Common mistakes in the administration of the EMDR standard protocol

TARGET SELECTION

1. Working on the distress presently experienced during the session (anxiety, sadness, etc.) or on the symptom, without reference to a specific event and without previous EMDR processing.

IMAGE

2. Suggesting a target image (instead of eliciting it)
3. Targeting the whole narrative, not the worst image
4. Investigating, exploring, asking for details, emotions, etc. after the client has identified the worst image.

NEGATIVE COGNITIONS

5. Asking what the client thinks in general about him/herself, without reference to the image.
6. Investigating on the NC and/or the PC in a complex and Socratic way instead of directly linking them to the image.
7. Immediately providing the sheet with the list of the NCs.
8. Accepting a NC on the same dimension of the PC and vice versa
9. Starting a long discussion on the NC, investigating on general issues
10. Asking for the NC with reference to the past, instead of "what is alive now" with reference to the target
11. Accepting a NC which is a description of emotions (e.g. "I am scared")

POSTIVE COGNITION

12. Failing to use the question in the protocol and directly suggesting the PC
13. Identifying the PC with the question "what would you have liked to be able to think", instead of using the correct formula, in the present tense with reference to the image
14. Unnecessarily exploring the PC (e.g. by saying, "maybe you feel at peace, you felt guilty, you did all you could do")
15. Accepting a PC without reference to the self and with a magical connotation
16. Accepting a PC not on the same dimension as the NC

VoC

17. Asking for the VoC without defining the target, the NC and the PC
18. Asking for the VoC with reference to the general situations, not to the target/event
19. Asking for the VoC without repeating the PC and the image
20. Accepting a VoC of 5.

EMOTION

21. Asking for the emotion while the client thinks of the NC, instead of the image and the NC

22. Asking for the emotions by bringing the client back to the image, without the NC
23. Failing to ask for the emotion, asking only about the physical sensation followed by the SUD
24. Asking for the emotions as they were experienced then, not now, when the client thinks of the image

SUD

25. Asking for the SUD before asking for the PC
26. Assigning a value to "remorse", "anger", or "failure", instead of the general disturbance

BODY LANGUAGE

27. Asking for the body location in a complex and convoluted way, instead of "where do you feel it in your body?"

BEGINNING OF THE DESENSITIZATION PHASE

28. Teaching the stop signal explaining that the client will be brought back to the "safe place" if needed (this is not necessarily true).
29. Starting the BS without telling the client to concentrate on the image, the NC and the physical sensation.
30. Starting the BS asking the client to concentrate:

    1. on the sensation, instead of the image, + NC + location of the disturbance.
    2. on the image, the anguish and the rigidity, instead of the image, the NC and the location of the disturbance
    3. "on that".

31. Providing all the details of the event; this is not necessary nor called for by the protocol.

SETS

32. Making too slow sets
33. Making too short sets (e.g. 10 – 15 seconds)
34. Making too long sets, in particular when not necessary. This could open new channels, especially if the client shakes his/her head, nods, changes position, inhales, provides other non-verbal signs of processing.
35. Pausing too much between sets and talking during a set.

THERAPIST INTERVENTIONS

36. Making unnecessary cognitive interweaves (e.g. "You are telling your mother things you did not actually tell her")
37. Commenting, summarizing, restructuring when unnecessary and not called for.
38. Intervening and starting a conversation during a session while the client is processing. This blocks the processing and confuses the client.

39. Asking, investigating, trying to restructure, exceeding in cognitive interweaves when not necessary, while the client's material is moving.
40. Interpreting (e.g. "I think you are on the defensive even now, because you are sitting with your back against the chair…") and making excessive discussions between sets.
41. Taking notes after each set, slowing down the process, asking questions, repeating the client's words, investigating after the client's feedback (e.g. "do you have a lot of friends?", "are you calmer now?", "where do you feel calm? In you arms, in your legs…?"), but especially taking notes.
42. Commenting and reflecting everything the client says
43. Intervening with unnecessary questions and goals (e.g. "What could you do instead?", "Can you make it now?", "You need to take care of yourself")
44. Distracting the client's processing by moving into issues unrelated with the target
45. Asking whether the "scene" described by the client is real or made-up, and how did things really happen (*this is not necessary nor called for by the protocol*)
46. Using a float-back or an affect bridge during desensitization. These techniques can be eventually used during target selection
47. Leading exchanges and conversations with the client to an excessively cognitive and rational level when the processing is very smooth and productive
48. Distancing the client from the image (e.g., "see it from a distance", "train metaphor", or "it's over") when not necessary

ABREACTIONS

49. Talking, commenting, asking irrelevant questions, instead of continuing with the BS until the abreaction is reduced
50. Talking the client out of the abreaction
51. Stopping, the desensitization when the client feels the emotion and says, for instance, that he/she "wants to cry"

