Adaptive Information Processing, Targeting, the Standard Protocol, and Strategies for Successful Outcomes in EMDR Reprocessing

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This article provides excerpts from each chapter of *An EMDR Primer: From Practicum to Practice* (Hensley, 2009) to assist novice eye movement desensitization and reprocessing (EMDR) clinicians who are learning how to use this approach and to serve as a refresher for therapists who have not used EMDR consistently in their practices. Actual cases are presented that demonstrate various strategies that the therapist can use to help clients reach adaptive resolution of trauma. Tables and figures highlight important features to explain the obvious and subtle nuances of EMDR. Focal points are the following: (a) the adaptive information processing model; (b) the types of targets accessed during the EMDR process; (c) the 8 phases of EMDR; (d) the components of the standard EMDR protocol used during the assessment phase; (e) past, present, and future in terms of appropriate targeting and successful outcomes; and (f) strategies and techniques for dealing with challenging clients, high levels of abreaction, and blocked processing.

Keywords: adaptive information processing (AIP); cognitive interweave; eye movement desensitization and reprocessing (EMDR); three-pronged approach; types of target; unblocking strategies

The purpose in writing the book *An EMDR Primer: From Practicum to Practice* (Hensley, 2009) was to offer a primer that can further facilitate mental health professionals in becoming more confident and experienced EMDR clinicians. The process has been simplified as much as possible with diagrams, tables, and other illustrations. Dr. Shapiro's (2001) basic text is a masterpiece in itself and contains a wealth of information on EMDR. One needs to read her text over and over again to savor all the kernels of significant information. EMDR is a significant contribution to psychology in the 20th and 21st centuries, and Hensley's (2009) primer was offered as a further learning tool.

Chapter 1: EMDR Overview

Adaptive Information Processing (pp. 5–8, 10)

EMDR is an integrative psychotherapeutic approach and is guided by an information processing model. Francine Shapiro developed a hypothetical model called the Adaptive Information Processing (AIP) model (changed from Accelerated Information Processing model in 1995) to provide a theoretical framework and principles for EMDR treatment. Accelerated information processing clarifies how EMDR works, and AIP guides how it is used. Dr. Shapiro recognized the need to more efficiently explain the consistent treatment effects being obtained and reported from EMDR.

Dr. Shapiro posits that inherent in the AIP model is a psychological self-healing construct similar to the body's healing response to physical injury (2001). For example, if you get a splinter stuck in your finger, your body's automatic response is to heal the area of injury. However, because the area is blocked by the splinter, healing cannot easily occur until the sliver is removed. In terms of mental processes, it is the inherent tendency of the information processing system to also move toward a state of health. So, when

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something mildly disturbing happens, you may think about it, talk about it, and process it. You usually find that, within a day or so, you are no longer thinking so intensely about the event and, when you do, you have come to a resolution. For instance, if you are angry at your spouse, you may start to remember that your spouse has some good qualities as well as these very annoying ones. It is a case of the mind adaptively processing the disturbing material and connecting that disturbance into the larger picture of the experience.

On the other hand, when a trauma occurs that is too large for your system to adequately process, it can become "stuck" (i.e., dysfunctionally stored) in the central nervous system. Maladaptive responses, such as flashbacks or dreams, can be triggered by present stimuli, and there may be attempts of the information processing system to resolve the trauma (Shapiro, 2001). When the system becomes overloaded as just described, EMDR is proving to be the treatment of choice for many to help restart this mental healing process and allow the traumas to be reprocessed.

The AIP model also posits that earlier life experiences set the stage for later life problems. Information from earlier disturbing life events can be physiologically and dysfunctionally stored in our nervous system if not properly assimilated at the time of the event. Problematic behaviors and disorders can occur as a result.

At the time of disturbing or traumatic events, information can be stored in the central nervous system in state-specific form (i.e., the negative cognitive belief and emotional and physical sensations the client experienced at the time of the traumatic event remain stored in the central nervous system just as if the trauma is happening in the now). Over time, a client may develop repeated negative patterns of feeling, sensing, thinking, believing, and behaving as a result of the dysfunctionally stored material. These patterns are stimulated, activated, or triggered by stimuli in the present that cause a client to react in the same or similar ways as in the past. Dr. Shapiro (2001) states in many ways throughout her basic text that the "past is present." Negative beliefs and affect from past events spill into the present. By processing earlier traumatic memories, EMDR enables the client to generalize positive affect and cognitions to associated memories found throughout the "neuro" networks (i.e., memory networks), thus allowing more appropriate behaviors in the present.

