



EMDRIA CONSULTANT DAY

AIP & THE 8 PHASES AS A FRAMEWORK FOR CONSULTATION

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ORIENTING

LEARNING OBJECTIVE

Participants will be able to describe a framework for EMDR consultation organized around the eight phases of EMDR therapy.

PRESENTATION SUMMARY

This session will examine how Consultants can use the eight phases to organize case discussions, strengthen clinical reasoning, and support consultees in developing greater confidence and competence in EMDR practice.





ORIENTING

TURNING INWARD



When the nervous system's natural coping mechanisms are overwhelmed, the experience fails to integrate as adaptive information. Instead of contributing to resilience and growth, these memories become "stuck" in isolated networks, triggering symptoms when activated in the present.

SHAME IS MALADAPTIVE

Many personality traits and self-beliefs have roots in a lack of safety – what parts of you have had to hide to experience safety in learning?

JOURNALING & EXPLORATION

Reflect on your past experiences as a learner, in classrooms, trainings, supervision, and the spaces in between.

How did those experiences shape you as a learner?

How do they show up in the way you teach and consult?

What have you carried with you? What have you left behind?



"I have used the figure of a fish caught on a hook: his gyrations must look peculiar to other fish that don't understand the circumstances; but his splashes are not his affliction, they are his effort to get rid of his affliction."

—KARL MENNINGER,
AMERICAN PSYCHIATRIST



AIP

DOESN'T JUST APPLY TO CLIENTS
IT APPLIES TO YOU AND YOUR CONSULTEES

We are naming and challenging the myth that the consultant *is the expert over the consultee*





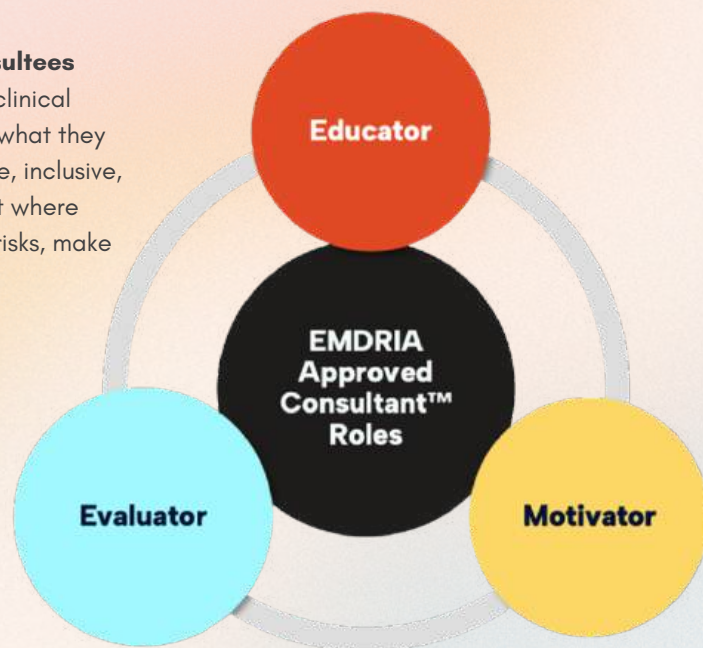
CONSULTATION THROUGH THE LENS OF AIP

- ◊ 90% of supervisees withhold clinically relevant information from supervisors
- ◊ Clinicians are more likely to attempt to manage personal reactions independently even when consultation would be more effective (Ladany et al., 1996)
- ◊ Supervisees report they withhold this information because it is too personal, a sense that it will not be received well, or the absence of a sufficiently safe relational alliance (Ladany et al., 1996)

WHAT THIS MEANS: Creating the conditions in which that material can be named is one of the consultant's most essential tasks.

"The **consultant** is who helps **consultees** explore the rationale behind their clinical decisions, rather than focusing on what they did 'wrong', and who fosters a safe, inclusive, and affirming learning environment where consultees feel supported to take risks, make mistakes, and develop new skills"

(EMDRIA, 2026, pp. 26-27).



A COLLECTIVE MODEL OF CONSULTATION

Rejects positioning consultation as an individual, authority-driven process. It teaches it as a collaborative model that relies on shared strengths, mentorship, and AIP principles.

Collective EMDR consultation is no longer just a collection of strategies; it is grounded in the AIP Model, backed by data, and designed to empower the next generation of consultants.



UNDERSTANDING AND KNOWING WHO WE ARE

- Per EMDRIA, 60% of current EMDR consultants have been practicing for fewer than five years
- EMDRIA's accessible pathway has brought many new consultants into the role, so much of our community is earlier in their EMDR development
- The challenge is not a lack of clinical learning and skill development; it lies in scaffolding the consultee's own learning
- Clear models give consultants a shared foundation, so consultation can grow beyond technique coaching into integrative mentorship

Our role is to help clinicians develop their own inner template for case conceptualization and clinical application, drawing out their natural brilliance rather than shaping replicas of ourselves.



AIP & MEMORY IN LEARNING



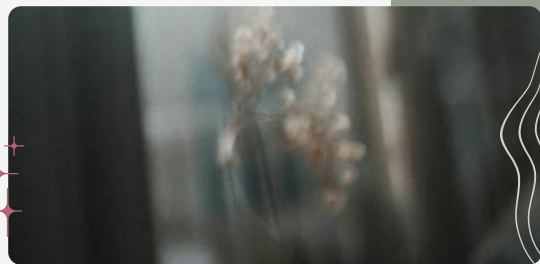
Memories are stored in associated channels.
They link together based on similar components.

