

**TARGET SEQUENCE
PLANNING:
EMDR, EMD, R-TEP & EMDr**

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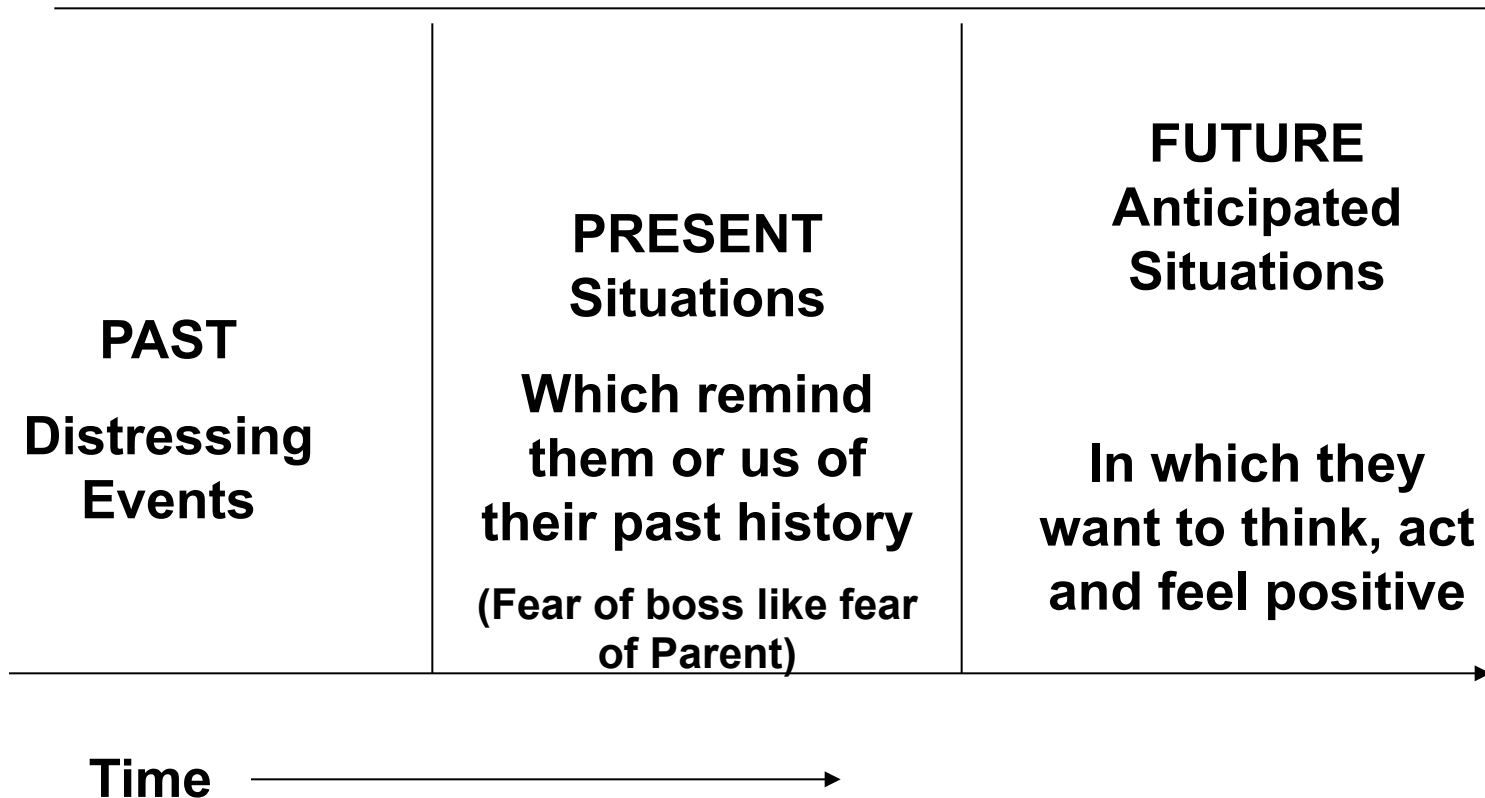
Target Sequence Planning