Because the heart of EMDR is the AIP model, it is critical that the clinician have a clear understanding of it before proceeding with EMDR. An adequate conceptual understanding helps the clinician determine a client's appropriateness for EMDR, as well as explain the process to the client during the preparation phase, so he has some understanding of the potential treatment effects. Table 1 highlights the before and after changes of EMDR in terms of the AIP model.

Figure 1 demonstrates in action the inherent information processing mechanism as it highlights the changes that occurred as a result of an individual's dynamic drive toward mental health with the use of EMDR.

Types of EMDR Targets (pp. 16–24)

As you think about your client sessions, do you recognize any of the types of targets, including the ancillary targets (i.e., other factors that may be contributing to a client's disturbance)? The following definitions are provided as a refresher:

Touchstone Memory. A memory that lays the foundation for a client's current presenting issue or problem. This is the memory that formed the core of the maladaptive network or dysfunction.

Example: As an adult, Mary Jane reported being uncomfortable engaging with large groups of people (i.e., 20 or more). She frequently experienced high levels of anxiety before and during office meetings, church, and social events. She was nervous and tentative, fearful and unsure because she could not trust herself to be in control. During the history-taking process, it was discovered that, when she was in the second grade, Mary Jane wet her pants often. She was afraid to use the restroom because she feared its "tall, dark stalls." Students often teased her, calling her "baby" and yelling out to the other students that she had wet her pants. What she came to believe about herself was, "I cannot trust myself." This belief carried over into her later life and caused her to react tentatively in group situations.

Progression. A progression is a potential node. It generally arises in the course of the reprocessing of an identified target during or between sets (Shapiro, 2001). It is a more serious issue that cannot be pursued when it arises in the middle of an EMDR session.

Example: Tricia was targeting incidents related to her mother publicly humiliating her when the memory of how her mother acted at her grandfather's funeral arose. The clinician knew from previous sessions that Tricia had a close, loving relationship with her grandfather and that he was her primary advocate in the family. The clinician wrote down in her notes that her grandfather's funeral may need to be targeted in and of itself. When a progression (i.e., potential

TABLE 1. Adaptive Information Processing Before and After EMDR

Negative Experience is Transmuted Into an Adaptive Learning Experience	
Before	After
Client experiences negative event, resulting in:	Client experiences adaptive learning, resulting in:
Intrusive images	No intrusive images
Negative thoughts or beliefs	No negative thoughts or beliefs
Negative emotions and associated physical sensations	No negative emotional and/or physical sensations
	Client possesses empowering new positive self-belief
What happens?	What happens?
Information is insufficiently (dysfunctionally) stored	Information is sufficiently (adaptively) processed
Developmental windows may be closed	Adequate learning has taken place
Resulting in:	Resulting in:
Depression	Sense of well-being
Anxiety	Self-efficacy
Low self-esteem	Understanding
Self-deprecation	Catalyzed learning
Powerlessness	Appropriate changes in behavior
Inadequacy	Emergence of adult perspective
Lack of choice	Self-acceptance
Lack of control	Ability to be present
Dissociation	

Note. EMDR = eye movement desensitization and reprocessing. From *An EMDR Primer: From Practicum to Practice* (p. 11), by B. J. Hensley, 2009, New York, NY: Springer Publishing. Copyright 2009 by Springer Publishing. Reprinted with permission.