Memories are made up of 4 components:

- 1 SENSORY INFORMATION**
Images, sounds, smells, tastes
- 2 COGNITIVE INFORMATION**
Thoughts and beliefs
- 3 AFFECT**
Emotions
- 4 BODY SENSATIONS**
Constriction, tension, numbness, etc.

CLINICIAN ADAPTIVE MEMORY NETWORKS CONTRIBUTE TO:

- Resilience & Mastery
- Safety/Control / appropriate risk taking
- "That was hard, but I did it."
- What it means to be supported through mentorship.
- What it is like to be seen.



MALADAPTIVE MEMORY NETWORKS CONTRIBUTE TO:

- Diminished sense of self-worth
- Decreased sense of control
- Freezing and not knowing
- Shame, anxiety, depression, fears
- Performing, Withholding, Pleasing

Consider the Three Prongs

Past Experiences

- Prior supervision and training
- Educational history
- Family roles that led to the work
- Relationship with authority

Present Day Triggers that activate distress

- Not knowing
- The consultant relationship
- Power, privilege, and evaluation
- When meaning-making framework no longer holds

Future Events & Desired Outcomes

- Their emerging clinical identity
- Tolerance for not knowing
- Consultation as an ongoing resource
- Independent AIP-informed reasoning

OVERVIEW OF 8 PHASES

As It Relates to Treatment

Phase 1	<i>History Taking</i>
Phase 2	<i>Preparation</i>
Phase 3	<i>Assessment</i>
Phase 4	<i>Desensitization</i>
Phase 5	<i>Installation</i>
Phase 6	<i>Body Scan</i>
Phase 7	<i>Closure</i>
Phase 8	<i>Re-evaluation</i>

OVERVIEW OF 8 PHASES

As It Relates to Consultation



Case Conceptualization	Phase 1	<i>Understanding Consultee</i>
	Phase 2	<i>Co-Creating Learning</i>
	Phase 3	<i>Narrowing Focus Protocols Techniques Skills</i>
	Phase 4	
	Phase 5	
	Phase 6	
	Phase 7	<i>Closure</i>
	Phase 8	<i>Re-evaluation</i>

PHASE 1

AIP-Informed History Taking
in EMDR Consultation

Understanding the Consultee

Developing a backdrop for effective consultation

"Most therapists grew up struggling to be loved and accepted by others. Because of these early experiences, many of us find it difficult to believe others can be of help to us. We carry this struggle into our adult lives and, inevitably, into our relationships with our clients."

— Louis Cozolino, [The Making of a Therapist](#)

PRESENTING ISSUE

In Consultation



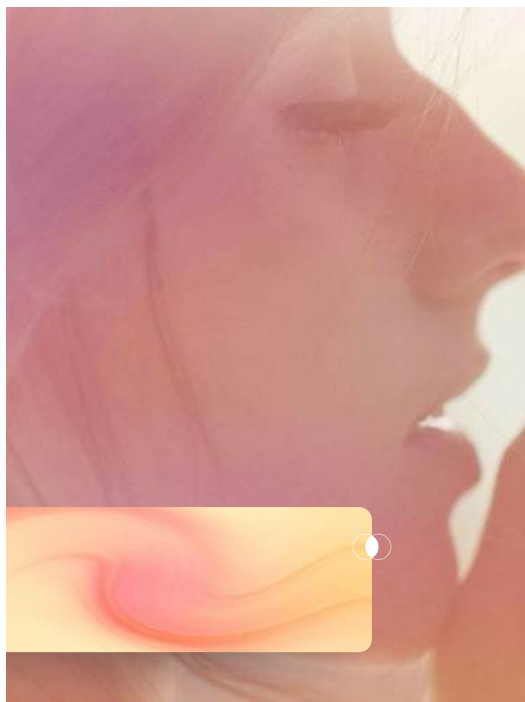
What does distress look like in consultation?

Consider case presentation, tracking, implementation of guidance, and the response to consultation.



“Research identifies consultation as among the most effective approaches for working through countertransference (Hayes et al., 2018). When clinicians bring their emotional reactions to trusted colleagues, they create the conditions to examine what they are experiencing, where it may be coming from, and what it might be telling them about the client, the relationship, or themselves. The task is to bring unconscious patterns of relating into conscious awareness, which requires someone outside the clinician's own perspective, someone close enough to the work to understand it and far enough away to see it with greater clarity.”

(Downs, Krajewski, & Thornton, 2026)



USING AIP TO GUIDE YOUR CONSULTATION & LEARNING PLAN

What is said and not said is of equal importance in the consultation relationship.

We invite you to get curious about the information in your consultee's:

- Case presentation
- Attitude toward self or client
- Perceptions and preparation
- Behaviors in response to your suggestions
- Emotions and Sensations (in them and you)

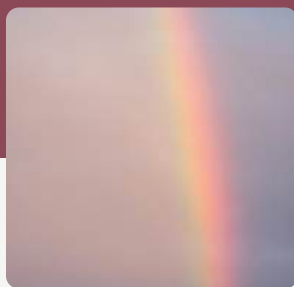
Case conceptualization is a process of hypothesizing, testing, and learning to manage and maneuver in the face of "failure" and "not knowing."

