EMDR Therapy Phase One: History Taking & Treatment Planning

Toolkit Introduction

What does this toolkit offer?

This toolkit is designed to help you—an EMDR therapist—in your EMDR therapy practice. It offers some reminders and guidance on history taking and treatment planning to help you successfully complete Phase One with your clients.

Goals of Phase One

1. Gather information and assess client's resources and events to reprocess.
2. Create a treatment plan.

Need help?

If you need help with Phase One or any other part of doing EMDR therapy with a client, consider:

- Posting a question in the Online Community (emdria.org/emdria-community).
- Seek the help of a Consultant. You can post in the Marketplace (community.emdria.org/communities/member-marketplace) or search online under Find a Therapist (emdria.org/find-an-emdr-therapist).

What's included?

Essentials for Getting Started

- Getting Started with Phase One
- Client Handout
- History Taking Timeline

Screening & Assessment

- Tools & Measures
- ACEs Questionnaire
- BCEs Questionnaire
- Yellow Flags

Treatment Planning Resources

- Issue-Driven Treatment Planning Video
- Issue-Driven Treatment Planning Worksheet
- Guidelines for Treatment Planning
- IDEA in Phase One

Tips & Troubleshooting

- 10 Tips from EMDRIA™ Members
- Challenges in Phase One

Review & Reflect

- Learning Recap

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Client Handout

What is Phase One of EMDR Therapy?

Most people start therapy because something is going wrong in their lives, such as relationship struggles, anxiety, depression, feelings of worthlessness, or feeling overwhelmed. EMDR therapy is an eight-phase psychotherapy approach that helps you tie your current problems to unresolved stressful situations. Those past events can be stuck in your system with the attached feelings, body sensations, thoughts, and/or images. During the first few sessions of EMDR therapy (Phase One), the goal is to learn enough about you to see how EMDR therapy might work for you, and to plan the course of your treatment.

What happens during the first few meetings?

Your EMDR therapist will build a strong working relationship with you by learning about who you are and valuing you as an individual. They will be curious about what identities you hold and be mindful of how your personal context and culture impact your present difficulties.

The therapist will assess your readiness for EMDR reprocessing and move at a pace that works for you. This may include (but is not limited to) exploring your support system, your ways of coping with distress, any physical health issues, and the history of your family and community.

While planning your treatment, your therapist will help you identify themes and make a game plan for how to tackle the sources of your current problems.

What do I need to do?

Be as honest as you can be.

You won't need to talk in depth about past trauma, but your therapist will need some idea about what you have experienced. If you compare your life to a book, your therapist needs to know the names of the chapters (like a table of contents), they do not need to know all the information within that chapter. With this approach, you can share as you feel comfortable.

Ask questions.

Feel free to ask your therapist any questions about the process at any time. Share your highs, lows, and in-between. Tell your therapist if you get overwhelmed during the process and need extra support and also share any successes or good things that are happening. Your therapist will be on the lookout for how you are doing, but they also need to hear from you.

Source: Urdaneta, V., & Triana, V. (2020). Playful and creative approaches for EMDR therapy with Latinx children. In A. Beckley-Forest & A. Monaco (Eds.), *EMDR with children in the play therapy room: An integrated approach* (pp. 223-250). Springer.

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History Taking Timeline

Instructions

Fill out this timeline with the client in session. It is an opportunity to build your therapeutic relationship, to talk through resources that were helpful throughout their life, and to identify events that need to be reprocessed. Consider using short phrases—think table of contents in a book, not full chapters.

1. Name three **good things** that happened in your family/community during each life stage:

Intergenerational	Childhood	Adolescence	Adulthood

2. Name three **not-so-good things** that happened in your family/community during each life stage:

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Tools & Measures

Below are some common tools and questionnaires for screening and assessment that might be helpful for Phase One. Each tool is briefly described with practical guidance for when and how to use it, helping therapists make informed decisions and build a trauma-informed, culturally attuned foundation for EMDR treatment.

Quick Reference Chart

Tool	Purpose	Type	Age Range	# Items	Use when...
ACEs	Childhood Trauma Exposure	Self-report	Adults & Teens	10	History of adversity suspected
BCEs	Positive/Protective Experiences	Self-report	All	10	Resilience factors needed
GAD-7	Anxiety Symptoms	Self-report	Adults	7	Anxiety suspected
PHQ-9	Depression Symptoms	Self-report	Adults	9	Depression suspected
DES-II	Dissociation Screening	Self-report	Adults	28	Screening for dissociation
A-DES	Adolescent dissociation	Self-report	Ages 11–18	30	Youth with trauma/dissociation
CDC	Child dissociation	Parent-report	Ages 5–12	20	Children with trauma flags
MID / MID-60	Full dissociation assessment	Self-report	Adults	218/60	Confirming DD diagnosis
CAPS-5	PTSD symptoms (DSM-5)	Clinician interview	Adults	30	PTSD diagnostic evaluation
ITQ	PTSD / CPTSD (ICD-11)	Self-report	Adults	18	ICD-11 formulation used
PCL-5	PTSD symptoms (DSM-5)	Self-report	Adults	20	PTSD symptom tracking
IES-R	Trauma distress	Self-report	Adults	22	Measuring impact of specific event
LEC-5	Exposure to trauma	Self-report	Adults	17	Screening for trauma events
Race, Culture, Identity Interview	Explore cultural identity, systemic stress, lived experience	Clinician interview	Adults & Teens	NA (open-ended prompts)	Building attunement and safety