Phase 3

Structured Accessing and Measuring of Target Memories

Standard EMDR

3 Pronged Protocol



TIME LINE: What has influenced your development? (Ch 2 EMDR Scripted Protocols)



A. Ten Best things that have happened in my life

10 Fantastic

8

6

5 Medium

4

2

0 _____ age 5 _____ age 10 _____age 25 _____ ...2013

-2

-4

-6

-8

-10 Horrible



B. 10 Worst Events/times or Most Distressing events/times that have happened in your life.

TIME LINE: What has influenced your development?

(Ch 2 EMDR Scripted Protocols)

- 1. Time Line: Put on the time line the Ten Best things that have happened in your life and the 10 Worst Events/times or Most Distressing events/times that have happened in your life.**
- 2. Try and give it an age or age period when it happened.**
- 3. You may need more paper...please use as much as you need.**
- 4. It could be events, illnesses, bullying, accidents, divorce, deaths, muggings, hospitalizations, separations, house or location moves, new schools, etc...**
- 5. Rate the event by thinking how you feel about it Today:
Either Positive on 0 to 10 scale or Negative on 0 to -10 scale.**

Past: *Process Memories of traumatically stored past events.*

1. **Using the Time Line Get 10 Best & Worst Memories starting from Childhood & discuss it with client.**
 - a. Look at their **10 Best Events** (Resources, Strengths, 'Can Do' Attitude & their Social Network)
 - b. **Look at their 10 Worst Events** (Early Attachment Issues, Themes, Triggers: People/Places/Things, etc).

Typically the better the childhood attachment the easier the therapy progresses.
 - c. **Socially Shy need lots of encouragement.** Emphasize their positives.

TEN MOST DISTURBING MEMORIES Phase 3 EMDR

Only do this by yourself if it feels comfortable,
otherwise we will do them together.

Memory 1 Worst Image:

NC: A negative thought that you have about yourself when you think about this situation.

PC: A positive thought that you would like to have about yourself when you think about this situation.

Memory 2 Worst Image:

NC: A negative thought that you have about yourself when you think about this situation.

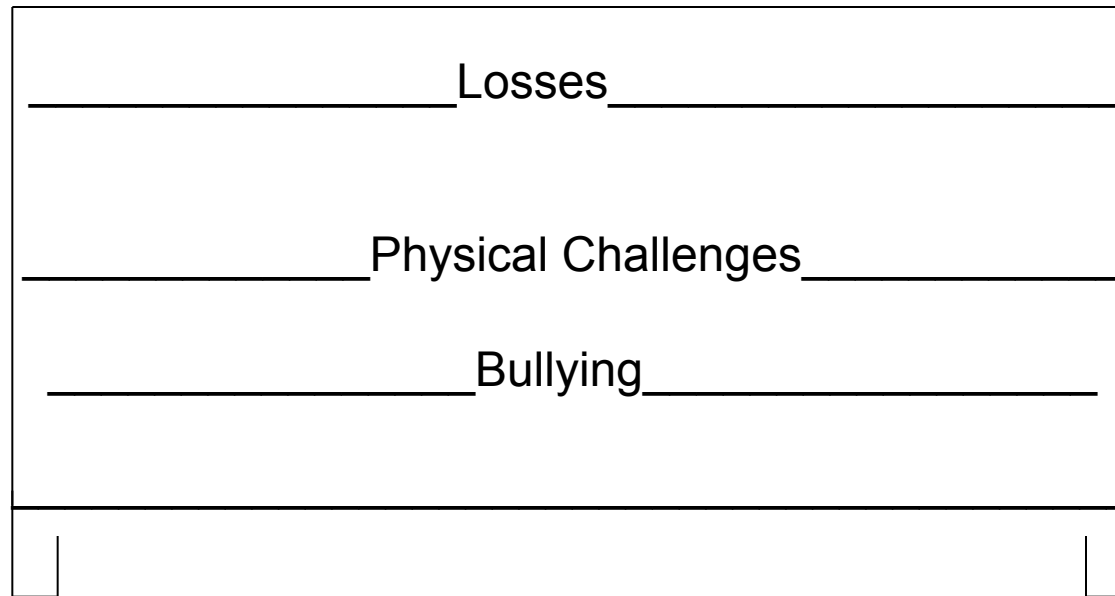
PC: A positive thought that you would like to have about yourself when you think about this situation.

