EMDR Deconstructed: Facilitator Guide ~ 6-Hour Training

Title: EMDR Deconstructed: Components, Modification, and Clinical Flexibility
Duration: 6 hours (360 minutes)
Audience: Any licensed clinician ~ no EMDR credential required
Presenter: Linda A. Curran, BCPC, LPC, CAADC, CCDPD
CE Credits: 6.0 contact hours

Learning Objectives

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

1. Identify the historical lineage from Wolpe's systematic desensitization to Shapiro's EMDR and explain why ABLS functions as both a regulation and processing tool.
2. Distinguish between restricted and unrestricted processing frameworks and articulate clinical indicators for each.
3. Describe the four decision points in complex trauma treatment (intake, session readiness, processing mode, compulsive thread) and apply them to case material.
4. Demonstrate at least three imaginal resourcing techniques (Comfortable Place, Triumphant Self, Wise Self) paired with ABLS.
5. Execute a complete behavioral rehearsal sequence combining resource installation with ABLS.
6. Identify when ABLS accidentally activates the trauma network during resourcing and apply appropriate containment.
7. Describe at least two EMDR-based protocols for compulsive behaviors (FSAP, DeTUR) and their clinical indications.

Materials Needed

- Projector/screen for slides and video clips
- Participant handouts: Resourcing & Behavioral Rehearsal worksheet; Compulsive Behavior worksheet
- Timer
- ABLS device or instructions for self-administered bilateral tapping

- Flip chart or whiteboard for case discussion

Timed Agenda

Morning Session (3 hours)

Time	Duration	Module	Activity
0:00	25 min	Module 1	The Deconstruction Premise
0:25	30 min	Module 2	Restricted vs. Unrestricted Processing
0:55	15 min	—	Break
1:10	35 min	Module 3	ABLS as a Standalone Tool
1:45	15 min	—	Video: Gerard ~ Restricted vs. Unrestricted
2:00	40 min	Module 4	Resourcing & Behavioral Rehearsal
2:40	5 min	—	Transition
2:45	15 min	—	Break

Afternoon Session (3 hours)

Time	Duration	Module	Activity
3:00	30 min	Module 5	The Decision Architecture
3:30	30 min	Module 6	Compulsive Behaviors ~ Flexible Interventions
4:00	15 min	—	Break
4:15	35 min	Module 7	Dyad Practice #1 ~ Resourcing with ABLS
4:50	35 min	Module 8	Dyad Practice #2 ~ Behavioral Rehearsal
5:25	20 min	Module 9	Live Demo + Debrief
5:45	15 min	Module 10	Integration, Q&A, Evaluation

MODULE 1: The Deconstruction Premise (25 min)

Core message: EMDR is an arrangement, not an invention. Its components predate the protocol and work outside it.

Talking points:

- Open with the Koffka quote: “The whole is other than the sum of its parts.”
- The standard protocol’s eight phases are not wrong ~ they are a sequence. This training converts the sequence into a set of capacities: tools you can build and verify in whatever order the client in front of you requires.
- Historical lineage:
  - Wolpe (1958): Systematic Desensitization = PMR + Gradual Imaginal Exposure
  - Shapiro (1987): EMDR = ABLS + Imaginal Exposure
  - The clinical implication: you can use ABLS the way Wolpe used PMR ~ for pure regulation, with no trauma exposure at all.
- Meta-analytic context: EMDR’s evidence base is built on single-incident, single-diagnosis adult PTSD. The CPTSD evidence base is minimal. That is the case for modification ~ and the case for pulling components out of the protocol and using them where they fit.
- Two audiences for this work:
  - Any clinician who wants to use EMDR’s components inside their existing modality (no credential required)
  - EMDR-trained clinicians whose complex trauma clients become destabilized with the standard protocol

Transition: “The first decision you make is which framework to work in.”

MODULE 2: Restricted vs. Unrestricted Processing (30 min)

Core message: Every EMDR protocol fits inside one of two frameworks. The client’s state makes the decision, and that decision is revisable mid-session.

Talking points:

- Define both frameworks (same content as 3-hour version, expanded):
  - **Unrestricted:** Full memory network engaged. Feeder memories surface. Free association encouraged. All sensory, emotional, cognitive elements active.

    - **Restricted:** Contains work to a fragment, trigger, or somatic state. Short ABLS sets, frequent pauses, containment. Network activation is what you're trying to avoid.

- Clinical indicators for each (detailed list)
- Restricted protocols table:

Protocol	Processing Focus	Best For
EMD	Desensitization only	High dysregulation; immediate symptom relief
EMDr	Contained processing	Limited stability; specific targets
Flash Technique	Minimal direct activation	Highly dysregulated clients
R-TEP	Recent trauma fragments	Single recent incidents

- The common thread across all restricted protocols: short ABLS sets, frequent pauses to assess client state, containment strategies, free association discouraged.
- Flexibility principle: you can move between restricted and unrestricted within a session or across treatment. A client may need restricted work one week and be ready for unrestricted the next.