Tool Summaries

ACES – Adverse Childhood Experiences Questionnaire

- Assess abuse, neglect, and household dysfunction before age 18.
- Higher scores = increased risk of health/psychological issues.
- Access ACEs

BCES – Benevolent Childhood Experiences Scale

- Identify resilience and protective factors in clients with adversity.
- Highlights positive experiences (e.g., stable caregivers, feeling safe). Useful to balance deficit-focused histories.
- Access BCEs

GAD-7 – Generalized Anxiety Disorder-7

- Screen for generalized anxiety symptoms.
- Aligned with DSM-5 criteria for GAD. Efficient for initial anxiety screening.
- Access GAD-7

PHQ-9 – Patient Health Questionnaire

- Assess depression severity and monitor symptoms over time.
- Used in primary care and therapy settings. Cutoffs for mild/moderate/severe depression.
- Access PHQ-9

DES-II – Dissociative Experiences Scale-II

- Flag potential dissociation prior to reprocessing.
- Normative cutoffs. Helps identify need for more assessment or stabilization.
- Access DES-II

A-DES – Adolescent Dissociative Experiences Scale

- Assess dissociation in adolescents ages 11–18.
- Adapted from DES. Useful in complex trauma cases involving teens.
- Access A-DES

CDC – Child Dissociative Checklist

- Screen for dissociation in children (ages 5–12).
- Parent-report. Can guide referrals and treatment planning in child trauma cases.
- Access CDC

MID / MID-60 – Multidimensional Inventory of Dissociation

- Comprehensive dissociation assessment when DID or OSDD is suspected.
- Full version = 218 items. Short form (MID-60) = 60 items.
- Available in English, Chinese, Dutch, Finnish, French, German, Hebrew, Italian, Norwegian, Portuguese, and Spanish.
- Access MID / Access MID-60

CAPS-5 – Clinician-Administered PTSD Scale

- Formal PTSD diagnosis and symptom severity tracking.
- Structured interview aligned with DSM-5. Considered gold standard.
- Access CAP-5

ITQ – International Trauma Questionnaire

- Assessing PTSD/CPTSD using ICD-11 criteria.
- Available in many languages. Ideal in global or ICD-11 contexts.
- Access ITQ

PCL-5 – PTSD Checklist for DSM-5

- Self-report PTSD symptom tracking.
- Widely used in VA, research, and therapy settings. Can be repeated to track treatment progress.
- Access PCL-5

IES-R – Impact of Event Scale – Revised

- Measure distress after specific traumatic event.
- Has intrusion, avoidance, and hyperarousal subscales.
- Access IES-R

LEC-5 – Life Events Checklist for DSM-5

- Screen for trauma exposure (not symptoms).
- Checklist of potentially traumatic events. Often paired with CAPS-5 or PCL-5.
- Access LEC-5

Identity, Race, and Culture Interview

- Semi-structured interview for use in Phase One to build attunement and safety
- Access Interview

Find these and more screening tools in the EMDRIA Library by setting the "Content Type" filter to "Screening Tools."

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Decision Tree for Phase One Screening

Does the client report childhood adversity?

- Use **ACES** to screen for risk
- Use **BCES** to balance with resilience factors

Are symptoms of depression or anxiety present?

- Use **PHQ-9** and **GAD-7**

To what extent is dissociation impacting the client's functioning?

- Adults: **DES-II** or **MID-60**
- Teens: **A-DES**
- Kids: **CDC** (parent-report)

To what extent are PTSD symptoms impacting the client's functioning?

- Use **CAPS-5** for diagnostic clarity
- Use **ITQ** if using ICD-11 or for CPTSD
- Use **PCL-5** or **IES-R** for tracking symptoms over time

Is there a need to confirm trauma exposure history?

- Use **LEC-5**

Additional Clinical Tips

Start small

- Use brief tools first (e.g., PHQ-9, GAD-7, DES-II) to avoid overwhelming clients early.

Be cautious with high dissociation scores

- Exercise clinical judgment when working with clients showing elevated dissociation scores. Adjust treatment planning to prioritize safety, stabilization, and relational trust.

Tailor to age

- Use age-appropriate tools and involve caregivers for child screenings.

Use cultural humility and sensitivity

- Explain the purpose of the screening tool, emphasize clients' autonomy to ask questions and offer additional context. Recognize behaviors or beliefs that might be culturally normative. When reviewing results, invite clients' interpretations ("Do you feel that this tool captures your experience accurately?"). If the client is multilingual, let them choose the language of the screening that allows them to express emotional or psychological states.