Past: *Process Memories of traumatically stored past events*

- 2. Discuss with and Teach Client about where we'd like to start and where they feel safe to start EMDR.**
 - a. **Try and start with the earliest traumatic event** linked to intrusive, avoidant or hyper-arousal symptoms.
 - b. Or **start with worst event** when it is the source of the most disabling symptoms.
 - c. **Ask them which memory they would like to start on** if they haven't come in with one Key theme they want to deal with. Eg. The car crash, the abuse, etc. Use handout on listing memories in 1-10 distressing order.
 - d. Keep them in **Window of Tolerance** so teach them Calm Place & have them practice it at home for 1 week at least.

**Keeping Track of Their Targets
when there are a number of them**

Image of a Bookshelf.
Looking at **Themes** and placing similar themes on
shelves:



1. **Lady:** Depressed/Near Retirement age/Chronic arthritis
2. **Man:** Am I a pervert? Bullying/unexplained erection at work/mental illness in family: Bullying from both sexes, shame, confused sexual identity

Keeping Track of Changes

TEN Best &/or MOST DISTURBING MEMORIES

	Memory	Age	SUD	SUD Post Processing
1				
2				
3				
4				
5				

TEN MOST DISTURBING MEMORIES

Therapists can use this to list and keep track of the Client's Targets

Memory 1 **Worst Image:** **Beg. SUDS/Date** **End Suds/Date**

NC:

SUDS

PC:

VOC:

Memory 2 **Worst Image:**

NC:

SUDS

PC:

VOC:

Case Study: Use of this recently as a review. It showed that our work had slowed down due to client's lack of motivation, over sleeping, & foggy head. Discussion: Result —————> Letter to GP re. change of anti-depressants.

Present: *Process life situations that trigger disturbance in their life Now.*

Sometimes people come in very focused on distress in their life Now.

a. Look for **Touch Stone Event** for this present distressing situation in their life.

b. Ask: When is the first time you remember feeling that way?

c. Ask: When did you first learn the negative theme you spoke about? Eg. "I'm not good enough"

d. If they don't have a specific event in mind use the float back technique to get to the first event.

Present: *Process life situations that trigger disturbance in their life Now.*

FLOAT BACK Technique:

- *“Now, please bring up that picture of _____ and those negative words _____ (repeat client’s disturbing image and NC.) Now, notice what feelings are coming up for you, where you are feeling them in your body, and just let your mind float back to an earlier time in your life- don’t search for anything-just let your mind float back and tell me the first scene that comes to mind where you had similar: Thoughts of _____ (repeat NC), feelings of _____ (repeat emotions above), in your _____ (repeat places in body where feelings were reported).”*

Future: Install Session by Session Positive Changes

- Process ‘successes’ which occur in-between sessions using short sets BLS:
‘Let’ s review your week since our last session.’

This positively reinforces growth.

Future: *Use Guided Imagery to imagine & install positive responses.*

- Once earlier memories and present stimuli are adequately resolved the clinician and client explore how the client would like to be perceiving, feeling, acting, and believing in the present and into the future. Once the client has received appropriate education (eg about assertiveness, social customs and norms, other skills), s/he is asked to imagine the optimal Behavioral responses, along with an enhancing positive cognition.
- I usually find that Completed EMDR establishes the positive adaptations. However, where attachment has been poor, there has been neglect & life skills/wisdom not taught we need to teach these.