The consultant becomes attuned to the consultee's stuck points, which often emerge in three interrelated domains:



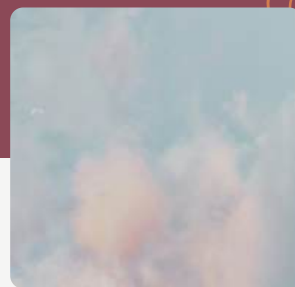
COGNITIVE STUCK POINTS

Such as rigid thinking or persistent misinterpretation of protocol



AFFECTIVE STUCK POINTS

Such as anxiety, fear of harming clients, or shame around not knowing enough



SOMATIC STUCK POINTS

Such as freezing, shutting down, or feeling overwhelmed during or after sessions

EXAMPLES

IF YOUR CONSULTEE...



Presents as already knowing



Challenge is to get curious about what competence protects and make room for not knowing.

Hesitates to try new skills



Challenge is to slow the pace, break plans into smaller steps, and explore the hesitation.

Wants to learn everything at once



Challenge is to explore what **knowing** would soothe and to refocus on what the current cases require.

Questions their place in the work



Challenge is to hold the question open, reconnect them with their reasons for the work, and find what still holds and what needs adjusting.

Seeks every next step



Challenge is to build their own clinical reasoning by asking before offering direction.

PHASE 2

Co-Creating Learning



Phase 2 Objectives

Preparation Phase in consultation is a process of co-creation

Therapeutic Alliance & Rapport

Connection creates safety. Ensure mutual trust has been established so the consultee feels secure bringing complicated, personally challenging content forward.

Orient to Process

Context creates safety. Establish shared language, format, process for case presentation, and consent to explore countertransference.

Develop learning plan around adaptive experiences

Introduce and reinforce strengths, learning styles and internal and external resourcing, tailored to the individual

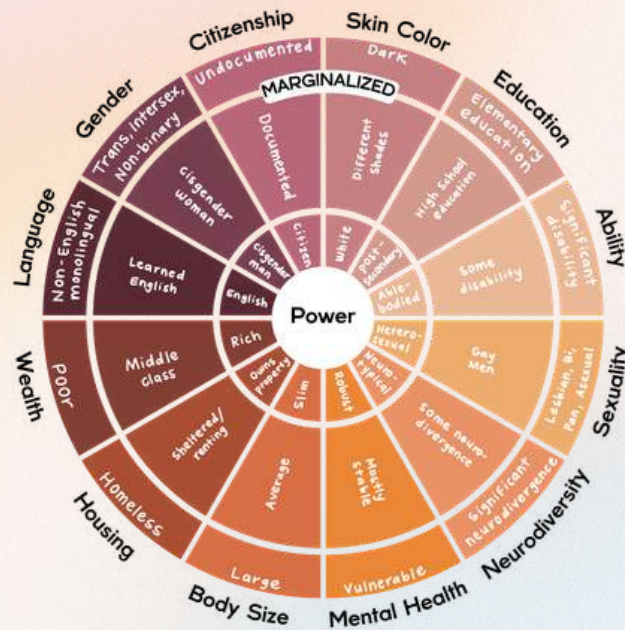
Widening Tolerance

Build capacity to notice and stay with one's own barriers, cultivating the dual awareness to hold both the client's material and one's own response.

THE WHEEL OF POWER/PRIVILEGE

"Trauma decontextualized in a person looks like personality. Trauma decontextualized in a family looks like family traits. Trauma in a people looks like culture."