Citations by Screening Tool

ACES – Adverse Childhood Experiences Questionnaire

- Centers for Disease Control and Prevention. (2024). *About adverse childhood experiences*. www.cdc.gov/aces/about/index.html
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14*(4), 245–258. doi.org/10.1016/S0749-3797(98)00017-8

BCES – Benevolent Childhood Experiences Scale

- Narayan, A. J., Rivera, L. M., Bernstein, R. E., Harris, W. W., & Lieberman, A. F. (2018). Positive childhood experiences predict less psychopathology and stress in pregnant women with childhood adversity: A pilot study of the Benevolent Childhood Experiences (BCEs) scale. *Child Abuse & Neglect, 78*, 19–30. doi.org/10.1016/j.chiabu.2017.09.022
- University of Denver. (n.d.). Instruments: Benevolent Childhood Experiences (BCEs) scale. *Department of Psychology, PROTECT Lab.* liberalarts.du.edu/psychology/protect/instruments

GAD-7 – Generalized Anxiety Disorder-7

- Patient Health Questionnaire (PHQ) Screeners (n.d.). Pfizer. www.phqscreeners.com
- Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine, 166*(10), 1092–1097. doi.org/10.1001/archinte.166.10.1092

PHQ-9 – Patient Health Questionnaire

- Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*(9), 606–613. doi.org/10.1046/j.1525-1497.2001.016009606.x
- Patient Health Questionnaire (PHQ) Screeners (n.d.). Pfizer. www.phqscreeners.com

DES-II – Dissociative Experiences Scale-II

- Carlson, E. B., & Putnam, F. W. (1993 March). An Update on the Dissociative Experiences Scale. *Dissociation, 6*(1):16-27.
- Dissociative Experiences Scale - II. (n.d.). Traumadissociation.com. Retrieved April 21, 2025, from traumadissociation.com/des.
- Wainipitapong, S., Millman, L. M., Huang, X., Wieder, L., Terhune, D. B., & Pick, S. (2024). Assessing dissociation: A systematic review and evaluation of existing measures. *Journal of Psychiatric Research*. doi.org/10.1016/j.jpsychires.2024.11.040

A-DES – Adolescent Dissociative Experiences Scale

- Armstrong, J. G., Putnam, F. W., Carlson, E. B., Libero, D. Z., & Smith, S. R. (1997). Development and validation of a measure of adolescent dissociation: The Adolescent Dissociative Experiences Scale. *The Journal of Nervous and Mental Disease, 185*(8), 491–497. doi.org/10.1097/00005053-199708000-00003

CDC – Child Dissociative Checklist

- Putnam, F. W. (1997). *Dissociation in children and adolescents: A developmental perspective*. New York, NY: Guilford Press.
- Putnam, F. W. (2014). Child Dissociative Checklist (CDC) [Appendix]. In C. A. Courtois & J. D. Ford (Eds.), *Treatment of complex trauma: A sequenced, relationship-based approach* (Appendix 2). Springer Publishing.

MID / MID-60 – Multidimensional Inventory of Dissociation

- Dell, P. F. (2006). The Multidimensional Inventory of Dissociation (MID): A comprehensive measure of pathological dissociation. *Journal of Trauma & Dissociation, 7*(2), 77–106. doi.org/10.1300/J229v07n02_05
- Dell, P. F., Coy, D. M., & Madere, J. (2022). *The Multidimensional Inventory of Dissociation (MID)*. www.mid-assessment.com/
- Kate, M. A., Jamieson, G., Dorahy, M. J., & Middleton, W. (2021). Measuring dissociative symptoms and experiences in an Australian college sample using a short version of the Multidimensional Inventory of Dissociation. *Journal of Trauma & Dissociation, 22*(3), 265–287. doi.org/10.1080/15299732.2020.1792024
- NovoPsych. (n.d.). Multidimensional Inventory of Dissociation – 60-item version (MID-60). NovoPsych. Retrieved from novopsych.com/assessments/formulation/multidimensional-inventory-of-dissociation-60-item-version-mid-60/

CAPS-5 – Clinician-Administered PTSD Scale for DSM-5

- National Center for PTSD, U.S. Department of Veterans Affairs. (2025, March 25). *Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)*. Retrieved from www.ptsd.va.gov/professional/assessment/adult-int/caps.asp
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ITQ – International Trauma Questionnaire

- Cloitre, M., Shevlin, M., Brewin, C. R., Bisson, J. I., Roberts, N. P., Maercker, A., Karatzias, T., & Hyland, P. (2018). The International Trauma Questionnaire: Development of a self-report measure of ICD-11 PTSD and Complex PTSD. *Acta Psychiatrica Scandinavica, 138*(6), 536–546. doi.org/10.1111/acps.12956
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PCL-5 – PTSD Checklist for DSM-5

- Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). *The PTSD Checklist for DSM-5 (PCL-5) – Standard* [Measurement instrument]. National Center for PTSD. www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp

IES-R – Impact of Event Scale – Revised

- Horowitz, M., Wilner, N., & Alvarez, W. (1979). Impact of Event Scale: A measure of subjective stress. *Psychosomatic Medicine, 41*(3), 209–218. https://doi.org/10.1097/00006842-197905000-00004

- Weiss, D. S. (2007). The Impact of Event Scale: Revised. In J. P. Wilson & C. S.-k. Tang (Eds.), *Cross-cultural assessment of psychological trauma and PTSD* (pp. 219–238). Springer Science + Business Media. doi.org/10.1007/978-0-387-70990-1_10
- Sundin, E. C., & Horowitz, M. J. (2002). Impact of Event Scale: Psychometric properties. *The British Journal of Psychiatry, 180*(3), 205–209. doi.org/10.1192/bjp.180.3.205
- U.S. Department of Veterans Affairs, National Center for PTSD. (n.d.). *Impact of Event Scale – Revised (IES-R) for DSM-IV*. Retrieved from www.ptsd.va.gov/professional/assessment/adult-sr/ies-r.asp