Future: *Use Guided Imagery to imagine & install positive responses.*

- Client imagines an adaptive response in the future and runs a movie of encountering in the future a previously disturbing (or unfamiliar) person, place or situation or doing any other specific action. This helps them overcome avoidance and encourages adaptation.
- After full validity of PC has been achieved, client imagines adaptive behaviour/response, and identifies empowering positive cognition, emotion, and physical sensations with BLS. At the end of this step, the client should feel emotionally, physically, and cognitively comfortable with the anticipated event.

Case Study

8 year old child: Fearful of teacher
“He’ s a giant dragon.”

40 yr woman: Now boss is a frightening
dragon

(her Mum & old boyfriend developed this
theme in PAST)

**Early EMDR Interventions (EEI):
The Widening Focus of
image-event-episode-theme
processing.**

**Early EMDR Interventions (EEI):
The Widening Focus of image-
event-episode-theme processing.**

**IMAGE
Processing
(EMD)
PERCEPTUAL**

**NARROW
FOCUS**

**On intrusive
Image**

**EVENT
Processing
(RE)**

**WIDE
FOCUS
On event**

**EPISODE
Processing
(R-TEP)**

**LEVEL:
Experiential/
Layers of
meaning
Transitional**

**ISSUES:
External to
internal
identity**

**WIDER
FOCUS
On multiple
targets of
the episode**

**THEME
Processing
(Standard
EMDR
Protocol)**

**LEVEL:
Meaning/
Assumptive
world**

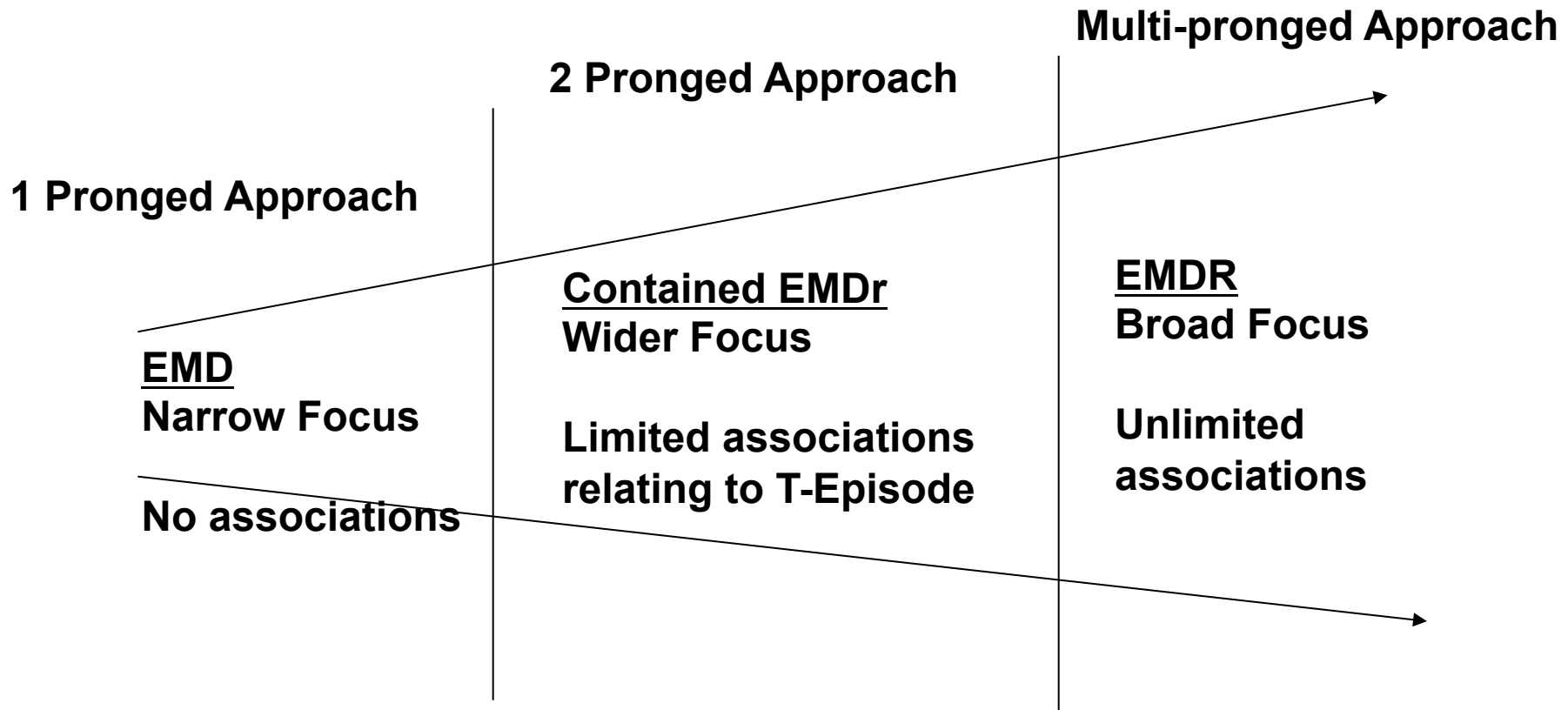
**ISSUE:
Internal to
Identity**

**WIDEST
FOCUS:
On themes,
schemas**

IMPLICIT MEMORY →

EXPLICIT MEMORY

Brief R-TEP “Telescopic Processing” Expanding from EMD to EMDr to EMDR



Continual assessment & keeping them in Window of Tolerance
is essential to stable processing.

EMD

Eye Movement Desentization Protocol

Recent Trauma Incident-RTI

- **Memory differs from distant trauma – it tends to be fragmented, disorganized, and less integrated into a coherent narrative.**
- **Consequently it may not be adequately represented or generalised by any single image of the event.**
- **It may not yet have been organised into a theme cluster either at an early stage.**

EMD: Recent trauma incident-RTI

- **In early weeks and months following a trauma modify treatment procedures to address these factors.**
