

A Proposal for an EMDR Reverse Protocol

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Introduction

Eye Movement Desensitization and Reprocessing (EMDR) based on Adaptive Information Processing Theory (AIP) was created by Shapiro (1987, 1989, 1995, 2001). Currently, significant clinical evidence exists to support the efficacy of EMDR; however, some clients with more complex trauma, children, clients who are extremely dysregulated and suffer from dissociative symptoms and disorders, along with witnesses to crime, may struggle for some to participate in the trauma reprocessing phases without extended resourcing and skills building. When this occurs, the therapist and client may find that the phases of trauma treatment are delayed.

Assessment, Desensitization, Installation, and Body Scan are the trauma reprocessing phases of the standard EMDR protocol (Shapiro, 2001); however, before proceeding with past trauma reprocessing, the client needs adequate skills at emotional regulation in order to continue. EMDR also includes a three-pronged-approach in case conceptualization for trauma reprocessing. The three pronged approach is the chronology for organizing targets for reprocessing – past/present/future. The Adaptive Information Processing Theory that Shapiro hypothesized explains the efficacy of EMDR concludes that current symptoms are driven by maladaptively encoded experiences from the past. Because the etiology of symptoms is theoretically driven by the past, targets are reprocessed in chronological order starting with the past.

The 8 phases of EMDR treatment are organized in a “three-pronged approach.” This approach focuses on reprocessing the events of the past first, then current triggers, and finally future concerns in a chronological fashion. This conceptualization is evidence based, has theoretical foundation from psychodynamic theory, and has face validity since it is commonly accepted that past experiences drive current symptoms. For many clients this is very effective, yet for some individuals this is overwhelming. Focusing on reprocessing past events and traumas may be too difficult initially because of age, life experiences, and or complex trauma. When this happens, the therapist may need to spend a great deal of time in the Preparation Phase of EMDR establishing resources with which the client can cope with the intensity of symptoms. There is however, another possibility to approach psychotherapy with children, and any age client where this three-pronged approach is overwhelming.

EMDR Three-pronged Approach in Reverse Chronological Order

The Reverse Protocol offers an alternative to stopping EMDR altogether or staying in the Preparation Phase for an extended period of time for clients who do not have enough resources to pursue trauma reprocessing. Research has suggested that using eye movements to focus on future concerns and or stressors is efficacious in reducing

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client visual vividness and emotionality about the future (Engelhard, van den Hout, Janssen, and, van der Beek, 2010). Adler-Tapia (2007) began using an EMDR “Inverse Protocol” however, this protocol was often confused with an “Inverted Protocol” that was used for resource development with EMDR; therefore, she later renamed the protocol “Reverse Protocol” to avoid confusion and accurately describe the protocol that is focused on reprocessing concerns about the future, rather than on developing client resources.

This protocol is helpful for clients who are extremely dysregulated and cannot explore trauma reprocessing of past events or current triggers because of attachment issues, dissociative symptoms and/or substance use disorders. The reverse protocol is an adaption of the original three-pronged-approach in which targets are reprocessed in reverse order – instead of past-present-future, the reverse protocol reprocess targets – future-present-past.

The remainder of this document is written as an extension of the chapter *Integrating Theories of Developmental Psychology Into the Enactment of Child Psychotherapy* in the book *Child Psychotherapy: Integrating Developmental Theory Into Clinical Practice* by Adler-Tapia (2012) in order to answer questions that have arisen out of clinical practice using the Reverse Protocol.

At times the client may have no hope for the future; therefore, dealing with the stress of reprocessing the past is too overwhelming. Because children are so present oriented, the therapist may struggle to address anything in the child’s history. If this is thwarting progress in therapy, the therapist may need to consider EMDR case conceptualization with a “Reverse Protocol” – where the EMDR work is addressed in a reverse chronological order - future-present-past. For children, this offers them a reason for participating in therapy, which at times might cause remembering very difficult events. Since children often do not understand the purpose of talking about the past and in fact, take significant steps to avoid even thinking about events from the past, focusing on the future is more desirable. The difference between the standard EMDR protocol and the reverse protocol is the temporal order of reprocessing targets.

EMDR Case Conceptualization with a Reverse Protocol

The Reverse Protocol is about a starting therapy with a future focus. The focus is on a more positive outcome for the client. Within an EMDR treatment template, this means reprocessing future targets before present triggers and past events. There is not an assumption that trauma exists for the child, but rather that something is interfering with this child’s ability to be happy and healthy.

This protocol uses all 8 phases of the standard protocol. It is not about beginning therapy with a future template or resource development (Korn & Leeds, 2002; Leeds, 2001). Therapists who are familiar with Solution Focused Brief Therapy (SFBT) (de Shazer, Berg, Lipchik, Nunnally, Molnar, Gingerich, & Weiner-Davis, 1982) will recognize the concept of focusing on the solution rather than the problem. The EMDR reverse protocol focuses on addressing the client’s negative beliefs about his or her future. The presenting symptoms provide direction for the answer. Treatment begins with identifying a positive future belief such as, “I will be ok.” Then the therapist distills the negative cognitions about why the client is currently unable to imagine a future free

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of symptoms. One possible negative cognition for the client could be, “I’ll never get over what happened to me. My future is terrible.”

This negative outlook for the future may be evident in beliefs such as, “I’m broken.” Or, “It’s going to always be this way.” In order to improve the client’s outlook about the future, the client’s anxiety and negative cognitions about the future need to be addressed in psychotherapy before reprocessing present triggers or addressing past events. One example is if a client’s presenting symptoms include anticipatory anxiety about a future surgery, then targeting past events is contraindicated. This is also true for clients with trauma, dissociation and depression who exist in survival mode. While in survival mode, a client is trying to survive moment to moment. Highly traumatized clients struggle to participate in past trauma reprocessing because they experience life through a lens of trauma with a foreshortened sense of future. Each day is filled with dysregulation and difficulty functioning. These clients need extended psychotherapy focused on skill building, affect regulation, and emotional intelligence in which the client can identify and tolerate intense emotions. Past trauma cannot be reprocessed without significant time in the Preparation Phase of EMDR. The trauma that the client needs to reprocess from the past is too overwhelming for the client at the moment. This can be exhausting and frustrating for both the client and therapist.

When this is true, an alternative for case conceptualization is to reverse the temporal order for treatment. This idea still considers that maladaptively encoded information from the client’s history is driving current symptoms; however, the client is not yet developmentally capable of focusing on trauma reprocessing about the past until the client could imagine a more positive future. Because of this, clients may linger in therapy for extended periods of time without successful outcomes or hope that the future will be any different. With many type of psychotherapies, the underlying belief is that learning to cope with current symptoms is the only possible outcome. With EMDR, the clinical perspective is that the future can be positive when the past events are reprocessed through to adaptive resolution.

The “Reverse Protocol” is about reprocessing targets in reverse chronological order after several additional skills are taught during the Preparation Phase. The purpose of the protocol is on developing the client’s future by asking, “What do you want your future to be?” Or, “How do you want to be thinking, feeling, behaving in the future?” This vision of the future is developed during the Client History and Treatment Planning Phase of EMDR when the therapist asks the child, “How are we going to know when you are ready to graduate from therapy? What will feel better in your life?” In treatment planning, the therapist is considering the most critical issues that need to be addressed first in therapy and the possible amount of time available for treatment. When treatment is limited by financial or time issues, the therapist might determine that the focus of treatment needs to proceed in reverse chronological order – future/present/past.