MEASURING SUD DURING DESENSITIZATION

52. Asking for the SUD after 2 sets (not called for by the protocol until it is apparently zero)
53. Failing to check that SUD is really zero
54. Ending desensitization before reaching a SUD of zero (except when time is running out)
55. Asking for the VoC when the SUD is still high (e.g., 3)
56. Checking the SUD without going back, or linking it to the target, (e.g. by asking, "What disturbance do you fell?")
57. Asking for the SUD on a 1 to 10 scale instead of on a **0 to 10** scale.
58. Asking for the SUD without going back to the original target.
59. Asking "What prevents it from going down?" practically every time the client is brought back to target, instead of asking what does the client notice, feel, what are the emotions or the sensations.
60. Asking the client what prevents the SUD from being a 0 when it is still high (e.g. 5). This question should be asked only when the client is blocked with a SUD or 1 or 2. A high SUD level does not indicate that the client is blocked, but that more material needs to be processed.

INBETWEEN SETS

AT THE END OF THE EACH SET

61. Not asking anything (e.g. "what do you notice?") especially when the client doesn't say anything.
62. Saying "come back here" as if the client was somewhere else
63. Asking for specific information (e.g. "do you feel the tiredness in your legs?", "how is your body now?", "is the image the same?", "did it go away"?") instead of the general question "what do you notice?"
64. Anchoring the client to the body processing.
65. Investigating and exploring client's reports.
66. Asking the client how does he/she feel "now" without waiting for the end of a chain of association. Bringing a client back to the original image or to the target when he/she is still associating, stops the processing
67. Repeating the client's words after each set.
68. Asking and investigating cognitively (e.g. "what prevents you from forgetting?") instead of saying "go with that"

AT THE BEGINNING OF A NEW SET

69. Failing to say "concentrate on this" or "go with that". The client loses concentration since he/she does not know what to do
70. Saying, "let's start again from the image"
71. Asking the client to take a deep breath before beginning a set rather than *at the end as required by the protocol*
72. Describing the situation reported by the client before starting a new set by repeating his/her words (e.g. "think about the last thing you told me, that is, that your mother was always acting like this and that you noticed she had the same attitude with your brothers")
73. Failing to allow a cognitive, emotional feedback, aiming only at reducing the SUD (a verification of SUD decrease between sets is not called for).

GOING BACK TO TARGET

74. Asking what the client feels "when you think of the image"
75. Asking for the body disturbance or the SUD without going back to target
76. Asking for the NC again.
77. Bringing the client back to the image after every set, because this blocks the processing
78. Describing the target and/or the whole event again
79. Asking "how much is this anger?" instead of the level of disturbance
80. Bringing the client back to target when the flow of association is still in progress
81. Having a one hour session without bringing the client back to target
82. Allowing the client to process always sin the present tense, instead of with reference to the target
83. Losing sight of the session goal, following the client's reports as in a normal session, with cognitive restructuring, questions, etc and failing to bring the client back to target.

PHASE 5 – INSTALLATION

84. Installing the PC without giving the assignment of the protocol
85. Starting phase 5 if the SUD is still 3, i.e. before completing phase 4
86. Failing to check if the PC is still appropriate before installing it
87. Asking "what prevents it to be a 7?" after only one set of installation
88. Failing to ask the client to link the PC with the target for the installation
89. Asking for the VoC on the initial image without checking the SUD and the PC
90. Asking for the SUD after measuring the VoC.
91. Asking again for the SUD after installing the PC with the VoC, etc.
92. Installing the PC with a SUD of 1 or 2.
93. Failing to check the VoC and moving immediately to the body scan

PHASE 6 – BODY SCAN

94. Starting the body scan without linking it to the event + PC
95. Asking only for the body sensation
96. Naming the body parts. Just to ask to scan the body (so the client can proceed at his/her own speed)
97. Doing the body scan with open eyes
98. Doing eye movements during the body scan
99. Saying just "everything OK in your body?" or similar questions
100. Having the client concentrate on the positive feeling during the body scan to strengthen it, without stopping on the negative feeling reported

PHASE 7 – CLOSURE

101. Doing more BS when the client is brought back to the safe place (*it is not only unnecessary, but it could stimulate more material, especially when closing an incomplete session)*
102. Doing a complete session in an incomplete session
103. Forgetting to inform of therapist availability
104. Forgetting to go through the closure
105. Having the client concentrate on the distress in an incomplete session, and then using taps to bring the client to the safe place.
106. Asking the client to recall the image and the NC, and checking if it is still as disturbing as at the beginning of the session, or lower. This is totally wrong in the closure phase. If the SUD is still above zero, do no go through the body scan or any other phase. Just go through the incomplete session closure.
107. Asking the client more questions on the distress (e.g. fear of dying, inadequacy, etc.) during the closure.
108. Opening new targets and channels during the closure

SAFE PLACE

109. Doing too short sets (3 EM)
110. Doing too long sets
111. Failing to ask and install the cue-word
112. Reinstalling the safe place, since it is not necessary