3.1 The Eight Phases of EMDR Treatment

PHASE	GOALS	TASKS
Phase 1 History Taking	■ Establish therapeutic alliance. ■ Gather psychosocial and medical history. ■ Develop the treatment plan and case formulation. ■ Rule out exclusion criteria.	■ Obtain narrative or structured history. ■ Objective assessment of symptoms. ■ Identify targets for reprocessing: (a) past events etiological to current symptoms; (b) current triggers, and (c) future goals.
Phase 2 Preparation	■ Obtain informed consent to treatment. ■ Offer psychoeducation. ■ Practice self-control methods. ■ Have patient start a weekly log. ■ Strengthen therapeutic alliance.	■ Orient patient to issues in trauma-informed psychotherapy with EMDR. ■ Provide metaphors for mindful noticing during reprocessing. ■ Verify from log patient is helped by methods for self-control.
Phase 3 Assessment	■ Access primary aspects of the target selected from treatment plan for EMDR reprocessing. ■ Obtain baseline measures on SUD and VoC.	■ Elicit the image, current negative belief, desired positive belief, current emotion, and physical sensation. ■ Record baseline measures for SUD and VoC.
Phase 4 Desensitization	■ Reprocess the target experience to an adaptive resolution as indicated by a 0 SUD.	■ Provide discrete sets of bilateral stimulation and assess changes via brief patient reports. ■ Return to target periodically to assess gains and identify residual material. ■ Use additional interventions only when reprocessing is overtly blocked.
Phase 5 Installation	■ Continue reprocessing target with overt inclusion of preferred belief. ■ Fully integrate preferred belief into memory network as indicated by 7 VoC.	■ Provide discrete sets of bilateral stimulation while patient holds target in awareness with desired positive belief. ■ Continue until patient reaches 7 VoC or "ecological" 6 VoC.
Phase 6 Body Scan	■ Verify any residual disturbance associated with the target is fully reprocessed. ■ Allow patient to reach higher levels of synthesis.	■ Provide discrete sets of bilateral stimulation while patient focuses on reprocessing any residual physical sensations until there are only neutral or positive sensations.
Phase 7 Closure	■ Ensure client stability and current orientation at the close of each reprocessing session.	■ Use self-control techniques if needed to assure stability and current orientation. ■ Brief patient about treatment effects. ■ Request patient to keep a log of self-observations between sessions.
Phase 8 Reassessment	■ Verify whether all aspects of the treatment plan are being addressed.	■ Adjust treatment plan as needed based on patient reports from log. ■ Recheck target(s) to assure stable treatment effects.

Note. From EMDR Institute Training Manual, by F. Shapiro, (Jan, 2008 & Jan, 2005), Watsonville, CA: EMDR Institute. Copyright 2008, 2005 by EMDR Institute. Adapted with permission.

Note. From Handbook of EMDR and Family Therapy Processes (pp. 3–34) by F. Shapiro, 2007, Hoboken, NJ: Wiley. Copyright 2007 by Wiley. Adapted with permission.

The Affect Bridge in EMDR

Ask the patient:

What picture represents the worst part of that experience? _____

What words go with that picture that represent your present negative belief about yourself?

_____

When you focus on that picture and those negative words _____*, what emotions do you feel now?*

_____

Notice those feelings and that thought and just let your mind float back to the earliest time in your life when you had the same thought and feelings. What memory comes up for you now?

The Somatic Bridge in EMDR

Ask the patient:

What picture represents the worst part of that experience? _____

What words go with that picture that represent your present negative belief about yourself?

_____

When you focus on that picture and those negative words _____*, what emotions do you feel now?*

_____

Where do you feel it in your body? _____

Notice that thought and where you are feeling it in your body, and just let your mind float back to the earliest time in your life when you had the same thought and with those same feelings in that part of your body. What memory comes up for you now?

THE DEFENSIVE URGE BRIDGE IN EMDR

Ask the patient the following starting with standard questions from the assessment phase:

What picture represents the worst part of that experience? _____

What words go with that picture that represent your present negative belief about yourself?

_____

When you focus on that picture and those negative words _____*, what emotions do you feel now?*

_____

Where do you feel it in your body? _____

As you focus on that picture, those negative words and where you are feeling it in your body, notice any behavioral impulses or urges to act that come up for you. What do you notice? _____

Notice that behavioral impulse or urge to act and just let your mind float back to the earliest time in your life when you had the same impulse or urge. What memory comes up for you now? _____

_____

Adapted from the *affect bridge* (Watkins, 1971, 1992) and the *floatback* technique (Shapiro, 2001, pp. 433–434; Young, Zangwill, & Behary, 2002, p. 195).