LEC-5 – Life Events Checklist for DSM-5

- Weathers, F. W., Blake, D. D., Schnurr, P. P., Kaloupek, D. G., Marx, B. P., & Keane, T. M. (2013). *The Life Events Checklist for DSM-5 (LEC-5) – Standard* [Measurement instrument]. National Center for PTSD. www.ptsd.va.gov/professional/assessment/te-measures/life_events_checklist.asp

Identity, Race, and Culture Interview

- Lord, C., & Morgan, S. (2020). EMDR Phase 1: Client history – Identity, race, and culture interview. In M. Nickerson (Ed.), *Cultural competence and healing culturally-based trauma with EMDR therapy: Innovative strategies and protocols*. Springer.

  Edited in consultation with Chaffers, Q., Hamilton, H., Kase, R., Marich, J., & Urdaneto Melo, V., and the EMDRIA Diversity, Community & Culture SIG (personal communication, July 2020). Open Permission Granted to Share and Reprint.

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ACE Questionnaire

(Adverse Childhood Experiences)

Instructions

ACEs are potentially traumatic events that occur during childhood (0–17 years), such as witnessing violence or experiencing food insecurity.

All questions pertain to experiences before the age of 18.

Client Information

Name

Birthdate Gender

Questions

1. Did a parent or other adult in the household often swear at you, insult you, put you down, or humiliate you? Or act in a way that made you afraid that you might be physically hurt?

   Yes No

2. Did a parent or other adult in the household often push, grab, slap, or throw something at you? Or ever hit you so hard that you had marks or were injured?

   Yes No

3. Did an adult person (at least 5 years older) ever touch or fondle you, or have you touch their body in a sexual way? Or try to have oral, anal, or vaginal sex with you?

   Yes No

4. Did you often or very often feel that no one in your family loved you or thought you were important or special? Or that your family didn't look out for each other, feel close to each other, or support each other?

   Yes No

5. Did you often or very often feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Or that your parents were too drunk or high to take care of you, or take you to the doctor if you needed it?

   Yes No

6. Were your parents ever separated or divorced?

   Yes No Never Married

7. Was your parent/caregiver often or very often pushed, grabbed, slapped or had something thrown at them? Or sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

   Yes No

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

   Yes No

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

   Yes No

10. Did a household member go to prison?

    Yes No

Source: Felitti, V. J., Anda, R. F., Nordenberg, D., et al. (1998). *Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study*. American Journal of Preventive Medicine, 14(4), 245–258. https://doi.org/10.1016/S0749-3797(98)00017-8

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BCE Questionnaire

(Benevolent Childhood Experiences)

Instructions

Developed to be the counterpart to Adverse Childhood Experiences (ACEs), BCEs are favorable experiences that occur during childhood (0–17 years), such as having social support and security.

All questions pertain to experiences before the age of 18.

Client Information

Name

Birthdate Gender

Questions

1.	Did you have at least one caregiver with whom you felt safe?	Yes	No
2.	Did you have at least one good friend?	Yes	No
3.	Did you have beliefs that gave you comfort?	Yes	No
4.	Did you like school?	Yes	No
5.	Did you have at least one teacher who cared about you?	Yes	No
6.	Did you have good neighbors?	Yes	No
7.	Was there an adult (not a parent/caregiver or the person from the first question) who could provide you with support or advice?	Yes	No
8.	Did you have opportunities to have a good time?	Yes	No
9.	Did you like yourself or feel comfortable with yourself?	Yes	No

Source: Narayan, A. J., Rivera, L. M., Bernstein, R. E., Harris, W. W., & Lieberman, A. F. (2018). *Positive childhood experiences predict less psychopathology and stress in pregnant women with childhood adversity: A pilot study of the benevolent childhood experiences (BCEs) scale*. Child Abuse and Neglect, 78, 19–30. https://doi.org/10.1016/j.chiabu.2017.09.022

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Yellow Flags

Be mindful of these factors when planning for EMDR therapy with a client. Some of these yellow flags will require more resourcing or preparation before reprocessing.

Drug or alcohol abuse?

Consider using the EMDRIA Addictions Toolkit and the *Healing Addictions with EMDR Therapy* issue of *Go With That Magazine®* to think through various factors when working with addictions.

Life support?

Does your client have a good support network outside of therapy? Encourage your client to increase their internal and external resources.

Dissociative disorder?

Always assess for dissociation. Consider slowing down and getting extra training if you need it. Consult the *EMDR Therapy and Dissociation Challenges* issue of *Go With That Magazine®*.

Adequate rapport?

Clients with severe abuse backgrounds often have issues with safety and trust. Be intentional in building a strong therapeutic alliance before beginning reprocessing phases.

Handle emotional disturbance?

Assess if your client can use relaxation, grounding, and containing techniques in case elevated levels of emotional distress arise during EMDR processing.

Enough stability?

Enough personal & environmental stability is needed for Phase 4 reprocessing. Be aware of family, social, financial or career crises when choosing targets and resources.