Show video (8:08): "Gerard ~ Restricted vs. Unrestricted Processing"

Discussion (7 min): Clinical scenarios ~ which framework would you choose and why?

MODULE 3: ABLS as a Standalone Tool (35 min)

Core message: ABLS is not just a processing tool. It is a regulation tool, a resourcing tool, and a rehearsal tool ~ and you can use it without ever touching trauma.

Talking points:

- ABLS modalities: eye movements, tactile (butterfly hug, tapping, havening), auditory. Modality choice is clinical.
- Three applications for any clinician:
    1. **Regulation** ~ calming the nervous system without activating trauma

2. **Resource installation** ~ strengthening adaptive neural networks
3. **Behavioral rehearsal** ~ bridging imaginal to real-world action

- Experiential: Walk participants through self-administered butterfly hug with slow bilateral tapping (5 min). Notice what happens to arousal, breath, body.
- When ABLS opens the trauma network accidentally:
  - Signs: sudden affect shift, dissociation, flooding
  - Response: stop, ground, contain. Don't process.
  - This is clinical judgment, not failure.

Show video (5:27): "Client can't create an imaginal container"

Discussion (5 min): What alternative approaches resonated? What would you try with your clients?

MODULE 4: Resourcing & Behavioral Rehearsal (40 min)

Core message: Resourcing without rehearsal stays imaginal. Rehearsal bridges the gap to real-world action.

Talking points:

- The RDI formula:
  1. Identify the resource
  2. Activate it sensorially
  3. Pair with ABLS (short sets, 6-12 passes)
  4. Check ~ strengthen or intrusion?
- Three specific resources (expanded from 3-hour):
  - **Comfortable Place** ~ not "safe place." For some clients, "safe" has no referent.
  - **Triumphant Self** ~ the client's own evidence of competence. Their fiero moment.
  - **Wise Self** ~ an internal figure who holds perspective the client cannot yet access.
- Behavioral Rehearsal sequence (detailed):
  1. Identify target behavior
  2. Resource first ~ activate felt-sense of capability
  3. Rehearse imaginally with full sensory detail

4. Pair with ABLS
5. Body check: does the body believe it?

- Distribute Resourcing & Behavioral Rehearsal handout. Walk through each section.

Show video (9:49): “Resourcing & Behavioral Rehearsal”

Show video (4:54): “Resourcing triumphant moments”

Transition: “Now let’s zoom out to the architecture ~ the four decisions that govern every complex trauma treatment.”

MODULE 5: The Decision Architecture (30 min)

Core message: Every complex trauma treatment passes through four decision points. Each has one governing question. Everything else is detail hanging off these four questions.

Talking points:

- **Decision Point 1 ~ Intake: What am I treating?**
  - The screening battery: ITQ (PTSD or CPTSD?), DES-II (how much dissociation, what kind?), Sensitivity Questionnaire (titration and pacing), AAQ (how will the client attach to you?), C-SSRS (does anything else have to wait?)
  - Output is not a diagnosis ~ it’s a treatment posture.
- **Decision Point 2 ~ Session by session: What can this nervous system do today?**
  - Mental level governs. Brief assessment every session: sleep, stressors, window of tolerance, dual awareness right now.
  - High-mental-level day may carry processing; low-mental-level day is a Phase 1 day regardless of where you left off.
- **Decision Point 3 ~ In processing: Restricted or unrestricted?**
  - The client’s state and stability makes the decision, and it’s revisable mid-session.
  - When processing stalls: the stall is never a mystery; it’s a diagnosis you’ve yet to make.
- **Decision Point 4 ~ The compulsive thread: Which driver, which protocol?**
  - When compulsive behavior is part of the picture ~ and with complex trauma it usually is ~ select by driver.
  - Preview for next module.

- These four decision points are not stages. They are nested loops. A clinician holding all four loops at once is not following a protocol ~ that clinician is practicing an architecture.

MODULE 6: Compulsive Behaviors ~ Flexible Interventions (30 min)

Core message: A compulsion is not a character flaw. It is a solution ~ a necessary one, a costly one, but a solution to a problem the client could not otherwise solve.

Talking points:

- Understanding compulsive behaviors:
  - Emotion regulation: temporary sense of control over intense distress
  - Avoidance: mechanism to avoid confronting painful emotions or memories
  - Reinforcement: temporary relief creates a loop
- EMDR-based protocols for compulsive behaviors:
  - **FSAP (Feeling-State Addiction Protocol)** ~ targets the fixation between a positive feeling state and the addictive behavior. When the driver is emotional payoff.
  - **DeTUR (Desensitization of Triggers and Urge Reprocessing)** ~ identifies and desensitizes triggers. When the driver is trigger-urge pathway.
  - **CravEx** ~ targets cravings directly by processing their emotional and sensory components.
- Clinical decision framework: select by driver
  - Emotional payoff → FSAP
  - Trigger-urge pathway → DeTUR
  - The craving itself → CravEx
  - Group setting → EMDR-IGTP-PLUS
- ABLS applications specific to addiction:
  - Reduce craving intensity
  - Desensitize triggers
  - Integrate adaptive behaviors via behavioral rehearsal
- Distribute Compulsive Behavior handout. Walk through the assessment and intervention sections.

