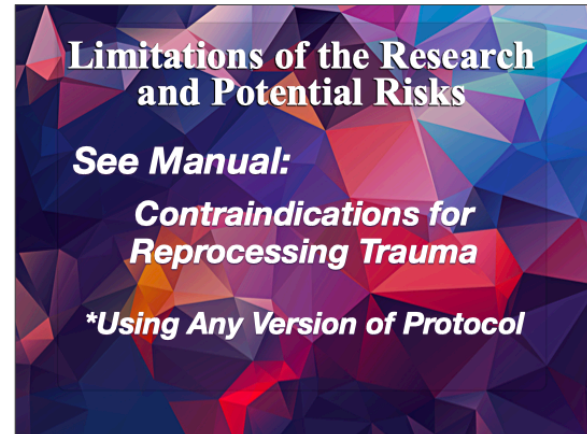
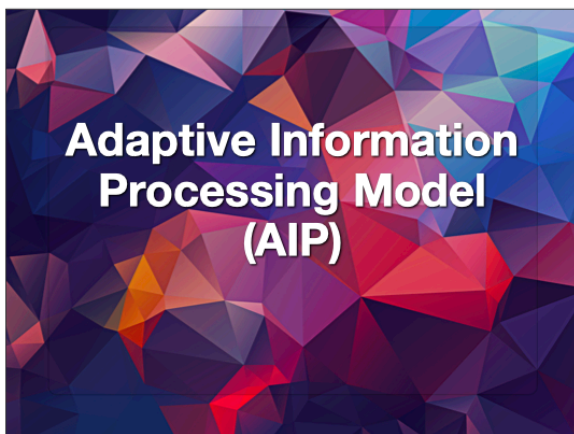
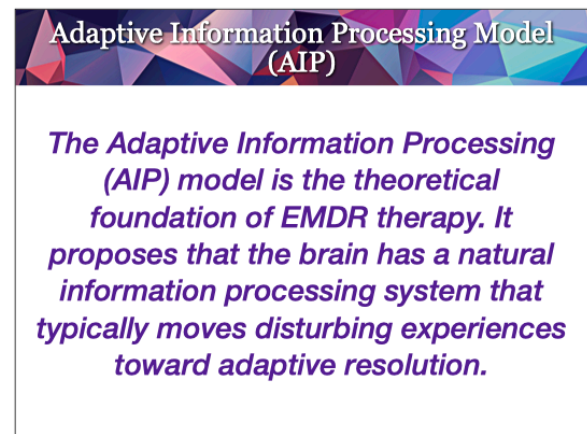
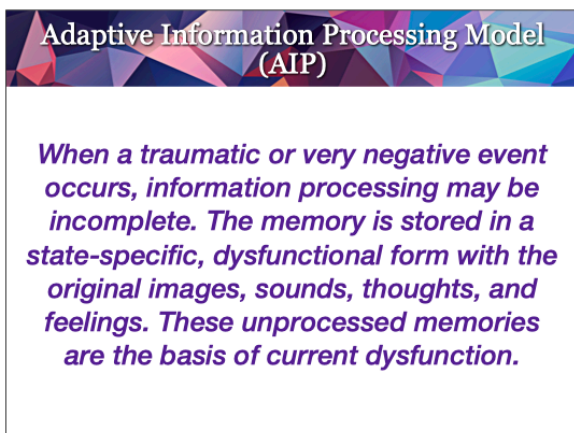
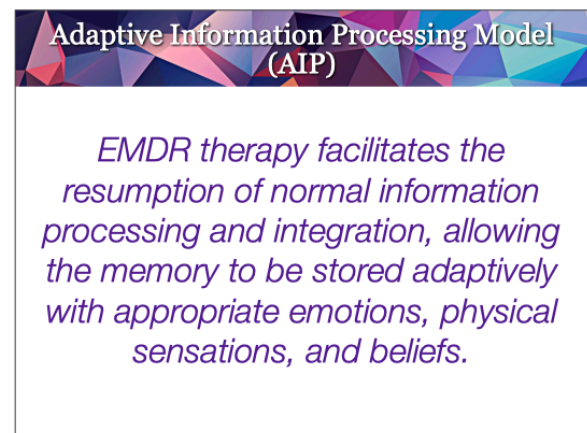
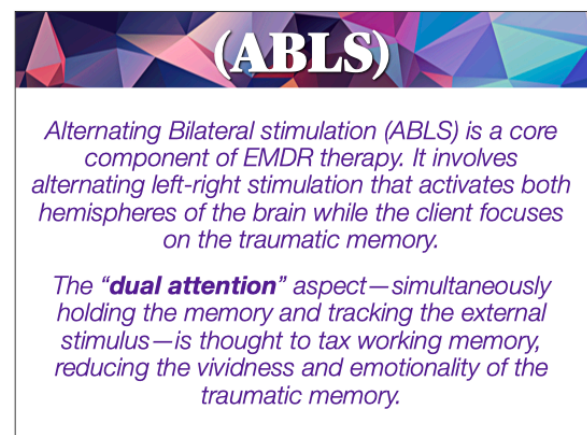
"Hey! Maybe We Should Tap on These Points"