The right time?

Is this the right time for your client to embark on trauma processing or are their life circumstances such that it is not a good time?

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Issue-Driven Treatment Plan Worksheet

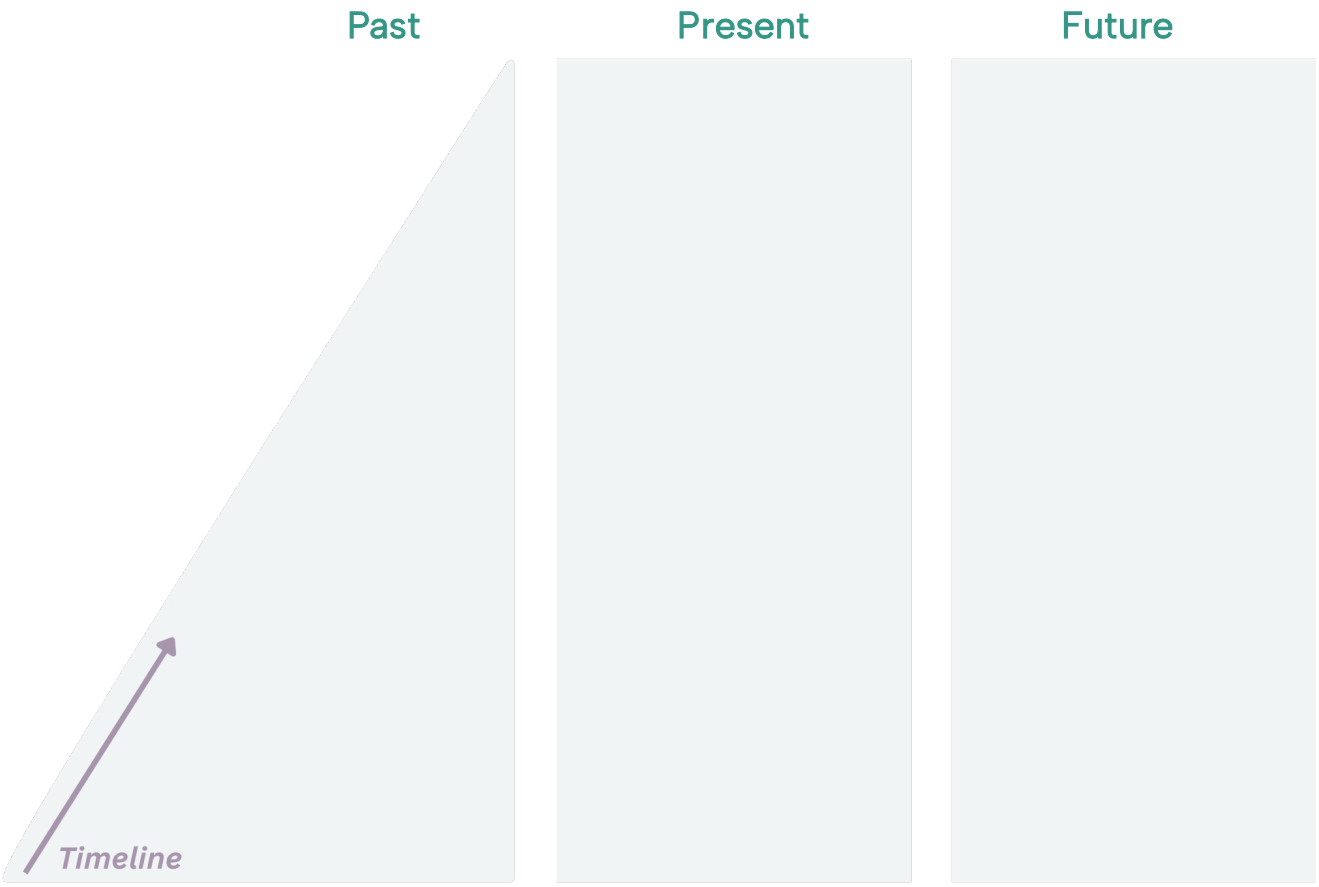
Introduction

Use this form to create an EMDR therapy treatment plan for the issues the client is hoping to address. Also see the video in this toolkit for more on issue-driven treatment planning.

See an example Issue-Drive Treatment Plan on page 2.

Primary Issues

(Presenting Problem):



Sources: Levinson, R. (2025, February 25). *Enhancing consultees' EMDR case conceptualization and treatment planning skills*. Presented at EMDRIA Consultant Day. emdria.org/course/consultant-day-2025

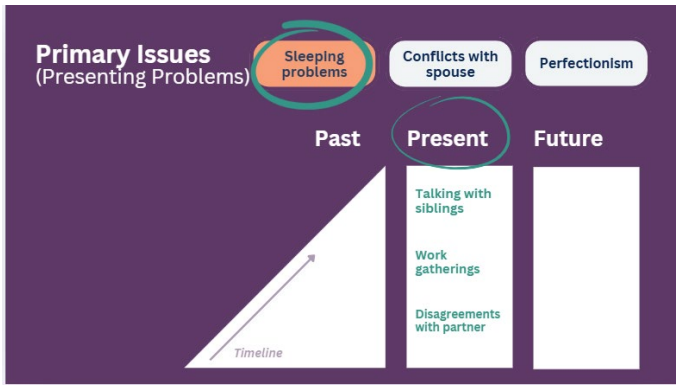
Korn, D. L. (2009). *EMDR and the Treatment of Complex PTSD: A Review*. Journal of EMDR Practice and Research, 3(4), 264–278. https://doi.org/10.1891/1933-3196.3.4.264

Example

1. Identify the primary issues (presenting concerns) that the client wants/needs to work in therapy. *"What are the issues/symptoms that brought you to therapy?"*

2. Identify the highest priority. " *Which one of the issues is the one causing the most struggle now?"* (Focus on one issue at a time).