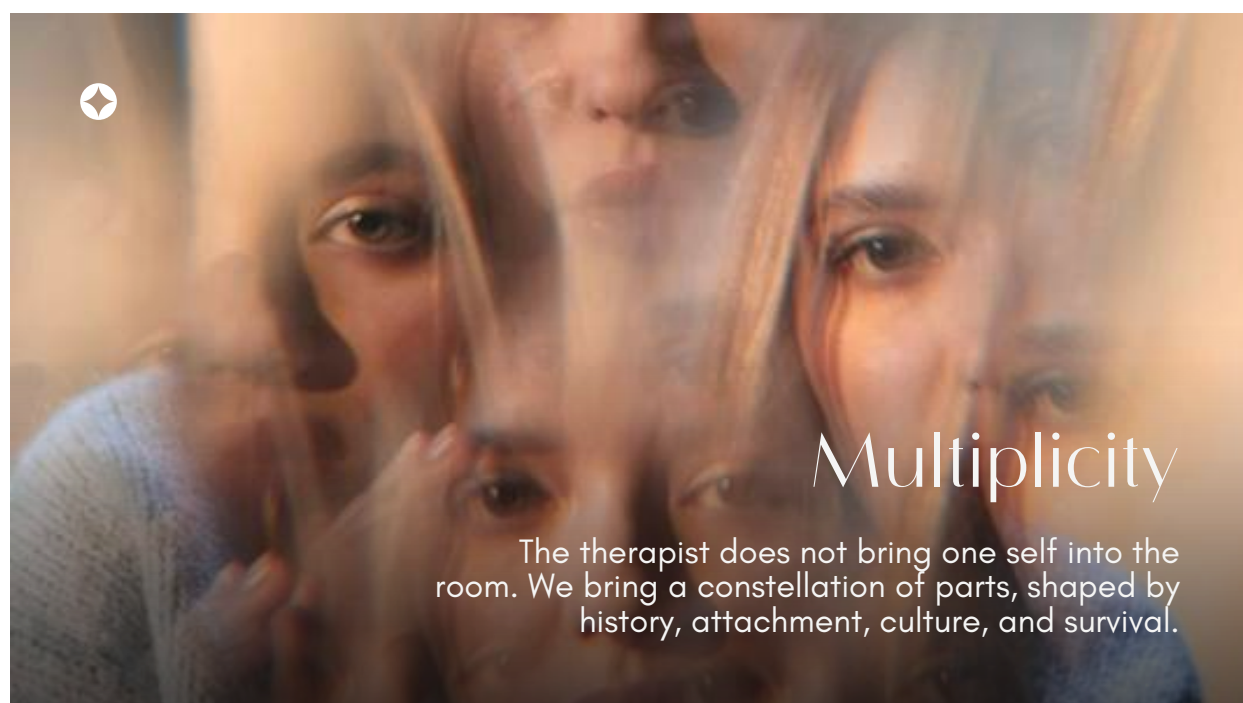
- Resmaa Menakem



*Adapted from ccrweb.ca



THE AIP MODEL AND THE WHOLE THERAPIST

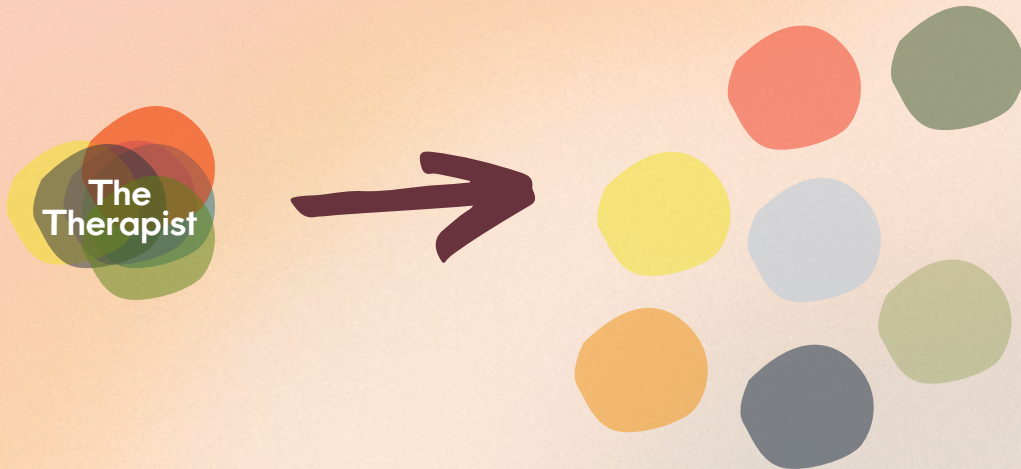


Multiplicity

The therapist does not bring one self into the room. We bring a constellation of parts, shaped by history, attachment, culture, and survival.