The therapist may also determines that the future is the focus of treatment because the client may need extensive resource development, personality and affect scaffolding, and emotional regulation skills due to symptoms of attachment trauma, complex PTSD and/or dissociation. Because trauma clients typically function in survival mode where the client lives moment to moment with no thought of the future, establishing hope for the future is imperative for successful outcomes in therapy. As is common with depression and anxiety, the client experiences a foreshortened sense of

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future. When someone is living moment to moment with no future, it is extremely difficult in psychotherapy to have the client reprocess a traumatic past.

It is also possible that with an impending and threatening future event, the past does not seem as pertinent as the client's current concerns about the future. This may occur when a child is anticipating medical care or has a parent who is being deployed in the military.

A ten-year-old girl was facing open-heart surgery over her summer break from school. Even though she had experienced multiple surgeries in her young life, the one that bothered her the most was the one that she would be having soon. She had many fears of dying. With the reverse protocol, the therapist had the child imagine returning to 5th grade feeling stronger and healthier than ever before. The child painted a picture of herself with her friends on the first day of school. The first day of school was to take place 6 weeks after her surgery. The child's negative belief about that future event was "I'm gonna die." Her positive belief she wanted to achieve was, "I'll be fine." The therapist and the child had agreed that some anxiety was normal for anyone facing surgery, but the child addressed all of her anticipatory anxiety and questions about what to expect during her surgery. The therapist worked through the phases of the reverse protocol as described below and the child was excited on her first day of school. This child's father later reported that this was the first year the child had ever been excited to go to school. Focusing on anticipatory anxiety about the future as the presenting issue in child psychotherapy requires that the therapist consider the need for a reverse protocol.

Future

The therapist might ask the client, "How do you see the future without these symptoms that brought you into treatment? What prevents you from accomplishing this future goal? (NC)". For children, the therapist can ask, "How do you want to do things differently at school when you feel good about your reading?" Or, "What would it be like if you felt better about going to visit your dad?" The therapist is exploring the child's beliefs about the future. If the child believes that the future cannot improve, it is difficult to convince him/her to participate in psychotherapy especially when treatment is focused on difficult past experiences.

The therapist is also exploring with the child what prevents him/her from having better thoughts about the future. Reprocessing frets or anticipatory anxiety about the future is also about creating alternative endings. "What could you do instead of hitting when you are angry with your little brother?" "Would you be willing to try that?" By having the child consider using replacement behaviors in the future the therapist is helping to broaden the options for the client. The therapist can also provide in-vivo practice in the office. "Let's pretend your brother is here with us and is getting into your toys and won't leave you alone, how would you feel?" Once the child answers, the therapist then coaches the child through the new behavior. "You told me that before you would get so mad that you would hit your brother and get in trouble. What do you think you could try now?" The therapist has the child practice the new response and then encourages the child to try this at home. "How do you think you would feel differently if you ask your mom for help keeping your brother away?" "Notice that feeling." The therapist proceeds with installing mastery experiences with bilateral stimulation. This can be a brief clinical intervention in that the therapist says to the child, "Imagine yourself going to school and feeling happy. Now cross your arms and tap on your

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shoulders to make that feeling get stronger.” Creating a positive future image and using bilateral stimulation to install that feeling about being successful can instigate a greater investment in psychotherapy. Once the child can imagine a positive future, the therapist continues by addressing present symptoms.

Present symptoms

While reprocessing the future targets, therapy simultaneously monitors triggers, stressors and the use of self-soothing/self-calming skills. After the client has reprocessed negative cognitions, emotions, and body sensations about the future, then present triggers are reprocessed.

Past events

Past events/targets are reprocessed using the standard protocol. This still includes reprocessing the past target, present triggers and completing the target by installing a positive future template consistent with the standard EMDR protocol. Essentially the temporal order of therapy is future-present-past (reverse protocol) and then past-present-future (standard protocol.) Why use the reverse protocol and the standard protocol? The therapist may consider the Reverse Protocol because the client cannot initially manage the standard protocol.

What are the goals and benefits of using the Reverse Protocol?

1. This protocol serves to engage the client in treatment and build rapport.
2. The client learns EMDR protocol and has experiences in psychotherapy with positive outcomes.
3. The client learns to be mindful and moves from the trauma focus of day-to-day survival, to having goals and objectives for the future. The foreshortened sense of future is relieved and the client's hope is reignited. With future goals most clients are more interested in addressing past etiology in order to move toward that future goal.
4. Clients learn that symptoms can be reduced and/or alleviated unlike other therapies that teach clients coping skills without the possibility of reprocessing the etiology of the client's symptoms to adaptive resolution.
5. This process also can improve attachment to self and others by encouraging the client to explore long abandoned dreams for relationships with friends, significant others, and possibly even dreams of having children with adult clients.
6. The client has identified a goal for a healthy future thus providing much needed hope. A sense of hope for a better future can serve to buoy the client through the work of reprocessing traumatic past events.

When might Psychotherapists consider the EMDR Reverse Protocol in Case Conceptualization?

There are several client presentations when case conceptualization with the standard EMDR protocol is not indicated. Those include:

1. *When the client's trauma history is too intense and/or chronic for the client to reprocess past events first.* Clients with more extreme symptoms of dissociation, PTSD, and personality disorders may not have the ability to even participate in exploring past events without decompensating; therefore, the Reverse Protocol may be indicated.

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2. *Limited time for treatment.* The Reverse Protocol is also indicated when there may be limited time for treatment when a client presents with an impending medical intervention such as upcoming surgery or pregnancy. When the episode of care does not allow for use of the entire standard protocol, the client can be taught skills to manage past events and present triggers in order to target the anxiety and negative cognitions about a future impending event. Military clients with future deployment or return to the service, clients with upcoming events that are very stressful such as medical procedures, court testimony, examinations, pregnancy, etc.
3. *Client lacks the personality structure and scaffolding to reprocess the past.* Clients who present with attachment trauma, dissociation, symptoms of a personality disorder and/or child clients may not have the developmental skills with which to proceed with past trauma reprocessing. Using the EMDR “train metaphor” (Shapiro, 2001), these clients lack the train track to lay down and do not have more adaptive skills with which to link up with during the trauma reprocessing phases.
4. *Age of the Client at the Time of the Memory:* The memory of the event is preverbal or early childhood and therefore is not recalled in a way that the client can now understand. Or the client is a young child who cannot recount a memory. Memories are so early that cognitive processing used in more traditional therapies is unsuccessful because the symptoms are rooted in preverbal memories that drive the client’s symptoms. Accessing sensory-motor memories of infancy and early childhood are too difficult to work with initially in EMDR treatment; therefore, focusing on targets in reverse order to assist the client to engage in treatment because progress is evident and the client gains confidence in them self and in the efficacy of treatment.
5. *Alteration of Traumatic Memory that Occurred at the Time of the Event:* For some clients the trauma included a medical assault such as a traumatic brain injury, loss of consciousness, and/or chemical assault that impacted the memory. For example, a child who was given medication or alcohol that impacted how the memory was experienced and encoded. Therefore, attempts at reprocessing were overwhelming to the client because the somatic flashbacks are confusing and distressing. In addition, the client was assisted in understanding that the narrative of the memory would never be reprocessed in a manner that the client could understand, but with EMDR the memory can still be reprocessed. The client’s positive belief was, “I can get over this even if I don’t remember what happened.”
6. *The memory includes material that is shaming and/or would require the therapists to make a child welfare and/or criminal report.* When working with parents from the child welfare system who may need to reprocess shame about hurting their child the Reverse Protocol offers an alternative to traditional processing while avoiding the traps of forensic issues. If the client is a potential suspect and discloses in treatment to the therapist, the therapist will have to report the client’s statements and potentially become a witness against the client. This is true when working with juvenile perpetrators who are sexually reactive/trauma reactive. One 13-year-old girl with a history of sexual abuse from her uncle was sexually acting out against her 5-year-old sister. The client was 5-years-old when she was molested by her uncle; therefore, her little sister’s behaviors were triggering the client. The therapist has the teen client focus on a positive future in which the girl could “feel those funny feelings in my body and not touch anybody else. I can learn to do something else until those feelings go away.” By focusing on a positive