~Gary Craig (EFT)

The EFT "Basic Recipe"







(ABLS)

ABLS works through several mechanisms:

1. **Orienting Reflex:** The natural tendency for the nervous system to orient to new stimuli. When engaged by ABLS, attention is diverted from distressing thoughts, preventing habituation and promoting relaxation.
2. **Attentional Capture:** ABLS continuously captures attention, making it difficult for the brain to remain fixated on distressing memories or thoughts. This allows for cognitive flexibility and helps in reprocessing traumatic memories (PLOS ONE, 2016).
3. **Physiological Relaxation:** The rhythmic nature of ABLS induces a relaxation response in the lower brain, decreasing physiological arousal and tension. This initial physical relaxation cascades upwards, leading to mental relaxation and reduced worry (Frontiers in Psychology, 2017).
4. **Non-Associative Learning:** ABLS helps in altering the way distressing memories are stored in the brain without linking them to rewards or punishments. This change in memory storage leads to a reduction in the emotional impact of the memories

EMDR In a Nutshell

According to Shapiro, Eye Movement Desensitization and Reprocessing (EMDR) is a complex, highly specialized therapy used to overcome the effects of traumatic or upsetting experiences. Psychologist, Francine Shapiro, developed EMDR after noticing her own stress reactions diminishing when her eyes swept back and forth as she walked through a park.

MYTH

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EMDR In a Nutshell

EMDR combines several therapeutic methods-psychodynamic, cognitive, behavioral, etc.,-with eye movements or other forms of bilateral stimulation, like hand taps or sounds. It involves recalling a stressful past event and “reprogramming” the memory in the light of a positive, self-chosen belief.

EMDR In a Nutshell

On the EMDR Institute’s website, Shapiro uses the example of rape to illustrate how we can get stuck in trauma. “A rape survivor may ‘know’ that rapists are responsible for their crimes, but this information does not connect with her feeling that she is to blame for the attack. The memory is then dysfunctionally stored without appropriate associative connections and with many elements still unprocessed.

EMDR In a Nutshell

- ♦ Impressions of the trauma get stored in the nervous system through the defense mechanisms we use to cope with the incident, such as dissociation, or “splitting off” from ourselves to handle the emotional pain.
- ♦ As a result, we are blocked from learning new ways of seeing the situation, therefore we re-experience the symptoms of the initial trauma when stressful events trigger us in the present. Thus, we can get trapped in recurring anxiety, depression, phobias, panic attacks, and the like.

EMDR In a Nutshell

When the individual thinks about the trauma, or when the memory is triggered by similar situations, the person may feel like she is reliving it, or may experience strong emotions and physical sensations.”

EMDR In a Nutshell

EMDR links the memory of trauma with present-oriented, adaptive information.

Though the exact mechanism is unknown, it appears that the alternating bilateral stimulation relieves the anxiety associated with the trauma so that the original event can be examined from a more detached perspective, somewhat like watching a movie of what happened-allowing for cognitive reorganization, which in turn leads to spontaneous emotional and behavioral life changes.



EMDR In a Nutshell

"If you are stuck in old memories, you can't have new behavior. Only changing the outcome of past events can result in new behavior in the future because the purpose of memory is to prepare you to deal with future events. In addition, traditional therapy focuses on talking about or playing out conflicts, which accesses the left side of the brain, while traumatic memories are stored in the right side of the brain...."



EMDR In a Nutshell

If the traumatic memories and experiences are to be resolved, the therapist must engage in activities that access the right side of the brain.

van der Kolk and others suspect that EMDR works because the alternating bilateral stimulation distracts the client from the traumatic memories and allows the brain to be changed.



ORIGINAL 8 PHASES

When the right side of the brain is triggered to produce traumatic memories, the focus of therapy needs to shift to triggering the left side of the brain- as it has the ability to help clients resolve trauma- while being stuck in the right brain only results in staying stuck in the trauma.



ORIGINAL 8 PHASES

History Taking & Treatment Planning

The therapist and client discuss what brings the client to therapy and develop a secure working relationship. The client's history is assessed and a treatment plan is developed with attention to pacing and selection of traumatic events for treatment.

Key Activities

- Develop therapeutic alliance
- Assess client history
- Identify target memories
- Evaluate resources and readiness

Clinical Notes

Assess both internal and external resources. Some clients need significant time in phases 1 and 2 before moving on.

1



ORIGINAL 8 PHASES

Preparation

The therapist explains the EMDR therapy process, terms, and sets expectations. A safe therapeutic alliance is established and specific coping techniques are developed for any emotional disturbance that might arise.