CLINICAL INDICATIONS TO CONSIDER RDI BEFORE STARTING STANDARD EMDR REPROCESSING FOR PTSD INCLUDE:

1) Patients who cannot control tension reduction, avoidant or aggressive behaviors that involve:
   a) Risk of serious self-injury, mutilation, death
   b) Life-threatening abuse of dangerous substances
   c) Harm to others
   d) Loss of economic stability, housing or essential social support with no acceptable alternatives
2) Patients who are afraid or unwilling to start EMDR and
   a) Standard self-care and self-regulation methods, such as structured relaxation and guided imagery methods (such as calm or safe place) do not alleviate patient distress in the office or are not useful to the patient between treatment sessions.
   b) This inability to regulate anxiety (or other affects) leaves the patient vulnerable to emotional flooding or acting out during and between treatment sessions.
3) Although the patient has indicated an interest in starting trauma resolution with EMDR, the clinician may determine there is a substantial risk the patient would abruptly terminate treatment if the clinician proceeded to use EMDR due to:
   a) Poor ego strength.
   b) Inability to tolerate suppressed or dissociated material.
   c) Already observed Borderline shifts from idealization to devaluing the clinician.
   d) Intolerable shame if they were to resume acting out in non-lethal ways or if they were to reexperience certain painful memories.
4) Patients who have episodes when they cannot speak or can barely articulate their thoughts. These patients appear confused or overwhelmed by emotional states at these times.
5) Patients who cannot give coherent narrative accounts of events of the week (even with clinician prompting) such as stressful interactions with family members or coworkers. Instead, these patients give fragmentary accounts of these situations and then lapses into vague self-critical comments.
6) Patients who become so flooded with affect, memories or maladaptive urges after starting standard EMDR reprocessing that their day-to-day functioning is adversely impacted.
7) Patients who have chronically incomplete EMDR reprocessing sessions

17.1 EMDR Case Inquiry Format

When consulting on clinical cases related to the application of EMDR, please provide the relevant portions of the following information. Keep in mind that you are responsible for obtaining your patient's written permission for the release of any confidential information and for disguising any identifying data.

CLINICIAN DATA

1.) Please indicate your work setting and licensure: _____

2.) Please indicate your theoretical orientation before EMDR training:

_____

3.) EMDR training status. Please specify: in training; completed basic training; additional advanced EMDR training; EMDRIA Certified.

_____

4.) Duration of EMDR experience: year completed training; amount of experience.

_____

Please describe the issue(s) you want to address through consultation on this case:

_____

_____

PATIENT DATA

Presenting problem(s) including duration, severity, and any remission:

_____

_____

Patient's treatment goal(s): _____

_____

Age: _____ Gender: _____ Marital status: _____ Ethnicity: _____

Current family system:

_____

_____

Social support system:

_____

_____

Synopsis of patient history including past and present life issues, traumatic events, childhood attachment status, legal issues, health history.

_____

_____

_____

_____

Resources including ego strengths, coping skills, self-capacities:

_____

_____

Past treatment episodes and diagnoses: _____

_____

Past responses to treatment both positive and negative _____

_____

Current diagnoses and medical health conditions (Axis I, II, and III)

Axis I: _____

Axis II: _____

Axis III: _____

Current Global Assessment of Functioning (GAF): _____

SCREENING FOR DISSOCIATION

DES II and DES Taxon scores: _____ SDQ20 or SDQ 5 score: _____

Dissociative symptoms: _____

_____

Other testing data: _____

Defenses: _____

PAST AND CURRENT STABILITY

Note any impulse control problems with alcohol, drugs, violent urges or behaviors, self-injurious behaviors, suicidal thoughts, urges or plan, compulsive sexual behavior, compulsive spending, etc.: _____

_____

TREATMENT PLAN:

Please describe your overall treatment plan and estimated duration of treatment:

_____

_____

Responses to stabilization and ego strengthening

Please describe methods of stabilization used and responses: _____

_____

RESPONSES TO THE CALM (SAFE) PLACE EXERCISE AND RDI:

Resource 1: _____

Response to bilateral stimulation: _____

Resource 2: _____

Response to bilateral stimulation: _____

RESPONSES TO EMDR REPROCESSING

Please indicate how many targets have been reprocessed and with what outcome. Copy this section if necessary for additional targets.

Target: _____ *past;* _____ *present;* _____ *future.*

Target situation: _____

Image: _____

NC: _____

PC: _____

VoC: _____ Emotion(s): _____ SUDs: _____

Location of body sensations: _____

End of session: SUDs: _____ VoC: _____ Body scan: _____

Session was: complete _____ ; incomplete _____.