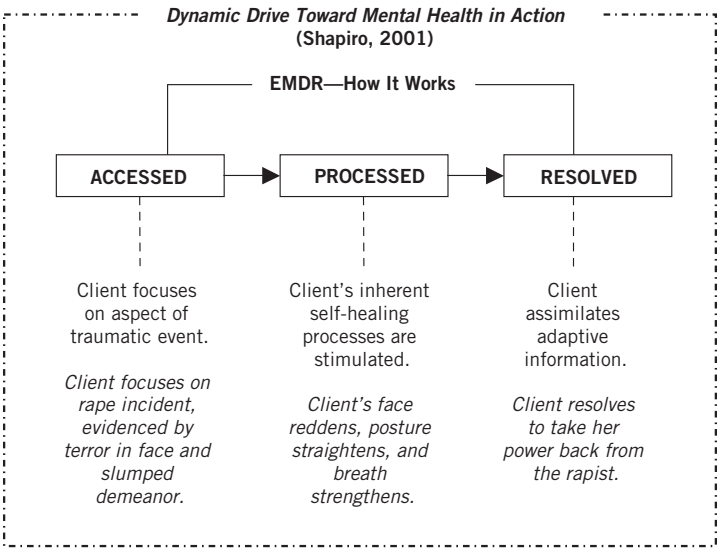

FIGURE 1. Adaptive information processing: Information processing mechanism. EMDR = eye movement desensitization and reprocessing. From *An EMDR Primer: From Practicum to Practice* (p. 10), by B. J. Hensley, 2009, New York, NY: Springer Publishing. Copyright 2009 by Springer Publishing. Reprinted with permission.

target) arises, it is important not to distract the client from her processing of the current target. Rather the clinician continues to allow the client to follow the natural processing of the present target and note any disturbance around this event that she may need to explore and target during a future session.

Peelback Memory. A peelback memory usually occurs when a touchstone has not been identified and, during reprocessing, other associations begin to "peel back" to expose prior disturbing memories.

Example: After the processing of an earthquake, Taylor continued to exhibit symptoms of PTSD for which there seemed to be no reason. She continued to have many problems associated with the earthquake despite the fact that her house had remained intact, and she or others in her family did not sustain any injuries. Her initial intake showed no indications of previous trauma. Upon further processing of the earthquake, an early association "peeled back" a memory in her 20s when she was date raped, and then again to an even earlier time when she was molested by a neighbor in her adolescence. Her initial negative cognition, "I am out of control," may have helped to uncover these earlier memories. Unlike a feeder memory, which is an earlier disturbance that blocks the reprocessing of the event, a peelback memory emerges spontaneously during reprocessing and is similar in terms of the emotional, physical, or cognitive content of the memory being reprocessed.

Chapter 2: Eight Phases of EMDR

Eye Movement Desensitization and Reprocessing (EMDR) is an eight-phase protocol—no less. Dr. Shapiro and the EMDR International Association (EMDRIA) are precise about what EMDR is and what it is not; and, if you eliminate one of the eight phases, it cannot be called EMDR. The intention of this article is to touch briefly upon some of the eight phases and more extensively on others. An effort is made to enhance and expand on key areas that can assist the clinician in client selection, target selection, and adaptive resolution.

Phase 3: Assessment (p. 22)

As target selection has been accomplished in previous phases, assessment is simply the measurements and amplification of the targets already selected. This is the phase where a client identifies the components of the target and baseline measures of his reaction to the process as its simplest explanation. The order of the EMDR components (i.e., image, negative cognitions [NC] and positive cognitions [PC], Validity of Cognition [VoC] scale, emotions, Subjective Units of Disturbance [SUD] scale, and body sensations) is specifically designed to access and stimulate dysfunctional target material. This is why a client's level of distress may become increasingly more agitated during the process, and the clinician needs to be prepared to activate processing soon after completion of the assessment to ease his disturbance.

Identify, Assess, and Measure (pp. 63–64)

The three words that Dr. Shapiro uses to represent the assessment phase are *identify*, *assess*, and *measure* (2001). The clinician assists and supports the client in *identifying* a specific pivotal picture and *assessing* its toxicity. This is accomplished by determining the NC, PC, and specific negative emotion(s) and body sensation(s) associated with the event. Then baseline *measurements* of the client's reactions to and progress within the phase are established and monitored.

Identifying the Target. The memory selected for processing is identified in the first two phases of EMDR (see Hensley [2009] Chapters 3 and 4 for more information about target possibilities).

Assessing the NC and PC and Emotional and Physical Sensations. Along with the memory to be identified and treated (i.e., the target), the clinician assists the client in identifying the negative self-belief or statement (i.e., NC), the desired direction of change verbalized by the client, and emotional and physical sensations associated with it.