Key Activities

- ♦ Establish safety
- ♦ Explain EMDR process
- ♦ Address concerns
- ♦ Teach coping techniques

Clinical Notes

Ensure client has adequate stabilization skills before proceeding. Teach safe place and container exercises.

2



ORIGINAL 8 PHASES

Assessment

The target event is identified along with images, beliefs, feelings, and sensations. Initial baseline measures are set using the SUD (Subjective Units of Disturbance) and VOC (Validity of Cognition) scales.

Key Activities

- ♦ Identify target image
- ♦ Establish NC and PC
- ♦ Rate SUD (0-10)
- ♦ Rate VOC (1-7)
- ♦ Locate body sensations

Clinical Notes

Identify the worst part of the memory, the negative cognition (NC), desired positive cognition (PC), emotions, and body location.

3



ORIGINAL 8 PHASES

Desensitization

Bilateral stimulation begins while focusing on the traumatic event and continues until the client's SUD reduces to zero. New thoughts, sensations, images, and feelings may emerge during this phase.

Key Activities

- ♦ Begin alternating bilateral stimulation
- ♦ Process emerging material
- ♦ Check SUD periodically
- ♦ Continue until SUD = 0

Clinical Notes

Follow the client's process with 'Is it okay to go with that.' Trust the brain's natural healing capacity. No need lead or interpret.

4



ORIGINAL 8 PHASES

Installation

The client associates and strengthens a positive belief with the target event until it feels completely true. This phase links the adaptive information with the original memory.

Key Activities

- ♦ Link Adaptive Cognition to target memory
- ♦ Strengthen with ABLS

Clinical Notes

Follow the client's process with 'Go with that.' Trust the brain's natural healing capacity. Don't lead or interpret.

5



ORIGINAL 8 PHASES

Body Scan

The client holds the target event and positive belief in mind while scanning the body from head to toe. Any lingering physical disturbance is reprocessed.

Key Activities

- ❖ Scan body head to toe
- ❖ Notice any tension or disturbance
- ❖ Reprocess remaining sensations

Clinical Notes

The body holds trauma. Complete processing requires clearing somatic residue.

6



ORIGINAL 8 PHASES

Closure

Every reprocessing session ends with closure, returning the client to a state of calm whether processing is complete or not. The client is prepared for between-session experiences.

Key Activities

- ❖ Return to equilibrium
- ❖ Debrief session
- ❖ Prepare for between-session processing
- ❖ Provide self-care instructions

Clinical Notes

Never leave a client in distress. Use resources: comfortable place, container, protector or other stabilization techniques as needed.

7



ORIGINAL 8 PHASES

Reevaluation

Each new session begins with reevaluation. The therapist and client discuss recently processed memories to ensure distress remains low and positive cognition remains strong.

Key Activities

- ❖ Review previous targets
- ❖ Check SUDs
- ❖ Address new material
- ❖ Plan next targets

Clinical Notes

Check if processing held. Address any new material that emerged. Determine next targets.

8



FILM CLIP

Standard vs. Modified Protocol



Master Clinician Series Disc 1
EMDR & Beyond

MANUAL PP



FILM CLIP

Emdr Essential Protocol



Master Clinician Series Disc 1
EMDR & Beyond

MANUAL PP

Essential Protocol

- ❖ **Create SAFETY**
- ❖ **Activate Trauma Memory**
- ❖ **Add Alternating Bilateral Stimulation**
- ❖ **End with Safety**

EMDR

Eye Movement Desensitization & Reprocessing

GIANT MISNOMER



EMDR In a Nutshell

- ❖ **Triune Brain**
- ❖ **Neural Networks**
- ❖ **Interrupting longterm relationships via the Orienting Response (Theratapper)**

FISH BOWL

EMDR Demonstration with volunteer

1. **INTRODUCE THERATAPPER:** Set intensity and speed (client preference)
2. **REACTIVATE RESOURCES:** Container, Comfortable Place, Protector Figure, Nurturing Figure, Triumphant Self (all 5 should take no longer than 20 mins)
3. **HARD STOP (once resources have been activated)**
4. **MEMORY PROCESSING**
5. **CLOSE SESSION**

EXPERIENTIAL

EMDR SESSIONS TRIADS

YOUR TURN!

WE WILL BE IN TRIADS FOR EMDR SESSIONS



BREAK OUT ROOMS

EXPERIENTIAL TRIADS

DIRECTIONS FOR EMDR SESSION

1. **INTRODUCE BUTTERFLY HUG:** Set intensity and speed (client preference)
2. **REACTIVATE RESOURCES:** Container, Comfortable Place, Protector Figure, Nurturing Figure, Triumphant Moment/Self (all 5 should take no longer than 20 mins)
3. **HARD STOP (once resources have been activated)**
4. **TURN TO PAGE ____ of MANUAL to the MODIFIED SCRIPT**
5. **YOU WILL BE READING the EMDR MODIFIED SCRIPT**
6. **CLOSE SESSION**

NOBODY IS OBSERVING: EVERYONE IS WORKING

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