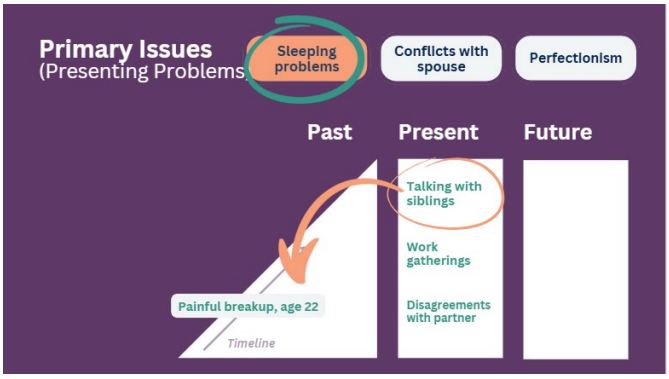
3. Identify Triggers. *"What are some recent situations that make this issue worse?"*



4. Identify which of the triggers is the most disturbing now. *"Which of the triggers is most disturbing now?"*

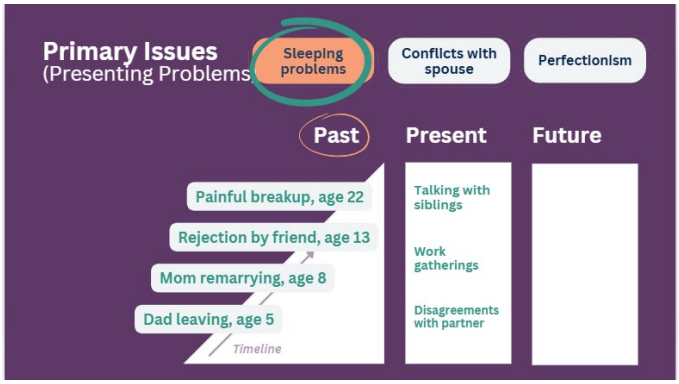
5. Find the past events using direct questioning, floatback technique, and/or affect scan until the touchstone event is identified.

   "Bring to mind the recent disturbing experience, identify the negative cognition [belief], and notice the associated physical sensations. Now just let your mind float back to an earlier time when you have felt this way before and just notice what comes to mind."



6. Identify any other related events. "*Are there other related events that come when you let your mind floatback to the past?*"

7. Identify touchstone event, if possible. (In the example below: Dad leaving, age 5).



8. Past: Reprocess the earliest event, if possible (Example: Dad leaving, age 5).

9. Reprocess the worst event.

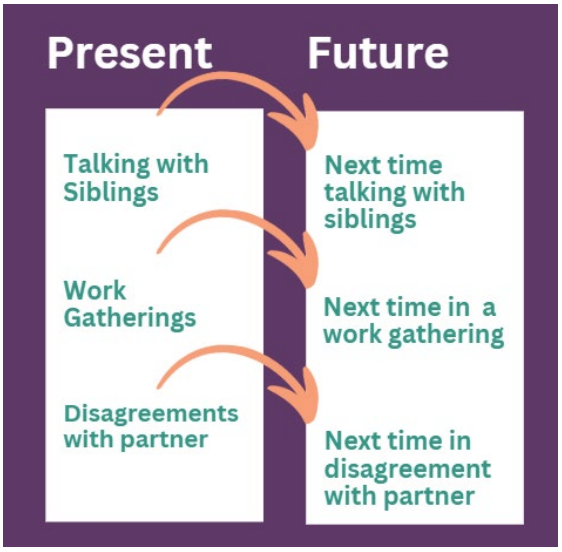
10. Reprocess other related events that still disturbing after reprocessing earliest/worst

11. Present: Check the present trigger again to see if there is still disturbance.

12. Reprocess current triggers (as needed).

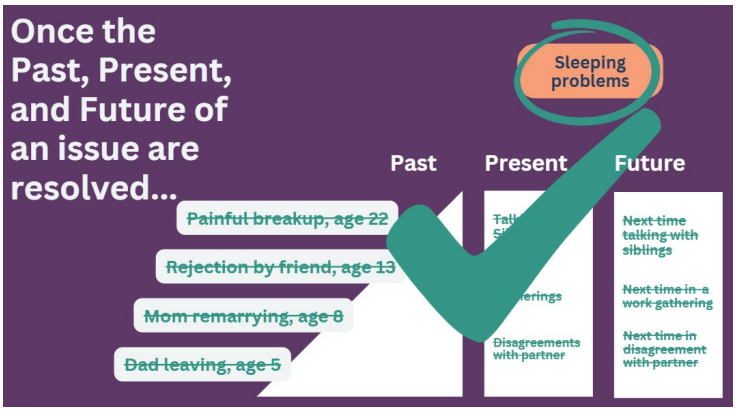
13. Future templates:" *Imagine yourself coping effectively with a similar situation [example: next time talking with your siblings]. Notice how you're handling the situation and how you are thinking, feeling, and experiencing it in your body.*"