Measuring the VoC and the SUD. The VoC scale is used to measure the PC for validity and to ensure that it is attainable and not a result of wishful thinking on the part of the client. It is rated to provide a baseline measurement as to how true (i.e., "How true do those words feel?") and how believable the cognition feels to the client (i.e., Is it wishful thinking on the part of the client?).

Chapter 3: Stepping Stones to Adaptive Resolution

Effective EMDR Equals Effective Targeting (pp. 88–89)

The assessment phase begins by confirming the specific target that the clinician and client previously agreed upon as part of an extensive treatment plan. In selecting the target, the clinician considered whether it was the most effective for resolving the client's issue. An effective target leads the way to the dysfunctionally stored *material* and, thus, the dysfunctional memory *networks*. Targets generally emerge during a thorough assessment of the client's presenting problems. From

the client's responses to the questions in the history-taking and treatment planning phase, the clinician is able to help identify salient targets for the client.

As stated earlier, in your initial interviews with the client, watch and listen for behavioral, emotional, cognitive, and physical cues; the duration of the presenting issue; how the problem manifests in the present; and what the client needs to be more adaptive in the future. In addition, assess whether the client possesses adequate affect tolerance and stability to process the negative states and access anything positive that may arise during the EMDR process.

Chapter 4: Building Blocks of EMDR

EMDR Is a Three-Pronged Approach (p. 127)

In the client history-taking phase of Eye Movement Desensitization and Reprocessing (EMDR), the clinician begins the process of identifying past disturbances/traumatic experiences, present triggers, and anticipated future occurrences or situations. These are the true building blocks of EMDR. A client's success with EMDR relies on a balanced focus on all three prongs of the EMDR protocol and the order of processing in which they are accessed and reprocessed. It is on these blocks—past, present, future—that the momentum and treatment effects can build and the healing process can be completed.

Building Blocks of EMDR: Past, Present, and Future (p. 128)

A client who has experienced a single traumatic event can usually be treated by targeting the disturbance/trauma-causing memory and additional incidents related to the primary event (e.g., car accident and related traumas: the car catching on fire while trapped in the car; being told she would never walk again; the long, difficult recovery). Clients who present with multiple issues and/or symptom presentations or with complex presentations of traumatic life events or extreme stress over a prolonged period of time will require a more comprehensive treatment approach. When a client's history is traumatically complex, it is important to identify and treat these three areas of concern: touchstone memories, present triggers, and future alternative behaviors. Whether targeting single or multiple traumatic events, it is necessary to sequentially target the traumatic event(s) and present triggers that have manifested as a result and work on skills a client needs to be more successful or comfortable in the future.

In the first prong of EMDR treatment, the clinician and client work together to reprocess incidents associated with the presenting issue and, if present, the early and critical touchstone memories (i.e., crucial memories that set the foundation for a client's current disturbance). The second prong is much like the first in that the clinician and client focus on reprocessing present triggers (e.g., people, circumstances, places, or other forms of stimuli that activate disturbing reactions or responses). The third prong focuses on alternative behaviors to aid the client in meeting his future therapeutic goals. Although past incidents, present triggers, and future outcomes associated with the presenting issue are initially identified in the assessment phase, they may also emerge anywhere throughout the eight phases (e.g., emergence of blocking beliefs or feeder memories, during reprocessing, between sessions).

Chapter 5: Abreactions, Blocked Processing, and Cognitive Interweaves

Cognitive Interweaves

The cognitive interweave is a proactive and powerful strategy used in EMDR to manage abreactions and to facilitate blocked processing in order to achieve full