PC: (final): _____

REASSESSMENT (FOLLOW-UP SESSION):

Please describe any observed or reported changes in patient functioning following session(s) in which reprocessing was used:

_____

_____

Adapted from Forgash and Leeds (1999)

Secondary gain/loss	When current secondary gain is moderate or severe, reprocessing is more likely to be incomplete and may require problem solving. Reprocessing may be attempted unless incomplete reprocessing would lead to premature discontinuation of treatment.
Trust or truth absent	When the patient lacks sufficient trust to be truthful *and* there are other dangerous or therapy-interfering behaviors, reprocessing may need to be postponed. Even without overt evidence of dangerousness, attempts to reprocess targets with inadequate trust or disclosure (truth telling) can lead to dangerous acting out or complications that might prevent future consideration of reprocessing.
External crises	When external work, personal, or family crises require patient's full attention, reprocessing may need to be postponed. Other patients may benefit from prompt reprocessing of associated early memories.
Financial instability	Inability to complete treatment or realistic fears of impending loss of basic financial security may need to be addressed before reprocessing.
Health risk	Any life threatening health risk that could be exacerbated by emotional reprocessing, and any history of eye problems should be evaluated and cleared by a physician before starting reprocessing. (Examples: risk of stroke, heart attack). Also potential risk to pregnancy requires informed consent and physician ok.
Bipolar depression	Bipolar depression carries greater risk of suicide attempts.
Suicidal ideation	Suicidal ideation requires careful assessment and ongoing monitoring for intent, plan, and lethality.
Suicide attempts	Past suicide attempts need to be fully understood to assess current risk. Risk factors need ongoing monitoring during treatment. When risk remains present, clinicians should be cautious in considering reprocessing. Clarify treatment contract and mandated actions to protect patient.
Self-injury	Self-harming behaviors need to be carefully assessed for dangerousness to life and risk of self-mutilation. Dangerous self-harm should be fully stabilized before reprocessing and carefully monitored during reprocessing. Clarify treatment contract and mandated actions to protect patient.
Injury to others	Past- and current-acts and urges need to be carefully assessed and monitored for risk and lethality. Clinicians should be cautious in considering reprocessing when risks factors are present. Clarify treatment contract with patient and that mandated reports may become necessary.
High-risk behaviors	Current vulnerability to high-risk behaviors should be carefully assessed and addressed to protect patient from dangerous self-injury, revictimization, or harm to others.
Denial of diagnosis	Attempts to proceed with reprocessing when the patient is in denial of a major diagnosis—such as substance abuse, dissociative identity disorder, bipolar disorder, or any psychotic disorder—can put the patient at risk.
Accident-prone self	Accident proneness can indicate unconscious acts of self-injury or assault and should be assessed carefully for current risk.
Substance abuse	For types of substance abuse that can be threats to life or health, reprocessing should be postponed until stable recovery is achieved. With limited published EMDR research for this population, clinical issues require careful consideration and informed consent.
Compulsive sex	Dangerousness to self and others needs to be carefully considered.
Compulsive acts ($)	Compulsive spending or gambling could remain unstable or be worsened by emotional reprocessing. Absence of controlled research needs to be part of informed consent. Stabilizing interventions should be considered.
Alexithymia	Mild alexithymia (such as problems naming emotions) should not interfere with reprocessing. Moderate to severe alexithymia—no access to affect—is more likely to interfere with reprocessing and may require modifications in procedure. Alexithymia by itself is seldom a reason to withhold EMDR, but it may be when present with other factors.
Flooded by affect	Prolonged intense weeping, anger, terror, or shame during verbal therapy may predict inability to reprocess. Affect tolerance and management skills building may need to be the focus. Standard reprocessing should not be withheld unless a failure at reprocessing would lead to a refusal to consider reprocessing in the future.
Depersonalization and derealization	Depersonalization and derealization experiences can be intensely painful, frightening, and shameful for some patients. Patients who frequently experience depersonalization or derealization in verbal therapy are more likely to do so and more intensely during reprocessing. Strategies for self-control and affect management may need to be practiced before reprocessing can succeed.
Amnesia or fugue	Evidence of past or current fugue or current amnesia episodes—loss of time—indicates a need for more complete assessment of dissociation before reprocessing to avoid risk of harm to patient.
DID or DDNOS	A possible current diagnosis of dissociative identity disorder or dissociative disorder not otherwise specified indicates a need for more careful assessment of dissociation before reprocessing to avoid risk of harm to patient. Lack of stabilization in DID or DDNOS such as uncontrolled rapid switching, uncontrolled flashbacks, and poor cooperation and communication among parts of the personality indicate a need to postpone reprocessing. ISST-D and EMDR Treatment Guidelines should be followed.