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future with replacement behaviors, the child was able to stop her offending behavior and the therapist was able to avoid the pitfalls of reprocessing past events and potentially having to make additional child welfare reports against this child. This purpose was not for the therapist to avoid the child's issues, but rather to provide the opportunity to reprocess the trauma that appeared to be driving the child's symptoms. While working with this client, the therapist also took steps to ensure the safety for the younger child. In this case, the child's attorney and the Judge in the case allowed the therapist to proceed with EMDR reprocessing about the past with specific instructions for the child to not incriminate herself. EMDR allows the client to address clinical issues without making inflammatory statements.

7. *The Client is a victim of crime and/or potential witness to criminal proceedings.* Some clients may be referred to an EMDR therapist for trauma reprocessing that is the result of a criminal or civil legal case. After addressing any concerns with attempting trauma reprocessing and the client memory as the result of EMDR, therapists may choose to focus on any anticipatory anxiety about the upcoming trial. Or if there are concerns about EMDR with an event for which the client will be asked to provide testimony, the therapist may need to contain the event and focus on reprocessing the client's concerns about the future. For example, a rape victim may need to testify in a criminal trial regarding this traumatic event, and prosecuting attorneys may be concerned about the EMDR focused on reprocessing the client's rape. If this is a forensic issue, therapists can focus on the client's future when he/she has healed from both the physical and psychological injuries. One client had a negative belief about the future of "I'll never get over this." The therapist used the EMDR Reverse Protocol to distill a more positive future for the client when she could see herself with her positive cognition, "I am happy and whole."

Clinical Decision Points in Psychotherapy

There are decision points in clinical practice arising out of case conceptualization. EMDR trained therapists who encounter highly complicated, dysregulated, and fearful clients who are unprepared for trauma reprocessing, are offered an alternative conceptualization for thinking through EMDR.

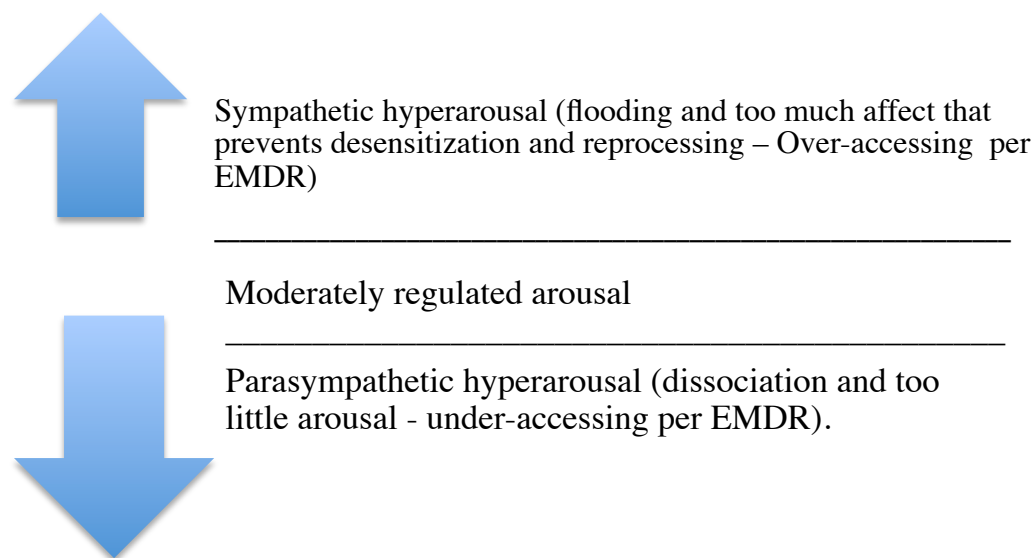
One clinical decision point when using this protocol is whether to do EMD (Shapiro, 1989) or EMDR (Shapiro, 2001) about the future. EMD is dedicated and "restricted reprocessing" (Outcalt, 2012, verbal communication) focused on reprocessing one target at a time rather than using the full EMDR (Shapiro, 2001) protocol in which all potential associative links are addressed. In case conceptualization with the reverse protocol, the therapist needs to decide whether or not to keep the client focused on the future target only while containing any association with the present or past, such as would occur with EMD? Or do the therapist and client contract to make decisions to follow whatever comes up with the standard EMDR direction, "let whatever happens, happen" as long as the client is able to stay within the window of tolerance (Seigel, 1999)? In this way, the reverse protocol is trauma reprocessing about the future with the understanding for both the therapist and the client that maladaptively encoded memory networks from past events and present life stressors will most likely link up with the future target.

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Siegel (1999) described a “Window of Tolerance” referring to the amount of affect a client can tolerate in order to most effectively work in psychotherapy. (See Table 1.1). In order to participate in trauma reprocessing, the client needs to have the resources available to tolerate a moderate level of arousal. Affect dysregulation can lead to flooding or dissociation in which trauma reprocessing is ineffective. This often happens with clients have no hope for the future, which is a common symptom of depression and post-traumatic stress disorder (PTSD).

The decision to proceed with EMD versus EMDR about the future depends on the stability of the client and his/her ability to tolerate affect that includes both positive and negative memory networks. The therapist and client need to determine how much preparation or resourcing the client needs in order to stay at a moderate level of arousal in the “Window of Tolerance.”

Table 1.1. Siegel’s Window of Tolerance with EMDR



Resource assessment and development are part of the goals of the standard Preparation phase of EMDR (Shapiro, 2001).

Phase 2: Preparation Phase

Using the standard protocol, the therapist and client need to jointly decide when to continue with the trauma reprocessing phases of EMDR. At this decision point in therapy, the therapist needs to consider the following questions:

1. Does the client have sufficient and effective resources to participate in the trauma reprocessing phases of EMDR?
2. Does the client have 2 portable state change skills? EMDR standard protocol includes “Safe/Calm Place” and other advanced resourcing skills.