MODULE 7: Dyad Practice #1 ~ Resourcing with ABLS (35 min)

Format: Participants pair up. One is “clinician,” one is “client.” Then switch.

Instructions to participants:

1. Clinician guides client through identifying a Comfortable Place or Triumphant Self (5 min)
2. Clinician guides sensory activation: “What do you see? Hear? Feel in your body?” (3 min)
3. Clinician guides ABLS pairing: butterfly hug, 6-8 slow passes (3 min)
4. Check: “Did it strengthen? Did anything intrude?” (2 min)
5. Switch roles and repeat (13 min)
6. Large-group debrief (9 min): What worked? What surprised you? What would you do differently?

Facilitator circulates during practice, offering guidance and noting common questions for debrief.

MODULE 8: Dyad Practice #2 ~ Behavioral Rehearsal (35 min)

Format: Same pairs. One is “clinician,” one is “client.” Then switch.

Instructions to participants:

1. Client identifies something they need to do in the next week that feels difficult (2 min)
2. Clinician guides resource activation first ~ “What resource do you need for this?” (3 min)
3. Clinician guides imaginal rehearsal: “Walk me through the scene. What do you see, hear, feel?” (5 min)
4. Clinician pairs rehearsal with ABLS: butterfly hug during the imaginal scene (3 min)
5. Body check: “Does your body believe you can do this?” (2 min)
6. Switch roles and repeat (15 min)
7. Large-group debrief (5 min)

MODULE 9: Live Demo + Debrief (20 min)

Format: Presenter demonstrates a complete resourcing → behavioral rehearsal sequence with a volunteer.

Demo structure:

1. Brief check-in (2 min)
2. Resource identification and activation (4 min)
3. ABLS pairing (4 min)
4. Behavioral rehearsal with ABLS (5 min)
5. Debrief with audience (5 min): What decisions were made? What did you notice about pacing, attunement, clinical judgment?

Show video (21:38): “Trauma network opens up while resourcing” ~ what to do when positive resourcing accidentally activates the trauma network. (Can show excerpt if time is tight.)

MODULE 10: Integration, Q&A, Evaluation (15 min)

Talking points:

- Recap the seven learning objectives ~ one sentence each.
- The architecture in one sentence: “You took the protocol apart. Now you have the pieces. Use them where they fit.”
- Resources for continued learning:
  - EMDR Deconstructed website (video library, screening tools)
  - The full workbook
  - ABLS Companion app for between-session practice
- Open Q&A (8 min)
- Distribute evaluation forms for CE credit.

CE Documentation

Program title: EMDR Deconstructed: Components, Modification, and Clinical Flexibility
Contact hours: 6.0
Instructional level: Intermediate
Target audience: Licensed mental health professionals
Instructional methods: Lecture, video demonstration, experiential exercise, dyad practice, case discussion, Q&A

Content outline for CE submission:

1. Historical foundations and deconstruction premise (25 min)
2. Restricted vs. unrestricted processing frameworks (30 min)
3. ABLS as a standalone regulation and resourcing tool (35 min)
4. Resource Development and Installation with behavioral rehearsal (40 min)
5. The four-decision architecture for complex trauma (30 min)
6. Flexible interventions for compulsive behaviors (30 min)
7. Supervised dyad practice: resourcing with ABLS (35 min)
8. Supervised dyad practice: behavioral rehearsal (35 min)
9. Live demonstration with clinical decision-making narration (20 min)
10. Integration, questions, and evaluation (15 min)

References

- Shapiro, F. (2018). *Eye Movement Desensitization and Reprocessing (EMDR) Therapy* (3rd ed.). Guilford Press.
- Wolpe, J. (1958). *Psychotherapy by Reciprocal Inhibition*. Stanford University Press.
- Curran, L. A. (2026). *EMDR Deconstructed: Flexibility Beyond Manuals & Protocols*.
- Popky, A. J. (2005). DeTUR, an urge reduction protocol. In R. Shapiro (Ed.), *EMDR Solutions*. Norton.
- Miller, R. (2012). Treatment of Behavioral Addictions Utilizing the Feeling-State Addiction Protocol. *Journal of EMDR Practice and Research*, 6(1), 2-15.
- Hase, M., Schallmayer, S., & Sack, M. (2008). EMDR Reprocessing of the Addiction Memory. *Journal of EMDR Practice and Research*, 2(3), 170-179.
- Parnell, L. (2013). *Attachment-Focused EMDR*. Norton.