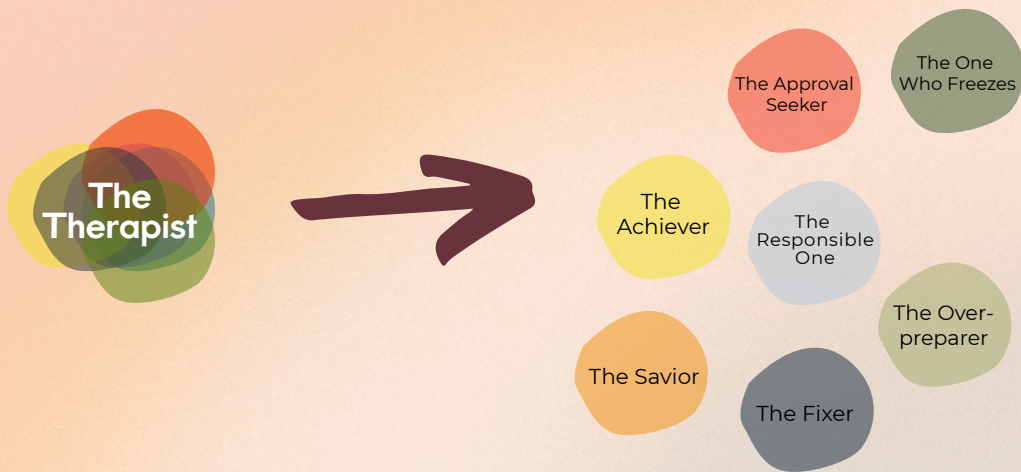
A closer look at our parts

SPACE + AUTONOMY

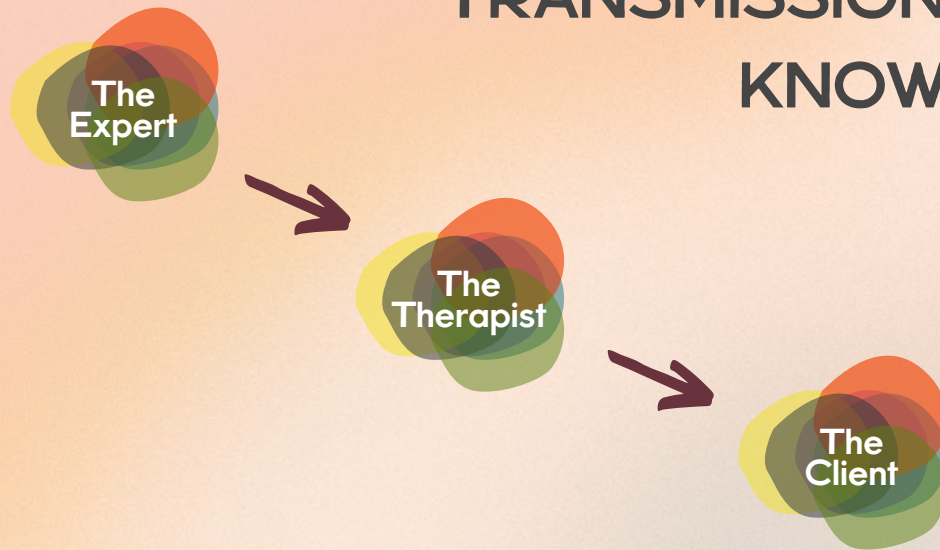


A closer look at our parts

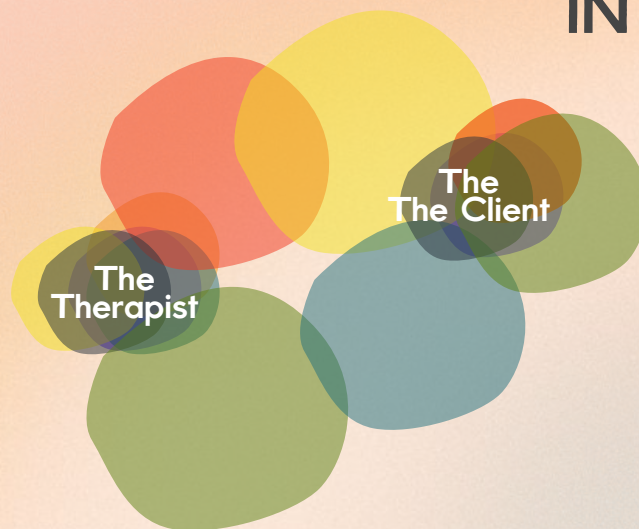
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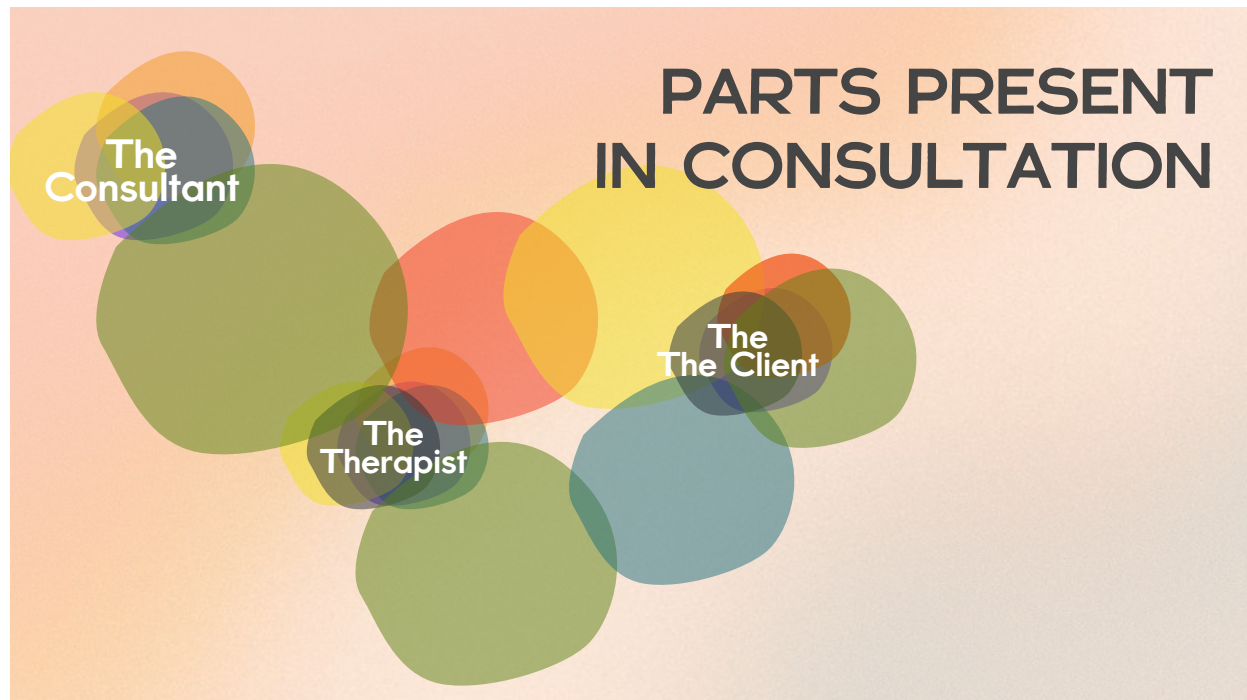