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In addition to “Resource Development and Installation (RDI, Korn & Leeds, 2002). Therapists can also teach the following skills when preparing for trauma reprocessing:

1. *Containers*: This process can be beneficial with any psychotherapy, but is especially helpful with the Reverse Protocol. Container exercises teach the client how to manage and contain negative symptoms and emotions until those can be reprocessed. There are two types of containers that can be taught to clients (Adler-Tapia, 2012).
 - a. *Containers*: A client is asked to put all the bad thoughts, feelings, and body sensations into a container to hold them until the client feels better and the things that are bothering him/her can get better. Containers are used to manage intense emotion and to prevent flooding. This can also be used at the end of sessions to manage the residual of incomplete trauma processing sessions.
 - b. *Launching containers into the future*: Once a client has created a container to hold all the bad thoughts, feelings and body sensations, the container can be launched into the future. To launch containers into the future, the therapist helps the client create a time capsule that is sealed for now. Then the therapist asks the client, “When do you think you will be able to open this container?” and “What resources do you need to acquire/learn so that we can empty this container in the future?” A time capsule is designed to hold all of the memories, emotions and body sensations that will require additional skills for the client to manage and reprocess maladaptively encoded information. The overwhelming memories/emotions/body sensations are placed into a container for the client to address in the future when the he or she feels better prepared. “What skills do you need to be able to deal with those issues in your container? How will you be thinking, feeling, acting in the future when you have more confidence that we can open your container and clear out those things that seem overwhelming right now?” This implies that the therapist believes the client will have the competency to address the issue in the future and installs hope.
 - a) The therapist can have the client create a time capsule with a tangible product such as using a box to put in any reminders of the disturbing symptoms. The therapist can offer for the client to leave the container in the office until the client feels prepared to reprocess the information. By leaving the container in the therapist’s office, the therapist also provides an attachment experience through object permanency. “We will keep your container right here in the office until you come back next time.”
 - b) The client can create as many time capsules as necessary and/or add to the others by making deposits into the time capsule. The time capsule cannot be opened without the invitation of the client and therapist.
 - c) The client can create additional containers as needed both in sessions and outside sessions. The therapist can provide a small container the client can carry with them in which he/she can deposit any distressing symptoms that the client feels that he/she cannot manage without the therapist. In doing this, the therapist

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- actually provides an affect management tool for the client to use between sessions.
- d) This process is especially important with the Reverse Protocol in order that the client has a tool to contain past and present triggers that may arise during reprocessing the future.
 - e) It is important to remind the client that these containers launched into the future will eventually be reopened for reprocessing when he/she is ready.
 - f) The therapist also needs to explain to the client that psychotherapy cannot prevent them from experiencing any more trauma because life has trauma; however, treatment is focused on clearing the old trauma in order to heal current symptoms and teaching skills for the client to improve his/her capacity to manage whatever the future holds. The therapist can suggest that one possible positive cognition for the future could be, “I don’t know what the future holds, but whatever it is I CAN HANDLE IT!” This sets the stage for the Phases 3-6 of the Reverse Protocol.
2. *Television remote:* The television remote exercise is used as a way to manage intense affect. This works for both adults and children.
- a. The therapist explains to the client that, “We are going to create a remote that allows us to contain memories on different channels. There are channels for safe people and safe places, while there are also channels for the memories that cause you distress or haunt you.” The therapist can use a real remote to demonstrate how to change the channels.
 - b. Next the therapist asks the client to identify people who are “safe people or people who have been kind to you. These can be real people.” If the client cannot identify anyone, then the therapist can ask the client, “Has there ever been a friend’s parent who you wished was your parent?” Or, “Has there ever been someone on television or someone in your life who you wished was your mother or father?” The therapist can coach the client to imagine what it would be like to have that type of parent. Developing these nurturing resources are important for people. These imaginal resources can come from the media, literature or other places the client reports.
 - i. After identifying these resources as might be done with Resource Development and Installation (Korn & Leeds, 2001), the therapist can then have the client put memories of safe people on channels 1-9 of the television remote. “Now I’d like you to imagine those safe people on any single digit channel. Tell me who you would like to put on channel number one.”
 - ii. The therapist can then explain to the client, “Next I’d like you to imagine safe places on double digit channels – channels 10-99. Let’s start with identifying one safe place. When you think about that safe place, what channel would you like to put that on?”
 - iii. “Finally, I’d like you to put any disturbing memories on the triple digit channels starting with channel 100.”

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- iv. “ At any time that disturbing material arises, you can choose to notice what comes up or change the channel. Do you have any questions?”
- c. Parade of Faces for First Responders:
 - i. When you think about the calls that haunt you, what calls are the most difficult? What is the first call that haunts you? (This first call can actually have occurred long before the client became a first responder. Often the individual witnessed something in childhood. For example, police officers might have witnessed someone being beaten such as domestic violence or a bully. EMS personnel have reported witnessing horrific injuries when they felt helpless.)
 - ii. Image the calls are like a parade that you watch from the first to the most recent.
 - 1. Suicides
 - 2. Severe bodily injury
 - 3. Children
 - 4. Body odors – blood, brain matter, decomposition, burning flesh.
 - iii. Now imagine we are going to take the parade and put it on one channel of your remote that you can change if you don’t want to watch it.
 - iv. When you think about those calls in that parade of faces that haunts you, what’s your negative belief about yourself now? “I should have done something? I’m powerless? I can’t forget or get over it.”
 - v. EMDR Grief question: “What do you need to hold on to and what can you let go of?”
 - vi. Is there anything left that you feel like you need to do?
 - 1. Law enforcement especially when someone died, might need to come to some resolution when killing someone.
 - 2. First responders might need some type of closer.
 - 3. Religious/spiritual closer?
 - 4. What ifs?
- 3. Distilling a positive future target scene. The therapist starts with assisting the client in designing a target for the future.
 - a. “When you imagine your future, what do you think about now?” (Therapists may need to assist the client to identify a specific time or event in the future such as a major birthday or event in the client’s life.). The therapist can ask some of the following questions:
 - i. “What is it that you want to accomplish in the future? “
 - ii. “What dreams do you want to have (or did you have in the past about the future?” That can be, “How are we going to know when we’re done and you’re ready to graduate from therapy?”

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- b. The therapist can assist the client in teasing out a more realistic future by asking the client about something they did well that made them feel proud. This is where a “mastery experience” can be installed.
- c. For some clients, the therapist may need to ask, “If you need additional skills/information to accomplish your dreams/goals then what’s preventing you from gaining those skills?”
- d. *Making the positive future real.* The therapist may ask the client to pick one dream or goal and instruct the client, “Now pretend you are watching a video of yourself and your dream is coming true. Are you able to watch your dream? What’s the positive thought?” Some clients may be able to identify a positive belief about the future while others may not.
 - i. If the client is able to identify a positive belief about the future, the therapist asks, “When you think about that coming true, what’s your negative belief about yourself now?”
 - ii. Some clients will not be able to identify a positive thought about the future and that negative belief about the future is the NC to be used in trauma reprocessing.
 - iii. Either way, the NC/PC identified about the future are those that are then used for the remaining phases of the EMDR protocol.

After developing resources for managing intense affect, and a positive future target scene, the therapist needs to encourage the client to use the resources on a daily basis. When the client has resources available for affect management about the future, the treatment continues with trauma reprocessing about the future. With some clients, identifying a positive future target offers hope that becomes a resource to tolerate intense affect. Reminding the client of the hope that is developing from the positive future target provides the willingness to participate in trauma reprocessing.

EMD/EMDR ON THE FUTURE USING THE REVERSE PROTOCOL

Phase 3: Assessment Phase

As previously noted, there are specific procedural steps in this phase that are the same as the standard EMDR protocol; however, with a reverse protocol, the steps are focused on the future rather than the past. This is different than doing a future template because the past and present triggers have not been cleared. It is also different from a future focused resource development (RDI) because the client is desensitizing and reprocessing the negative beliefs about the future even though it hasn’t happened yet. This option is actually trauma reprocessing focused on an upcoming event or a client with no hope for the future. The reverse protocol explores and creates a future target that might be for a feared future event (such as upcoming surgery), or a positive desired future that currently feels unattainable.

This reverse protocol is creating hope for the future that is often not present with attachment issues and/or PTSD. The reverse protocol creates a desired future while

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reprocessing the barriers – the associated negative memory network that is blocking access to health and healing.