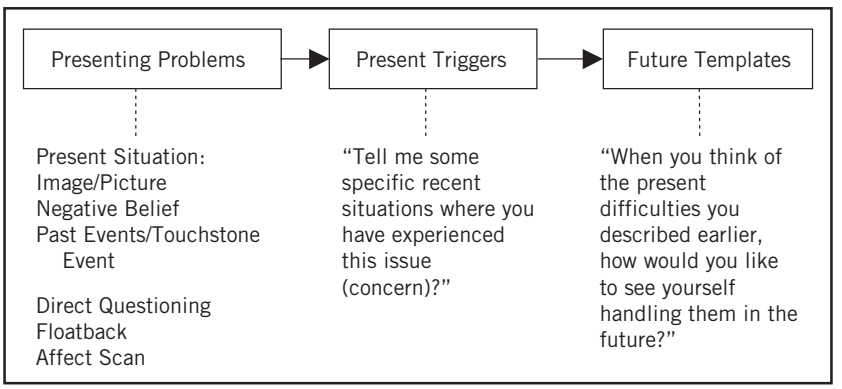

FIGURE 2. Three-stage protocol: Targeting sequence model. From *An EMDR Primer: From Practicum to Practice* (p. 129), by B. J. Hensley, 2009, New York: Springer Publishing. Copyright 2009 by Springer Publishing. Reprinted with permission.

therapeutic treatment effectiveness with challenging and highly disturbed clients. The following is excerpted from Hensley (2009, pp. 178–179; pp. 181–184).

Case Example 5a

Renee, age 25, was 10 years old when she was involved in a car accident in which her 34-year-old mother was seriously injured. Renee was strapped in the front seat opposite her mother, who was driving, when a semitruck hit them head on. Her vivid memories include her mother being unconscious and slumped over the steering wheel while Renee crawled out of the window of the car and rushed to the other side to help her mother. The impact of the semi rendered it impossible to budge the bent and crumbled door. No matter how hard she tried, she could not open the door to rescue her mother. The smell of gasoline helped Renee to choke back her tears as she tried to tug the door open. She was near hysteria when the firemen pushed her aside and pulled her mother out of the car just before it exploded into a fiery inferno. She stood and watched as her unconscious and helpless mother was removed from the car with a crowd of strangers looking on in horror. In a matter of minutes, Renee's world became empty and unsafe, and she went on to live a life of anxiousness and uncertainty.

Renee, age 10 at the time of the crash, had experienced fear, terror, disbelief, and helplessness as she viewed her trapped mother, and she continued to experience deep sadness and guilt for her mother's injuries. When Renee presented for therapy 15 years later, she was overweight, struggling with insomnia, and having frequent nightmares and flashbacks of the accident. She also suffered from depression and anxiety.

According to the Adaptive Information Processing model (Shapiro, 2001), Renee's information processing system (i.e., her natural healing mechanism) "stalled on the track" on the day of the accident. The extreme levels of stress that she experienced that tragic day remained in the same emotional and cognitive state until EMDR helped her to clear the debris from the "track" and allowed natural processing to occur. What this means is that the disturbing memories left on the "track" (i.e., the image of her mother slumped helplessly over the steering wheel, the firemen pulling her away from the devastating scene, the fiery explosion, the range of emotions she felt throughout the event, the rise of her adrenaline as she climbed out of the car to rush to her mother's aid) became stuck and isolated in a memory network in the same state-specific form as she had originally experienced it. This dysfunctional material stored in Renee's nervous system subsequently was responsible for the symptoms described above, and she was eventually diagnosed with posttraumatic stress disorder (PTSD).

Even years later, when she passed by an automobile accident or heard about an explosion on the news, Renee experienced the same fear, terror, disbelief, and helplessness, just as if the accident was occurring all over again. The information (i.e., thoughts, images, cognitions, emotions, sensations) from the original accident had been isolated into its own memory network and frozen in time. No new learning appeared to be able to penetrate the steel lining that insulated the information in it. It was only when the memory networks were connected that insight and integration could naturally occur for Renee. With the aid of EMDR, Renee was able to bring up the accident and assimilate the related negative information into its proper perspective (i.e., that it belonged to the past). Renee was able to discharge the dysfunctional affect that caused generalization of the adaptive cognitive content throughout her memory network. The negative material had been isolated since the time of her accident.

During the majority of an EMDR session, adaptive processing spontaneously links dysfunctional or disturbing material to the appropriate memory networks. What would happen if this does not occur? What would have happened during the session if Renee's "train" got stopped by "a fallen timber lying across the track" or if there had been a landslide or an avalanche and "her train could not move further down the track?" What resources are available to help Renee continue her healing journey? The answer is the cognitive interweave.