TRANSMISSION OF KNOWING



PARTS PRESENT IN SESSION

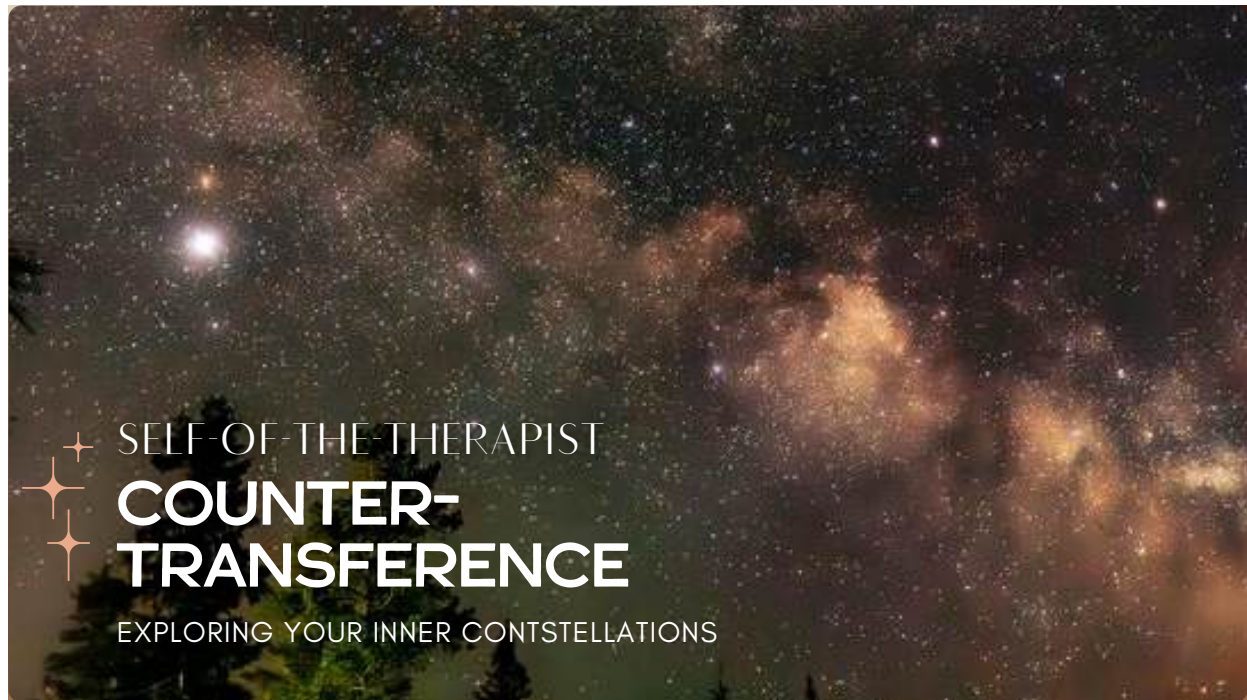




IT'S ALL JUST INFORMATION

- The AIP model holds that experiences naturally move toward adaptive resolution
- What blocks that movement is not the feeling itself, but the absence of a safe enough container in which to attend to it
- This holds as true for the clinician's internal experience as for the client's
- The reframe invites clinicians to extend to themselves the same non-pathologizing stance they extend to clients: there are no bad reactions, shameful emotions, or wrong associations, only experience that has or has not yet been attended to
- The experience itself is not the ethical question; what the clinician chooses to do with it is, and this is where clinical judgment and ethics enter the work





DISCOVERING AND EXPANDING

What feelings is this client bringing up for me?

Where is it coming from — me or the client? Does this client remind me of something in my own life?

Is this feeling familiar to me with this client? Is this familiar to me in contexts outside of this therapeutic relationship?

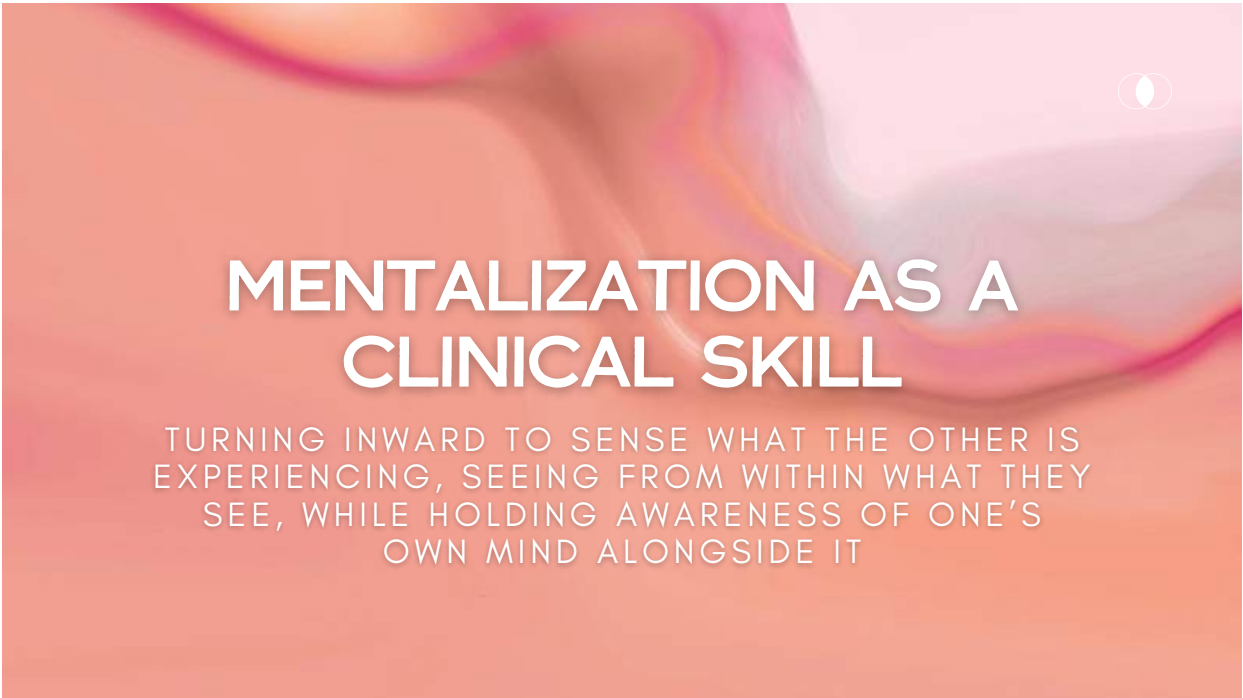
Did something happen right before this session that influenced how I'm feeling?