Procedural Steps of the Assessment Phase with the Reverse Protocol

The procedural steps of the Assessment Phase (Shapiro, 1995, 2001) start with identifying the image that represents the worst part about the future (See Adler-Tapia & Settle, 2008 for more extensive directions on working with children). For some clients the issue may be considering his/her death. If the client is experiencing medical issues such as breast cancer and having great anxiety about dying, it may be very helpful to target the client's fears of death and dying. At times the therapist needs to set this up as a future protocol focused on what the client wants to accomplish before they die. As much as the time and health of the client allows, it is important to help the client explore what is reasonable to pursue in the future and what unfinished life goals may not be achieved? In this instance it is important to help the client reprocess any regrets. This is often a place where clients get stuck because the anxiety about the future is so great.

Another option is to assist the client in developing a positive future, and from there identifying the block to this future – the dysfunctional memory network that keeps this client from being able to connect with that positive future.

Target:

The therapist reminds the client about the future event that has been previously distilled in the Preparation Phase and this becomes the target for the Assessment Phase. “I want you to think about the future even we previously discussed.” It is important for the therapist that this future target has to be a clearly identified time and image about the future. The future target cannot simply be a goal such as “I want to learn how to manage stress better.”

Image:

Identifying a future target: As you imagine that future we identified, what image comes up for you right now? The image may stay the same as previously identified, or the client may see a negative image about the positive future such as imaging something go wrong. In this case the therapist may then needs to ask, “When you think about the future, what is the worst thing you can imagine right now?”

Cognitions:

Negative belief about the future. “As you imagine this future, what’s your negative belief about yourself now?” (If necessary, “what’s your bad thought about you now?” in the case of a desired future, “what is the bad/negative thought about you that may keep you from this future?”)

“If you have not been able to accomplish your future goal/dream, tell me where you got stuck and/or where it was uncomfortable.”

These two steps help the client to identify the target about the future that is the focus of reprocessing. For example, “when I imagine myself having that surgery, I see the electricity going out and I die.” Clients may catastrophize and imagine all of the bad things that could happen in the future. Clients may also consider all the “what if’s” about the future. “What if the doctor dies while he’s operating on me?” “What if something

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goes wrong with my surgery?” All of these can be negative beliefs that are contributing to present symptoms about a future event. (For some clients the NC is “I’m going to die.”) The therapist is exploring anticipatory anxiety and/or missing skills preventing the client from accomplishing future dreams and ultimately a healthier future.

Positive belief about the future: What would you rather believe instead or the positive cognition (PC)? The positive cognition is typically a version of the client coming to resolution that the client can handle whatever the future has to hold. The PC very often includes an element of hope. (So for the NC of “I’m going to die. The PC could be, “Everyone dies someday. I can live my life the best I can and I can handle whatever happens.” One little boy with upcoming heart surgery had the NC “I’m gonna die.” Initially his PC was “I’ll be ok no matter what happens.” During reprocessing he started laughing and said, “If I die, I won’t be worried any more so who cares.”)

Validity of Cognition (VOC) – The therapist asks the client to hold together the worst part about the future event and the positive cognition about successfully accomplishing the future event, and then rates the validity of the positive cognition from one (1) completely false to seven (7) completely true. For younger children, the therapist might say, “Let’s make a bridge from your bad thought to your good thought with 7 steps between the on the bridge. If you start at the bad thought, where are you on the bridge?” The therapist can draw this and make the motions to demonstrate the child walking from the bad thought to the good thought.

Emotions

Emotion: The therapist says to the client, “When you think of that future event and your NC, what emotions do you experience now?” For young children, the therapist may need to rephrase this by saying, “When you think about that thing you’re worrying about, how do you feel right now?”

Subjective Units of Disturbance (SUDS): The therapist then says, “When you hold together that future event and the NC, how disturbing does it feel to you now from zero (0) no disturbance to ten (10) the worst feeling you can imagine?” For younger children, the child might say, “When you think about that thing you’re worrying about happening soon, how much does it bother you right now? A little bit or a lot”

Body Sensations

The therapist says to the client, “And where do you notice that disturbance in your body now?” With younger children, the therapist can point to different parts of the therapist’s body by saying, “Do you feel that in your head, your heart, your tummy, your legs or maybe another part of your body?”

The therapist asks the client to hold together the image of the future that was previously identified, the negative cognition/belief about the future, the emotions, and body sensations, and to start a moving going forward from now until the identified future event. Next the therapist starts the previously agreed upon type of bilateral stimulation that is the beginning of the Desensitization Phase of EMDR.

Assessment Phase With Children. The therapist can use a sandtray to elicit these steps of the Assessment Phase. The therapist first divides the sandtray into two parts where on the left side the child designs the bad thought about the future and the right side

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is the good thought about the future. The therapist can then draw the 7 steps from the bad thought to the good thought in order to measure the VoC. The therapist can then ask the child, “When you look at what you made, what’s the feeling you get about that bad thought?” And once the child answers, therapist asks, “How much does that bother you right now?” in order to assess the SUDS. And finally, the therapist asks the child, “Where do you feel that bad thought in your body? Once these procedural steps have been completed, the therapist can cover the good thought and ask the child to focus on the left side of the sandtray. The therapist can use a device to create bilateral tactile stimulation while the child works on the left side of the sand tray that represents the bad thought. Therapists may also use a device to create auditory bilateral stimulation by placing speakers on either side of the sandtray and then alternating the bilateral stimulation as the child works with the toys in the sand tray. As the therapist begins to see more positive examples in the sandtray, the therapist can remove the cover on the right side of the sandtray that represents the good thought and ask the child if anything has changed about the good thought. Eventually the entire sandtray will be used to create the positive future.

Phase 4: Desensitization Phase

This is where the differentiation between EMD and EMDR begins. For EMD, the Desensitization Phase starts with the addition of bilateral stimulation and therapy is focused on reprocessing disturbance about the future. If present triggers and past events arise during this time, the therapist can offer the client two options. First, the therapist asks the client “Do you want to think about that thing from the past now?” If so, the therapist continues with reprocessing. Or, if the client wants to return to refocusing on the future, cognitive interweaves are used to suggest that the client might want to place those triggers and events in the previously created future container/time capsule for later reprocessing.

Cognitive interweaves may include:

- “It is ok to put that past memory into a container to be reprocessed later. You have choices here. Just notice that.”
- “You can choose whether you want to follow that memory from the past or not. You will know what’s right for you.”
- Other cognitive interweaves may be necessary to keep the client focused on the future such as would be necessary with EMD.

Motor interweaves:

- “Tap your feet. Notice that you’re with me.”
- “I’m getting up to spray the aroma you said you liked because it reminds you of your safe place. Let me know when you start to smell it.”
- “Remember you are in my office and we are here together. Where am I now? Look at me and what color is my shirt?”

For children, the therapist can provide tangible evidence of this process by pointing to pictures that were drawn or to the scene the child designed in the sand tray

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about the future. With EMD, the therapist takes the client to the original target and a SUDS score after each set of BLS.

If a clinical decision has been made to do EMD, it is important for the therapist to keep redirecting the client to the previously identified future event in order to achieve success on creating a positive future. In addition to engaging the client in therapy, this process also implies a “demand characteristic” in that the therapist conveys to the client that he/she believes that the client CAN be successful in the future.

With either EMD or EMDR, the therapist continues reprocessing issues about the future. The therapist has the client assess the level of disturbance about the future and when the SUDS equals zero, the future is considered reprocessed and the client is ready to proceed with installation of the positive cognition about the future.