Choices of Cognitive Interweaves (p. 179)

Dr. Shapiro (2001) identifies and explains several choices of cognitive interweaves. To reiterate, the cognitive interweave is a deliberate effort by the clinician to mimic spontaneous processing by either directly infusing or eliciting information from the client. In doing so, the clinician is attempting to access the more adaptive memory network that contains information that is relevant to the client's present processing. The cognitive interweave may consist of an educational statement, relevant question, or direction in terms of imagery, thought, or movement. It may consist of introducing new information or stimulating presently held information for the client.

Case Example 5a: Renee Cont'd

It was during an EMDR session where Renee ran into a huge timber lying on her "train track." No matter what strategy was used to unblock processing, nothing seemed to work. When she accessed this particular part of the memory,

Renee expressed inappropriate feelings of guilt for failing to be the one who got her mother out of the car. Nothing in Renee's previous learning or education seemed to provide salvation from her guilt. What was needed was a piece of dynamite to obliterate the debris from the blocked "track." During this session, a cognitive interweave was utilized to remove the timber from her "track." It was used to strategically introduce new, but pertinent, information to Renee's system to quick-start her stalled healing process.

Renee: If I only could have jerked the car door open. I could have helped her. I should have done something differently.

The issue of responsibility comes to the foreground.

Clinician: Renee, I'm confused. Are you saying that a 10-year-old should have been strong enough to open a jammed car door and drag an adult to safety?
Renee: Well, I suppose not.
Clinician: Go with that.

From the examples in Table 2, a number of different interweaves could have been utilized if continued processing did not cause a spontaneous change in her feelings.

In introducing the information in that manner, Renee was able to get in touch with her more adaptive adult perspective and assist in linking the information that was deliberately inserted to the appropriate memory networks. Remember, Renee's perspective, somatic responses, and personal referents of the accident came from that of a 10-year-old, the age she was at the time of the accident. The cognitive interweave served to link dysfunctional information stored in an isolated memory network to Renee's present-day adult and to activate the adaptive material stored in a healthier network. This provided her with a more realistic adult perspective of the accident.

After eliminating the guilt she had felt for her mother's car accident, Renee realized that she was just a child at the time of the accident. Since the accident, she had difficulty riding in a car for sustained periods of time, and it was a struggle for her to drive. During a subsequent session, she began seeing images of the semitruck hitting them head on and her mother's injured body slumped over the steering wheel. Renee's reprocessing had stalled for the last few sets of bilateral stimulation. The following is how the clinician attempted to unblock her processing and her issue of safety played out during the session:

Renee: I just keep seeing the semi coming at us. It is as if it were yesterday. It came so fast and "bang," it was over. The next thing I noticed was my mother's limp body slumped over the steering wheel. I don't know if she was breathing or not. I didn't take time to think about myself. When I think of it now, I am fearful.
Clinician: Where do you feel the fear in your body?

The clinician used a somatic interweave to help move "the train further down its track."

Renee: In my chest.
Clinician: Go with that.
Renee: I am so vigilant when I drive now. I can never take my eyes off the road. I never feel safe in the car. I'm always too tense in the car.

The issue of safety emerges. The clinician probed further by eliciting information with a pertinent question:

Clinician: Is that what your mother did? She took her eyes off the road?
Renee: Yes. No. For some odd reason, I am seeing my mother slumped over the steering wheel before the semi hit us.
Clinician: Just think of that.
Renee: She was . . . Oh, my God! My mother had a seizure. That's why the semi hit us. I never made that connection before. My mother was an epileptic, and she had a seizure. She hit the truck and not the other way around. She couldn't help it. That's why the truck driver was not charged. I never could figure that one out. It was no one's fault. My mother would have kept me safe if it were in her power.

Renee never made this connection, even though her mother had told her at the time of the accident that she had a seizure.

Clinician: Go with that.
Renee: No wonder I am so tense when driving. I thought that, if I ever took my eyes off the road, I would crash just like my mom. She couldn't help it. It wasn't her fault. She didn't mean to . . .
Clinician: Go with that.