- **EMDR theory/philosophy – promotes the view of natural self healing in relation to traumatic experiences, with the minimum of intervention – However, when intrusive imagery, sounds, smells or other repetitive sensations ‘sensory images’ are stuck at a perceptual level and creating major disturbance, consider using EMD.**

EMD

- **Consider carefully when to intervene or when not to interfere with the natural healing process of traumatic material.**
- **Give consideration to history of past traumas**
- **Prioritise stability, preparation and resources for the client**
- **Quality of therapeutic relationship and contract**
- **At all times focus upon the safety and containment of the client.**

RTI / EMD

- **EMD differs from EMDR in that it focuses on the desensitisation of the intrusive sensory symptoms, ‘sensory images’.**
- **EMD addresses stuck processing at the perceptual level taking a narrow focus and relates to Implicit memory, compared to EMDR which has a wide focus and relates to Explicit memory.**

EMD Protocol

- **Begin with a relaxation exercise eg Safe Place, heart coherence, or 4 elements grounding exercise.**
- **Use a distancing metaphor such as viewing the ‘sensory image’ on a TV screen.**
- **Obtain the ‘sensory image’ that is most disturbing and a negative cognition or words that are relevant for the client that go with that sense**
- **Obtain a SUDs rating from 0 – no disturbance – to 10 the highest disturbance**

EMD Protocol

- **Ask the client to be aware of the ‘sensory image’ and the words that go with it and complete between 12-24 movements of BLS**
- **Then after EVERY set, ask the client to bring up the picture and words again and check the SUDs level.**
- **Occasionally, asking ‘What do you get now’ or ‘has the picture changed’ etc. This may offer new insights and associated limiting beliefs that can then be included in the desensitisation.**
- **Continue in this way until the SUDs level is reduced to 0.**

EMD Protocol

Some special concerns:

- **Insufficient history taking and triggering old unprocessed memories.**
- **Insufficient therapeutic relationship, contract and rapport.**
- **Follow up may be neglected.**
- **Insufficient preparation**
- **Cutting corners by being impatient to intervene too quickly may give us an inadequate map.**