Phase 5: Installing the Positive Cognition about the Future

In this phase the therapist guides the client in installing the positive cognition about the future event. The therapist says, “Hold together the future we discussed and do the words (positive cognition) still fit or are there better words to describe what you think about your future now?” Whatever the answer from the client, the therapist then has the client hold together the future and the positive cognition, and measures the strength of the belief on a scale of 0-7 where 0 is completely false to 7, which is completely true. Once the validity of cognition (VoC) is measured, the therapist continues with the same type, speed, and number of repetitions of bilateral stimulation as used during the desensitization phase to continuing reprocessing anything that might interfere with the full positive installation of the positive cognition. This continues until the client reaches a VoC of 7. After this happens, the client is ready to proceed with the next phase of EMDR.

With some clients, it may be difficult to establish a VoC of 7 until the client has the opportunity to experience some hope for the future. After a few weeks of imaging a positive future, the VoC may spontaneously become 7. Either way the therapist needs to assess the VoC again to make sure a rating of 7 is reached.

For other clients this may not occur because the client has a “blocking belief” (Knipe, 1998). A blocking belief is one that interferes with the positive cognitions such as “I don’t deserve to be happy” or “If I am happy something will always go wrong.” The therapist may choose to use a cognitive interweave such as, “What would you tell your best friend if he/she said that?” Just notice that” and continue with bilateral stimulation to clear the blocking belief. For other clients, identifying and reprocessing these blocking beliefs may require a full assessment starting over with the Assessment Phase. This is a decision point in therapy where the therapist needs to make a clinical decision on how to proceed with the protocol. If a blocking belief exists that cannot be cleared and requires a full assessment, then the therapist needs to help the client contain the current incomplete target and return to the Assessment Phase.

There are 4 possible choices at this point in the protocol:

1. The positive cognition cannot be installed to a VoC of 7 and the therapist proceeds with the Body Scan Phase.
2. The positive cognition cannot be installed to a VoC of 7 because the client needs to have some experience with the PC.

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3. The blocking belief cannot be installed to a VoC of 7b because earlier memories have not yet been reprocessed??
4. The positive cognition cannot to be installed because of a blocking belief and the therapist uses cognitive interweaves to help clear this belief.
5. The positive cognition cannot be installed because of the blocking belief and the incomplete target must be contained and the blocking belief is such that the next step in psychotherapy requires that a full Assessment Phase be conducted on the blocking belief.

If the PC is installed, the therapist continues with the Body Scan Phase about the future target.

Phase 6: Body Scan Phase

The next step is for the therapist to have the client imagine the future and to hold that together with the positive cognition installed in the previous phase of EMDR and to scan his/her body from head to toe noticing any disturbance or body sensations that are of concern. If any arise, the therapist proceeds with reprocessing using the same type, speed, and number of repetitions of bilateral stimulation as used during the desensitization phase to continuing reprocessing anything that might interfere with a clear body scan. This process continues until the client reports a clear body scan.

At this point the future target is completed; however, in some instances the entire process may not be able to be completed in one session. When this occurs, the therapist may need to take steps to close an incomplete session.

Choice points in reprocessing the future

There are clinical choice points on when to continue working on the future, or return to the standard protocol. This is a decision made jointly between client and therapist depending on the client's circumstances and current stability. Some clients may be willing and able to address past traumas once a future has been established. Hope for the future often changes the client's willingness to use EMDR to reprocess the past and leave it behind.

Other clients may experience anticipatory anxiety and/or missing skills preventing client from accomplishing future dreams. The therapist asks the client, "When you think about that future, do you experience anxiety about what might happen?" This anticipatory anxiety may require intervention as might be needed with missing skills.

Missing skills are assessing what the client needs in order to achieve the positive future he/she imagines. The therapist asks the client, "When you think about the positive future we discussed, what skills do you think you need in order to be able to achieve those skills?" Once the missing skills are identified, the therapist and client may need to make a plan for how the client can acquire those skills. For example, one client wanted to earn a college degree; however, after enrolling in college and withdrawing 10 times, the therapist and client determined that her math anxiety needed to be addressed in order for her to be successful. The client began math tutoring and was successful in completing all the math classes she needed for her college degree. Her math issues were a combination

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of anxiety and missing skills. When the therapist asked the client to floatback to the first time she remembered having this math anxiety, she was able to recall struggling with math in elementary school. The positive future was the client imagining herself graduating from the local university.

Incomplete Session Follow-Up

Questions therapists have encountered using the Reverse Protocol include:

1) **Do you have the client come up with an image representing the worst part of the future? Yes, during Assessment Phase.** The therapist asks the client to notice an image that represents the worst part when they imagine what their future might be. Or, the therapist can decide to explore how the client wants to see the future? The therapist could ask the client to bring up the positive image of the future and ask, “When you think about that coming true in your life, what’s your negative belief about yourself now?” Either way the therapist is trying to get the client to focus on the future. The therapist can ask the client to image a specific date in the future such as, “What do you image your life will look like on your 40th birthday?”

2) After an incomplete session, the therapist follows the same steps as during the standard protocol and can ask “what comes up today/now?” After an incomplete session, the therapist can ask the client to bring up the future that you have been working on and ask, “What do you get now?” Or start with the image from the previous session? Is it appropriate if it’s a new image? Hopefully it’s a new image because with AIP it’s always changing. You do not check in on the NC as the cognitions may also have changed, like the image it was only a component of how the information was stored before reprocessing. With AIP, the memory network is changing as it is accessed, activated, and reprocessed.

Summary and Conclusions

Eye Movement Desensitization and Reprocessing (EMDR) based on Adaptive Information Processing Theory (AIP) was created by Shapiro (1987, 1989, 1995, 2001). EMDR is highly efficacious and is considered evidence-based treatment; however, there are some clients who because of age or symptom acuity who may not be able to participate in the trauma reprocessing phases of EMDR initially. When this occurs, therapists may need to consider that using the Reverse Protocol will improve the efficacy and speed of treatment. The Reverse Protocol is a comprehensive approach to psychotherapy that adheres to the 8 phase EMDR protocol with case conceptualization that includes reprocessing targets in reverse order with the hypothesis that the client has no hope for the future and limited resources to deal with the past or trauma reprocessing. Instead of the standard EMDR protocol that conceptualizes target reprocessing in a past-present-future chronology, this Reverse Protocol conceptualizes targets in a future-present-past order. This Reverse Protocol serves to engage the client in treatment, create direction for the train in EMDR, and help the client when the future is what brought the client into treatment.

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SCRIPT FOR REVERSE PROTOCOL

Once a therapist has decided that the Reverse Protocol is indicated for the client, the treatment plan focuses on the three-pronged-protocol starting with the future.