14. Continue reprocessing all Present Triggers and doing Future Templates (as needed).

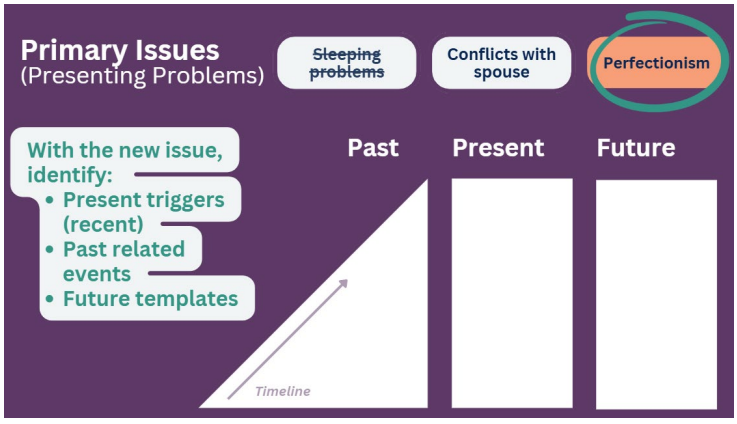


15. Future Reprocessing: If the client presents with anticipatory anxiety that is not resolved with the Future Template: **Reprocess the future event with Phases 3 to 8, targeting this future situation.**

16. Once the Past, Present, and Future of an issue are resolved.



17. Focus on the next issue. Return to the list of primary issues and help client identify the next issue to address.



EMDR Therapy Phase One: History Taking & Treatment Planning

Guidelines for Treatment Planning

This sample case follows the patient "Clara" through treatment planning in Phase One of EMDR therapy.

About Clara

- **Background**: Female, married client in an abusive relationship (not her first).
- **Emotions**: Shame, powerlessness.
- **Negative Cognitions**: "I am worthless," "I am not in control," "I cannot succeed," "I am dirty".
- **History**: Childhood physical abuse.

Symptoms

- What are the problematic behaviors?
- What are the primary emotions?
- What are the negative cognitions?
- What physical symptoms?
- What are the current triggers (including frequency, timing, location, other characteristics)?

Clara's Symptoms

Client experiences panic and memories of abuse when:

- Husband acts coldly.
- Boss becomes angry.
- Anytime she has to assert herself.

Duration

- How long has this issue been apparent?
- How has it changed over time?
- In what ways have the contributing factors to the client's distress evolved?

Clara's Duration

- Clara's problems have existed since childhood.
- Her panic attacks have increased in number and intensity in recent years.
- Since having a baby, Clara feels more vulnerable and out of control.

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Initial Cause

- When was the first time you can remember feeling this way?
- Find touchstone event.
- What was the worst event (might be touchstone)?
- What were the circumstances at the time of the touchstone event (social, family, etc.)?

Clara's Initial Cause and Past Experiences

- Youngest of three children.
- Physical abuse by father for minor infractions.
- Bullied by siblings.
- First panic attack when she sought assistance from her mother and was pushed aside.
- Mother believed siblings and said, "Wait until your father gets home!"

Past Experiences

- What other incidents have been instrumental in reinforcing the pathology?
- What other significant variables exist?
- Who are the major participants?
- How can events be clustered or grouped?
- Identify 10 most disturbing memories.
- Identify 10 most positive memories (these are potential resources).
- If the client cannot identify positive memories, then additional stabilization may be needed.

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IDEA in Phase One

(Inclusion, Diversity, Equity, and Accessibility)

Why does IDEA matter in Phase One?

- Experiences of marginalization and oppression may be central to trauma stories.
- Centering inclusion builds trust and safety in the therapeutic relationship.
- Attuning to IDEA needs and cultural context supports more accurate case conceptualization and treatment planning.

Key Considerations

1. Normalize Conversations about Identity, Culture, and Systemic Factors

- Ask open-ended, non-assumptive language: "What identities are important for me to know in order to support you best?"
- Validate the fact that cultural and identity-based trauma is real and significant.

2. Address Power Dynamics

- Acknowledge differences of identity between therapist and client.
- Invite discussion about how these differences may impact safety, disclosure, and/or the therapeutic relationship.

3. Practice Cultural Humility

- Be curious and open to learning about the client's culture and lived experiences.
- Reflect on your own biases and cultural lenses regularly.
- Empower clients with options and collaborate on case conceptualization by inviting the client's input throughout treatment.

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Sample Questions

- Some people have experienced harm related to race, gender, ability, or other aspects of identity. Would you feel okay discussing those experiences here?
- What are some aspects of your identity or background that you'd like me to know in order to best support you during the therapy process?
- How do your cultural background, values, or traditions shape how you understand and cope with distress or trauma?
- What parts of your identity have been misunderstood or ignored in past therapy or healthcare experiences?
- How do your cultural background, values, or traditions shape how you understand and cope with distress or trauma?
- In what ways do your community or family views influence how you talk about mental health or trauma?
- Are there things that might affect your comfort or sense of safety in our work together that you'd like me to know?