Is there a personal situation happening in my life/workplace that's interfering with my work?

What cultural and institutional systems have trained and shaped me to feel this way?

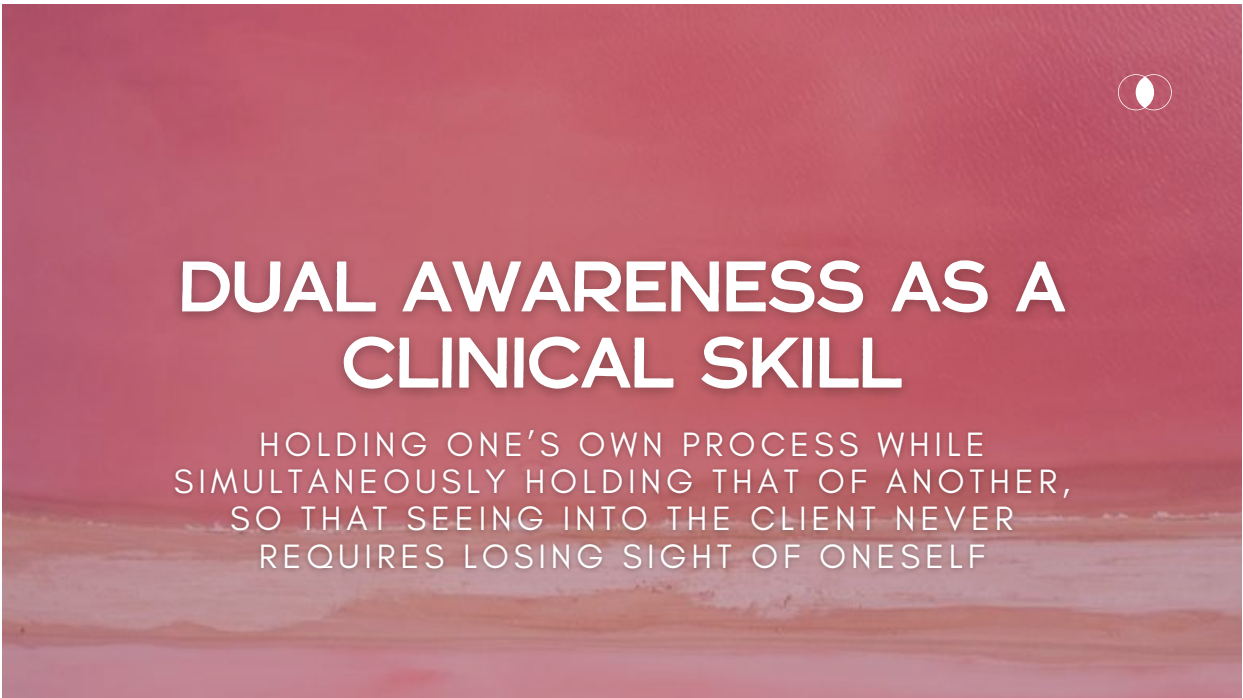
What do I need to do to take care of myself given this information?

What does this reaction tell me about what might be happening between us, in me, or in my client?