I. TREATMENT PLAN:

Say, *"What dreams do you want to have (or did you have in the past) about the future?"* _____

"How are we going to know when we're done and you're ready to graduate from therapy?" _____

"How do you want to be thinking, feeling, behaving when you know you are ready to graduate from therapy?" _____

"If you need additional skills/information to accomplish your dreams/goals then what's preventing you from gaining those skills?" _____

What's the negative belief you have about yourself when it comes to achieving/accomplishing that future?" _____

"When you think about that coming true, what's your negative belief about yourself now?" _____

II. PREPARATION PHASE:

1. Containers:

Script for Containers

Say, *"Sometimes we have thoughts, or feelings, or body sensation that get in the way at work or at home. Do you ever have thoughts or feeling like that? I want you to know that if we need to we can put those thoughts or feelings in a container like a box or something really strong that they can't get out. What do you think you would need to hold those thoughts or feelings?"* _____

Next say, *"I want you to be able to put all of those thoughts or feelings, or what we worked on today in that container. Sometimes we need different containers for different thoughts or feelings. Sometimes, it helps to draw pictures of the _____ (container) and make sure it's strong enough to hold everything that you need it to hold. Let's imagine that everything you worked on today is put in the container and we lock it away/seal it away until we meet next time when we can take it out to work on it again. When we get together we will work to empty your container so there's always room for new stuff if you need it. If you start thinking about things that bother you that are too hard to handle or it seems to come out before our next session, you can just imagine putting it into the container and sealing it in there until we meet again. You could use a safe, or a tank, or some type of container that is strong and can be locked. What do you think would work for you that you can use until you come back to it later?"* _____

Say, *"Now imagine putting 100% of the thoughts, feelings, emotions, body sensations, and disturbance into the container that is sealed tightly, and let me know when you're finished."*

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- 2. Resources:** (Not all questions are necessary. Therapist and client determine how much resourcing is necessary to continue with the protocol).

Say, *“What resources do you have? _____
What resources do you need to manage any overwhelming disturbance about the future?” _____*

Say, *“What are the types of resources that you count on?” _____*

After the client responds, then ask, about needed resources.

Say, *“What resources do you need?” _____*

Say, *“Ask yourself:*

Do I need to assess my diet and improve my eating? _____

Do I need to improve sleep hygiene? _____

Do I need to care for my physical health? _____

Do I need to learn stress management skills? _____

Do I need to explore my spiritual needs? _____

Do I need to use the skills I already have? _____

Do I need to learn interpersonal skills in order to have healthier personal and professional relationships? _____

- *If I do, how do I process current stressors and traumas?*

- *What skills and/or tools do I use? _____*

- *What skills and/or tools do I need? _____*

Therapist notes resources as previously identified during Preparation Phase.

Therapist teaches the “mechanics of EMDR” per Shapiro (2001) that include seating, stop signal, bilateral stimulation, and some type of train metaphor to help the client understand how trauma reprocessing unfolds.

III. ASSESSMENT PHASE:

1. Target:

The therapist starts with assisting the client in designing a target for the future.

Distilling a positive future target scene:

Say, *“When you imagine your future, what do you notice now?” _____*

Say, *“What is it that you want to accomplish in the future?” _____*

Say, *“What date will that be exactly?: _____*

Where are you?(Location): _____

What are you doing? _____

Who’s there with you? _____

What can you see? _____

What do you hear? _____

What do you smell? _____

How do you feel? _____

Next say, *“What word or phrase could we use to remind you of that future?” _____*

2. Image:

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Say, *“As you imagine that future we identified, what image comes up for you right now?”* _____

(The image may stay the same as previously identified, or the client may see a negative image about the positive future such as imaging something going wrong. In this case the therapist may then need to ask)

Say, *“When you think about the future, what is the worst thing you can imagine right now?”* _____

3. Cognitions: (Only one of these questions may be necessary to establish the negative belief about the future.)

Negative belief about the future:

Say, *“As you imagine your future, what’s your negative belief about yourself now?”* _____

In the case of a desired future, *“what is the bad/negative thought about you that may keep you from this future?”* _____

“If you have not been able to accomplish your future goal/dream, tell me where you got stuck and/or where it was uncomfortable.” _____

Positive belief about the future:

Say, *“What would you rather believe about your future instead?”* _____

Or, *“What is the positive belief you would like to have about your future now?”* _____

Validity of Cognition (VOC)

Say, *“Now hold together the worst part about the future event and the positive cognition about successfully accomplishing the future event, and on a scale from one (1) completely false to seven (7) completely true, how true does those words about your future feel right now?”* VoC = 1 2 3 4 5 6 7

4. Emotions

Say, *“When you think of that future event and your NC, what emotions do you experience now?”* _____

Subjective Units of Disturbance (SUDS):

Say, *“When you hold together that future event and the NC, how disturbing does it feel to you now from zero (0) no disturbance to ten (10) the worst feeling you can imagine?”* _____

SUDS = 1 2 3 4 5 6 7 8 9 10

5. Body Sensations

Says, *“When you bring up that incident and those emotions, where do you feel that in your body now?”* _____

After eliciting the procedural steps of the Assessment phase, the therapist continues with the desensitization phase of EMDR. This is where the differentiation between EMD and EMDR begins. **If a clinical decision has been made to do EMD**, it is important for the therapist to keep redirecting the client to the previously identified future event in order to achieve success on creating a positive future. During the desensitization phase, the therapist is regularly helping the client to contain other associations and focus on the specific future that is the focus of this episode of care. Other associated incidents need to

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be documented for possible future care. With EMD, the therapist takes the client to the original target and elicits a SUDS score after each set of BLS.

IV: DESENSITIZATION PHASE

Desensitization Phase starts with the addition of bilateral stimulation and therapy is focused on reprocessing disturbance about the future.

EMDR

To begin desensitization:

Say, *“Now hold together the image of the future that was previously identified, the negative cognition/belief about the future, the emotions, and body sensations, and start going forward from now until the identified future event.”*

Begin the BLS. (You established the BLS method and speed during the introduction to EMDR). The type of BLS may need to be changed often in order to assist the individual in sustaining attention.

If the client appears to be too upset to continue reprocessing, it is helpful to reassure the client that by saying the following:

Say, *“It’s normal for you to feel more as we start to work on this. Remember we said it’s like _____(metaphor) so just notice it. It’s old stuff.”* (This is not always necessary.) _____

After a set of BLS, instruct the individual by saying the following:

Say, *“Take a deep breath.”* (It is often helpful if the therapist takes an exaggerated breath to model for the client, as the therapist asks the client for brief feedback on the process.) And then say, *“What did you get **now**? Or, “Tell me what you got?”* _____

Or if the client needs coaching, say, the following: *“What are you thinking, feeling, how does your body feel, or what pictures are you seeing in your head”?*

(It is not unusual for some clients to report detail as if writing a report, so therapists may need to teach clients to notice his/her own thoughts, emotions and body sensations.) If this occurs, it is helpful for the therapist to say, *“When you saw that, how did you feel and what did you notice in your body?”* _____

After the client recounts his/her experience, therapist says the following:

Say, *“Continuing with that future we’re working on, just notice what comes up, and go with that,”* and do another set of BLS. (Do not repeat the client's words/statements.) As an optional phrasing you can say, *“Just notice that.”* The therapist does not need to understand what is happening, because what matters is how the individual has maladaptively encoded the information.

Again ask the following:

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Say, *"What do you get now?"* _____

If new negative material presents itself, continue down that channel with further sets of BLS.

If present triggers and past events arise during this time, the therapist can offer the client two options.

Say, *"Do you want to think about that thing from the past now or contain it for later?"* _____

1. If the client wants to continue with what has arisen, the therapist continues with reprocessing"

Say, *"Go with that."*

2. If the client wants to return to focusing on the future, cognitive interweaves are used to suggest that the client might want to place those triggers and events in the previously created future container/time capsule for later reprocessing.