Strengths, Supports & Cultural Resources

- What practices, people, or traditions support your healing or resilience?
- What has helped you stay connected to your identity or values through challenging times?
- Are there community spaces or cultural teachings that feel grounding for you?

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10 Tips for a Successful Phase One: Advice from EMDRIA™ Members

1. Use Assessment Tools

"Phase One is the foundation of sound EMDR therapy. Utilizing structured assessment tools decreases the time spent in this phase and provides titration."

– Danyale Weems, LCSW, RPT-S

2. Ask About Intersectionality

"In addressing our clients' intersectionality (experiences of oppression) in Phase One, we can simply ask them what identities they are bringing to the table."

– Roshni Chabra, LMFT

3. Engage & Explore

"Engagement as you explore the presenting issues and window of tolerance."

– Deborah Almonte, LCSW

4. Assess Client Readiness

"Building a solid relationship allows both therapist and client to collaborate openly on present triggers, possible targets, and what might stand in the way of client reprocessing readiness."

– Susanna Kaufman, LPC Associate

5. Collaborative Treatment Plan

"Identify presenting problem, collect history, formulate AIP understanding of client's issues, and develop a treatment plan that is collaborative and ongoing."

– Allison Acton, LMFT

6. Build a Therapeutic Alliance

"It is crucial for building trust and establishing safety. Creating a strong therapeutic alliance lays the foundation for successful trauma processing and healing."

– Arielle Jordan, NCC, LCPC

7. Incorporate Your Style

"Phase One & Phase Two can be done according to a person's individual therapeutic style and perspective as long as the goals of these phases are maintained and accomplished."

– Francine Shapiro, 2009 EMDRIA Conference

8. Regarding Complex Trauma

"Chronological histories are rarely practical or feasible with complex trauma. Let the presenting issues lead you to a theme and let that then lead you to target selection."

– Jamie Marich, Ph.D.

9. Create a Timeline

"Ask (without details) for 3 to 5 'good' and 'not so good' events that happened during childhood, adolescence, & adulthood. Include experiences from their family/community to capture intergenerational resilience or trauma."

– Viviana Urdaneta Melo, LCSW

10. Family & Vulnerability

"Many clients have done past trauma work. Asking 'What did you learn from your family about emotional vulnerability?' can yield a goldmine of untapped targets."

– Heidi J. Dalzell, PsyD

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Challenges

Here are some common challenges that you might face during Phase One and some ideas of how to handle them.

Getting the Right Balance of Information

Avoid getting too much or too little information. We need the "table of contents" of the book of a person's life, not the entire book.

Dysregulated Client

Taking a good history can be difficult to impossible if your client is either disconnected or crying too much during history taking. Consider using resourcing and containment.

Inconsistency

Check with your client and continue building a therapeutic relationship if the scores achieved on assessments are not consistent with the client's presentation.

Too Much Shame

Shame can make talking at all a difficult task. You may need to slow down and work on trust and rapport building.

A Client Who is Too Eager

Some clients are eager or impatient to move quickly to begin reprocessing. They may need psychoeducation about the importance of ALL phases of EMDR therapy.

Dissociation Assessments

If your client scores too low (which is not realistic) or too high on dissociation assessments, you need to address that in your treatment planning.

Juggling gathering info & supporting clients

Use your clinical skills to help clients identify internal and external resources. Continue using empathy and a strengths perspective, especially for clients with multiple traumas.

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Learning Recap

Multiple Choice

1. **What is the primary goal of Phase One in EMDR therapy?**
   - A. Processing traumatic memories.
   - B. Gathering client history and identifying targets for reprocessing.
   - C. Teaching relaxation techniques.

2. **The three-pronged protocol refers to which of the following:**
   - A. Fears related to a traumatic event, attachment experiences with primary caregivers, and structural dissociation of the personality.
   - B. Identify, target and process the earlier memories causing the problems, present experiences triggering the disturbance, and the behaviors needed for adaptive future functioning.
   - C. Sensory experiences related to the trauma, unacted urges and impulses related to the trauma, and emotions related to the trauma.
   - D. The negative cognition, the positive cognition, and the body sensations.

3. **Some of the tasks involved in history taking during Phase One are:**
   - A. Delineating the client's presenting issue and its symptoms.
   - B. Identifying initial causes, duration, and additional past occurrences
   - C. Planning treatment with the expertise of therapists and client's input.
   - D. All of the above.

True or False

4. **EMDR therapy can begin reprocessing in Phase One if the client is eager to start.**

5. **The therapeutic relationship and client safety are foundational elements of Phase One.**

6. **A comprehensive trauma history should always be collected in a single session.**

Short Answer

7. **What is a Touchstone Event?**

Reflection

Reflect on your own, with a colleague, and/or with your consultant.

8. **How do you plan to use the information in this toolkit to enhance your clinical practice of Phase One?**

9. **How do you balance gathering important clinical information with honoring the client's pace and boundaries?**

10. **What support or further learning would help you feel more confident in implementing Phase One with client?**

Answers: 1. B; 2. B; 3. D; 4. False; 5. True; 6. False; 7. A core past experience that significantly shapes the presenting situation.

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