RTI-EMD Protocol

CASE STUDY:

Young woman – RTC – death of best friend

RECENT TRAUMATIC EVENTS PROTOCOL R-TEP

- **This protocol is appropriate when SUDs rise having completed or during EMD.**

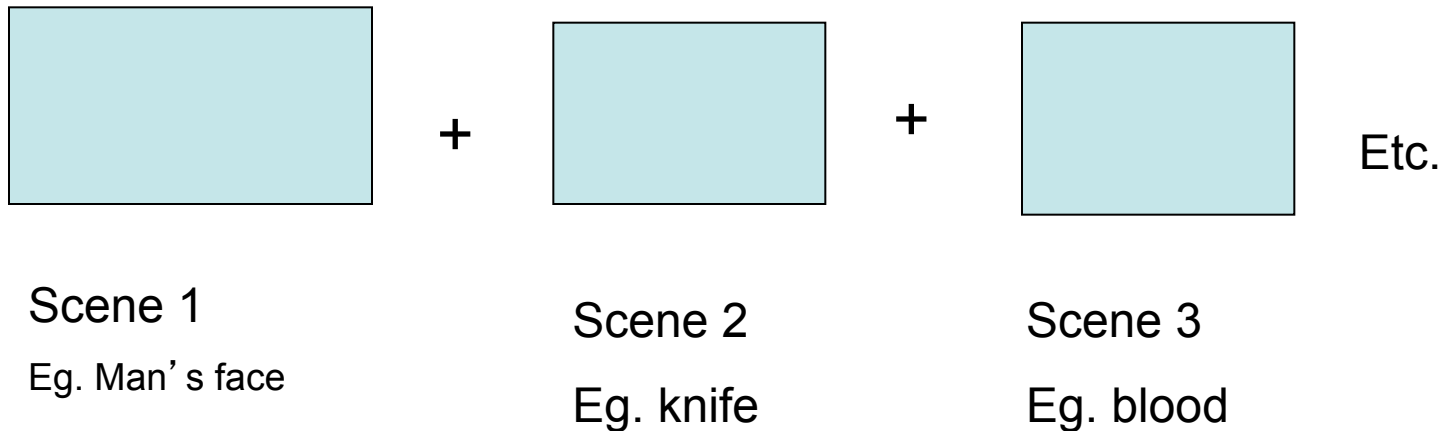
MEMORY

- **This protocol is appropriate when working with a recent traumatic event where the memory remains fragmented, disorganised and less integrated into a coherent narrative.**
- **Where any specific image of the event is not therefore, generalized and where BS does not desensitise other parts of the traumatic event, as a result.**
- **Where possible EMDR should follow as a natural progression after R-TEP.**

RECENT TRAUMATIC EVENTS PROTOCOL R-TEP

- Obtain a narrative history of the event.
- *Clinician should take note of the separate aspects of the event and desensitise each aspect with the appropriate negative cognition.*
- Desensitise the most traumatic aspects of the event, if necessary.
- *Desensitise the traumatic aspects in chronological order.*
- Desensitise the remainder of the event, chronologically.

Have Client state what the scene Headlines of the event would be:



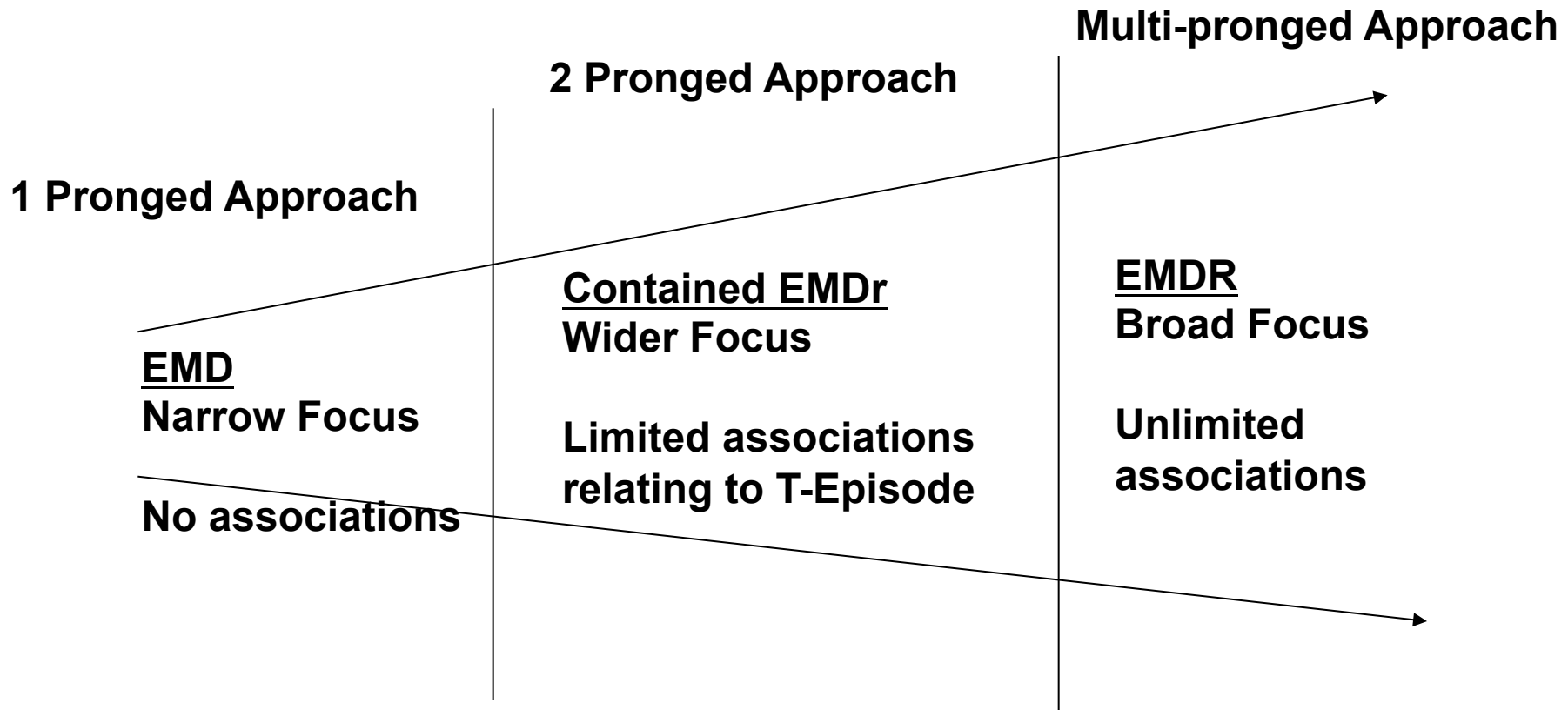
Focus on Scenes 1 by 1 and return to SUDs after each scene.

After 1 Scene's SUDs down low, go to next scene and repeat until they can process the whole event.

RECENT TRAUMATIC EVENTS PROTOCOL R-TEP

- Have the client close their eyes and visualise the entire event.
- *Desensitise any disturbing aspect as it arises, until the entire event can be run through from start to finish without disturbance.*
- Have the client visualise the event from beginning to end with eyes open, and install positive cognition.
- Do Not complete the body scan until you have desensitised each and every aspect of the event.

Brief R-TEP “Telescopic Processing” Expanding from EMD to EMDr to EMDR



**Continual assessment & keeping them in Window of Tolerance
is essential to stable processing.**

EMDr

- EMDr is often used in complex trauma cases to restrict processing around certain target memories and not to migrate into other memories as this may take a person outside their particular window of tolerance. It is an intervention to use even if there is evidence of reprocessing taking place.

EMDr

Special Attention to Containment and Safety

- In addition to the containment and safety provided by the adapted 8 phase framework, there are some other measures.