Cognitive interweaves may include:

Say, *"It is ok to put that past memory into a container to be reprocessed later. You have choices here. Just notice that."* _____

Say, *"You can choose whether you want to follow that memory from the past or not. You will know what's right for you."* _____

Other cognitive interweaves may be necessary to keep the client focused on the future such as would be necessary with EMD. With either EMD or EMDR, the therapist continues reprocessing issues about the future. The therapist has the client assess the level of disturbance about the future and when the SUDS equals zero, the future is considered reprocessed and the client is ready to proceed with installation of the positive cognition about the future.

Continue with sets of BLS until the client's responses indicate that he/she is at the end of a memory channel. At that point, the client may appear significantly calmer with no new disturbing material is emerging. Then, return to the target by having the client evaluate the progress.

Say, *"When you think about the future we first talked about today, what happens now?"* _____

There may be no more disturbing material for them to access or describe about the target memory. After the client recounts his/her experience, add a set of BLS.

Say, *"Go with that."*

If positive material is reported, add one or two sets of BLS to increase the strength of the positive associations before returning to target.

If the therapist assesses that the client has reprocessed the future because the material reported is neutral or positive, then say the following:

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Say, “*When you go back to the future we talked about today, what do you get now?*”

Say, “*Go with that.*” _____ and add a set of BLS.

If the response is neutral or positive and no change occurs, then check the SUD.

Say, “On a scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does it feel now?”

[illegible]

If the SUD is greater than 0, continue with further sets of BLS, time permitting. Say, *“Go with that.”*

If the SUD is 0, do another set of BLS to verify that no new material emerges and then proceed to the installation of the PC. Say, “*Go with that*”

With either EMD or EMDR, the therapist continues reprocessing issues about the future. The therapist has the client assess the level of disturbance about the future and when the SUDS equals zero, the future is considered reprocessed and the client is ready to proceed with installation of the positive cognition about the future.

Note: Proceed to Installation Phase only after you have returned to target, added a set of BLS, no new material has emerged, and the SUD is 0.

V: INSTALLATION PHASE

During the installation phase the therapist has the client hold together the future target and assess the efficacy of the positive cognition exploring for more expanded positive cognitions.

Say, “When you bring up that future and the words _____ (PC), does that one still fit or does something else fit better now?” _____

The individual may have a new positive cognition that is now installed with BLS.

Say, “When you think of the incident (or picture), how true do those words _____ (clinician repeats the positive cognition) feel to you now on a scale of 1 to 7, where 1 feels completely false and 7 feels completely true?”

[illegible]

Use a set of BLS and then repeat this statement until the PC is at a 7.

Say, “*Go with that.*”

After each set of BLS in the Installation phase, Say, “*What do you get now when you consider of your future, how true do those words _____ (clinician repeats the positive cognition) feel to you now on a scale of 1 to 7, where 1 feels completely false and 7 feels completely true?*”

1 2 3 4 5 6 7
(completely false) (completely true)

Once the positive cognition is installed, the final phase of trauma reprocessing is the body scan.

VI: BODY SCAN PHASE

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The Body Scan Phase may be surprising and even disturbing to clients who have never experienced or dealt with physical sensations. Since many clients use dissociation and have learned to ignore physical sensations, paying attention to those for the first time may be difficult and even alarming. The therapist needs to teach the client mindfulness while also helping him/her to understand what is happening.

Say, *“Close your eyes and keep in mind your future and the positive cognition. Then bring your attention to the different parts of your body, starting with your head and working downward. Any place you find any tension, tightness, or unusual sensation, tell me.”* _____

Say, *“Go with that.”* Then use another set of BLS.

Continue until the client reports a clear body scan. Once the client’s issues about the future have cleared, therapists may need to determine if the client wants to continue with additional trauma work or if EMD for this one event is sufficient.

Say, *“It is important that you continue to practice the resources we previously identified. What I recall is that you told me _____ are resources for you.”*

VII: CLOSURE PHASE

Complete as much work as time and circumstances allow, leaving adequate time for closure and debriefing.

VIII: RE-EVALUATION PHASE

With each new session the therapist obtains feedback on experiences/observations since last session. The therapist continues to check for new traumatic or positive events. The therapist needs to check the SUD and VOC on the previous incident, and for any unprocessed material from previous sessions and probe for any new material that might have emerged.

Say, *“When you think about the incident we worked on last week, what do you get now?”* _____

After the client responds say, *“On the SUDS scale, what do you get now?”* _____

If SUD rating on previous week’s incident is greater than 0, continue desensitization.

Say, *“Bring up that incident, those words _____ (repeat the negative cognition), and notice where you feel it in your body”* and begin BLS. If the SUDS is zero, but the VOC rating for the previous week’s incident is less than 7 continue with the Installation Phase.

If the previous week’s target appears to be resolved (SUDS = 0, VOC = 7), then complete the body scan. After completion of the Body Scan, then move on to the next target on the treatment plan target list OR move on to target current triggers associated with the critical incidents.

Incomplete Session

If the session is incomplete, remind the client of Container Exercise and other relaxation technique to prepare for ending session. Skills were discussed earlier in this

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chapter. Remind the individual to practice relaxation skills and containers in order to continue being successful in the line of duty.

Say, *“You’ve addressed a great deal of intense issues today and reprocessing could continue over the next few days. Remember to use your container that we talked about earlier and the relaxation techniques we’ve practiced in your sessions. Feel free to contact me if you need additional support.”*

This provides a scripted protocol for proceeding through the eight phases of the EMDR Protocol specifically focused on working on a reverse protocol.

Reverse Protocol Adaptions for Children

Assessment Phase With Children.

VOC: Say, *“Let’s make a bridge from your bad thought to your good thought with 7 steps between the on the bridge. If you start at the bad thought, where are you on the bridge?”*

The therapist can draw this and make the motions to demonstrate the child walking from the bad thought to the good thought.

EMOTIONS: *“When you think about that thing you’re worrying about, how do you feel right now?”*

SUDS: For younger children, say, *“When you think about that thing you’re worrying about happening soon, how much does it bother you right now? A little bit or a lot”*

The therapist can use a sandtray to elicit these steps of the Assessment Phase. The therapist first divides the sandtray into two parts where on the left side the child designs the bad thought about the future and the right side is the good thought about the future. The therapist can then draw the 7 steps from the bad thought to the good thought in order to measure the VoC. The therapist can then ask the child,

Say, *“When you look at what you made, what’s the feeling you get about that bad thought?”*

And once the child answers, therapist asks,
“How much does that bother you right now?” _____ in
order to assess the SUDS.

And finally, the therapist asks the child,
“Where do you feel that bad thought in your body?” _____

With younger children, the therapist can point to different parts of the therapist’s body by saying,

“Do you feel that in your head, your heart, your tummy, your legs or maybe another part of your body?” _____

Once these procedural steps have been completed, the therapist can cover the good thought and ask the child to focus on the left side of the sandtray. The therapist can

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use a device to create bilateral tactile stimulation while the child works on the left side of the sand tray that represents the bad thought. Therapists may also use a device to create auditory bilateral stimulation by placing speakers on either side of the sandtray and then alternating the bilateral stimulation as the child works with the toys in the sand tray. As the therapist begins to see more positive examples in the sandtray, the therapist can remove the cover on the right side of the sandtray that represents the good thought and ask the child if anything has changed about the good thought. Eventually the entire sandtray will be used to create the positive future.

Desensitization Phase With Children

For children, the therapist can provide tangible evidence of this process by pointing to pictures that were drawn or to the scene the child designed in the sand tray about the future.

Next the therapist starts the previously agreed upon type of bilateral stimulation that is the beginning of the Desensitization Phase of EMDR.