After this session, Renee was able to drive with a higher comfort level. She started to relax more and, as a result, actually became a better driver in her eyes. The resolution of her issue of safety also opened the door to various choices in her life. Previously, Renee had never traveled too far from home. It was beyond her comfort level. Being more comfortable behind the wheel empowered her to drive to different places

TABLE 2. Choices of Cognitive Interweaves

Choice	Purpose	Examples
New Information or Perspective	Used when the client lacks the information needed to correct a maladaptive cognition.	Renee: I should have been able to get the car door open. I did not try hard enough. Clinician: Most 10-year-old children do not have the strength to do what you are suggesting, even in the worst of circumstances. Were you stronger than most children your age? Renee: No. Clinician: Go with that.
"I'm confused . . . "	The clinician uses this when it is believed the client already knows the answer to the question.	Clinician: I'm confused. Who was bigger, you or the fireman? Renee: The fireman. Clinician: Just think of that.
"What if it were your child?"	As a variation of the above, this interweave uses the client's children (if any) as a convenient intervention.	Clinician: Do you mean that, if it was your daughter who was trying to get you out of the car, you would want her to stay and save you regardless of the outcome? Renee: No! I would want my daughter safe and out of harm's way. Clinician: Go with that.
Metaphor/Analogy	The clinician uses stories (i.e., fables, fantasies, personal stories) to introduce therapeutic lessons to the client.	Clinician: Recently, I watched a segment on the news about a 10-year-old boy. His father was up in a tree cutting limbs with a chain saw when he cut the limb he was sitting on. He fell 10 ft out of the tree and then the limb dropped on him. Someone videotaped the little boy trying to lift that big limb off his father. He tried really hard, but he was not strong enough. He had to stand back and let his relatives take charge. Renee: Oh, there wasn't anything I could have done either. I was so small.
"Let's Pretend"	To help the client move through issues of inappropriately placed responsibility, the client is asked to visualize a more positive outcome to the issue at hand.	Clinician: Pretend that your mother would say something to you if she were here now. What would she say? Renee: I'm glad you're safe. There was nothing you could have done to get me. You did the right thing. I love you. Clinician: Go with that.
Socratic Method	The clinician leads the client to a logical conclusion by asking questions that are easily answered.	Renee: I feel like I am to blame. Clinician: What could you have done differently? Renee: I could have smashed the window in. Clinician: Did you have anything that you could have used to smash the window in? Renee: No. Clinician: Did the firemen break the window in and save your mother? Renee: Yes. Clinician: Go with that.

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and try new activities. She actually accepted a teaching position one summer that required her to drive 50 miles round-trip to another city.

After the issues of responsibility, safety, and choice were resolved, Renee was able to complete the session by reaccessing and fully reprocessing the original target. Once the block has dissipated, the client can continue the process of spontaneously resolving associated channels of dysfunctional material that may still exist.

Regardless of how a client moves through these important plateaus, the successful negotiation of one facilitates the possibility of resolution in the next. The client may successfully negotiate these plateaus on her own, or she may be assisted by the use of questioning or educating by the clinician.

Chapter 6: Past, Present, and Future

Summary (p. 248)

Since its introduction in 1989, the treatment effects of EMDR continue to be experienced throughout the world by clients who have suffered from anxiety, depression, obsessions, phobias and panic, stress, relationship conflicts, addictions, chronic and phantom limb pain, grief, and more. Thousands of clinicians have been trained worldwide in this efficacious method since its inception, but many practitioners have chosen to lay EMDR aside and continue using only traditional treatment methods. Some may have deemed EMDR to not be a good fit with their current therapeutic model, work setting, or clinical population. Or, perhaps, managed care or limited sessions appeared to render EMDR impractical or impossible. Whatever the reason, the desire in writing the primer (Hensley, 2009) was to help newly trained EMDR practitioners keep on track and to provide a refresher for those who have not consistently used EMDR in their practices.

The intent of the primer (Hensley, 2009) is to provide a learning tool to assist newly trained and previously EMDR-trained clinicians to better understand the basic principles, protocols, and procedures of EMDR. Hensley's (2009) primer is neither a substitute for formal EMDR training nor for Dr. Shapiro's basic text (2001). I encourage you to go back and reread Dr. Shapiro's (2001) basic text again to see what kernels of information leap off the page at you.

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