T-Episode Narrative (Trauma-Episode Narrative)

- During phases 1 & 2, the client is deliberately **not** asked to recount the details of the trauma yet, **except in general terms**, so as to avoid triggering abreaction and possible retraumatization before containment and safety measures are in place and treatment processing can begin. The T-Episode narrative is carried out adding BLS during the telling of the story with an optional distancing technique. This appears to increase the sense of safety because of the presumed grounding and de-arousal effects of the BLS.

EMDr

Telescopic Processing

- The possibility of regulating chains of associations can provide boundaries for focused contained processing. Identified targets are processed with a strategy of a widening focus, beginning with the narrow focused EMD protocol (going back to target after each set). If the SUDs is not reducing after several sets, the focus can be expanded to permit associations related to the Current Traumatic Episode, which is called the EMDr protocol. (R. Kiessling, 2008, personal communication).
- If the SUDs is still not reducing or processing gets stuck, the focus expands further (with consent) to permit all associations as in the Standard EMDR Protocol processing using Telescoping Processing: the step is optional.

Resources:

- **EMDR Scripted Protocols: Basics and Special Situations Ed. Marilyn Luber, 2009 Springer Publisher**

The Following can be found in the above book:

- **Ch 2 Time Line**
- **Ch 3 Target Sequencing**
- **Ch 18 Single Traumatic Event**
- **Ch 20 Recent Traumatic Event**
- **Ch 27 Recent Traumatic Episode Protocol (R-TEP): An Integrative Protocol for Early EMDR Intervention (EEI) by Elan Shapiro & Bruit Laub**

Resources:

The same article in:

- **Early EMDR Intervention (EEI): A Summary, A theoretical Model, and the Recent Traumatic Episode Protocol (R-TEP) Elan Shapiro & Bruit Laub Journal of EMDR Practice & Research, Vol 2, Num 2, 2008, Springer Publ.**
- **Laurel Parnell A Therapist's Guide to EMDR and Healing without Freud or Prozac by Dr David Servan-Schreiber.**

Sugaring the pill? From EMDR Now April 2011 Vol 3 No 2 CIPOS Method for Children

We know that EMDR works fast and works well, particularly for reprocessing traumatic experiences. And with careful preparation we can coax clients into the reprocessing phase. But it's even harder with young children – why would any child choose to face the 'nasty' things that happened?

In a lively and engaging whistle-stop tour through four case studies, Whitney, Senior Psychologist with Clackmannanshire Council, showed how Constant Installation of Present Orientation and Safety (CIPOS) can create the sense of safety necessary for children to engage in trauma work.

CIPOS intersperses graduated exposure to traumatic memory with fun activities such as playing catch or, in the case of one particularly creative boy that Whitney worked with, negotiating an assault course he'd constructed from the office furniture!

The child draws a picture that represents the traumatic event and then looks at it for three seconds. Then comes the fun activity, with the good feelings reinforced with bilateral stimulation. The child then looks at the picture again, perhaps for 4 seconds and again is encouraged to play and notice the positive feelings. This continues throughout the session, gradually increasing the exposure time and allowing the child to be in charge of the exposure – the child turns the picture face up whilst the therapist counts down in seconds and then turns the picture face down when the time is up. The child continues to draw new pictures in each follow up session until the material ceases to be distressing

.

In the examples that Whitney presented, the progress was clear from the pictures, although she discussed the level of distress

some children can experience after each exposure. All the children improved significantly and within very few sessions.

Whitney speculated that the standard EMDR protocol may be necessary for processing of deeper, more complex issues

but it was clear that CIPOS had allowed the children she talked about to, very successfully, process their trauma in a safe and non-threatening manner.

How successful?

Whitney drew attention to several factors which she thought may contribute to the success of this approach:

- Face validity - the children understand why the process works
- It's controlled and predictable
- It's like jumping in puddles – children can enter and emerge from difficult material, which is how developmentally they process events and information anyway
- It involves multi-sensory and sensorimotor elements – children like to do, rather than talk
- It's fun, especially with parents, perhaps bringing back memories of good times they've had together.