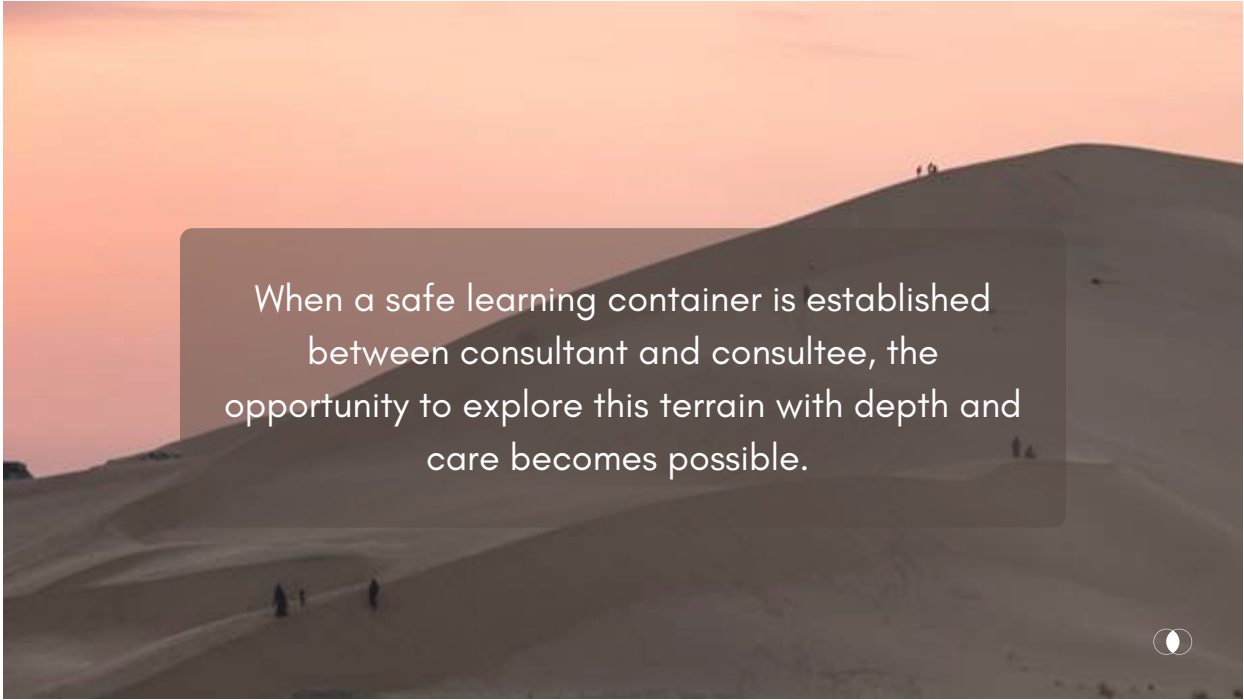
MENTALIZATION AS A CLINICAL SKILL

TURNING INWARD TO SENSE WHAT THE OTHER IS
EXPERIENCING, SEEING FROM WITHIN WHAT THEY
SEE, WHILE HOLDING AWARENESS OF ONE'S
OWN MIND ALONGSIDE IT

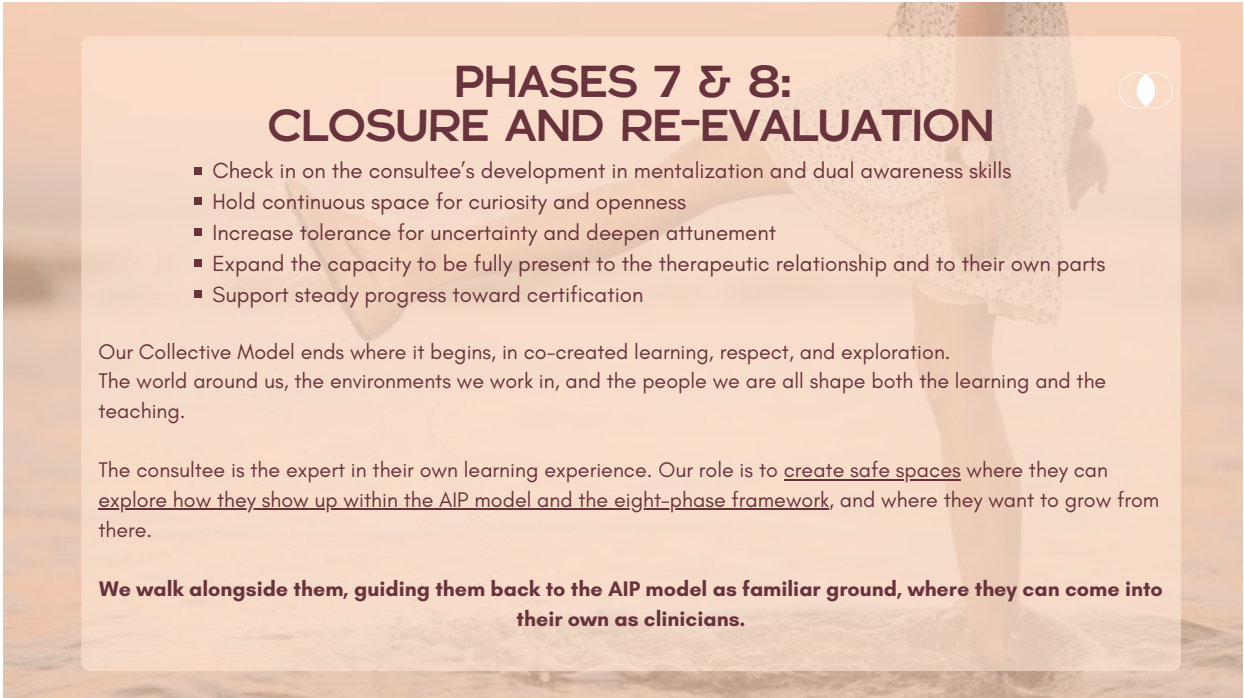


DUAL AWARENESS AS A CLINICAL SKILL

HOLDING ONE'S OWN PROCESS WHILE
SIMULTANEOUSLY HOLDING THAT OF ANOTHER,
SO THAT SEEING INTO THE CLIENT NEVER
REQUIRES LOSING SIGHT OF ONESELF



When a safe learning container is established
between consultant and consultee, the
opportunity to explore this terrain with depth and
care becomes possible.



PHASES 7 & 8: CLOSURE AND RE-EVALUATION

- Check in on the consultee's development in mentalization and dual awareness skills
- Hold continuous space for curiosity and openness
- Increase tolerance for uncertainty and deepen attunement
- Expand the capacity to be fully present to the therapeutic relationship and to their own parts
- Support steady progress toward certification

Our Collective Model ends where it begins, in co-created learning, respect, and exploration. The world around us, the environments we work in, and the people we are all shape both the learning and the teaching.

The consultee is the expert in their own learning experience. Our role is to create safe spaces where they can explore how they show up within the AIP model and the eight-phase framework, and where they want to grow from there.

We walk alongside them, guiding them back to the AIP model as familiar ground, where they can come into their own as clinicians.



OUR CLOSURE

