MINDLIFT ALLIANCE

EMDR THERAPY

Clinician Manual & Session Guide

8-Phase Framework | Treatment Planning | Session Tools | Documentation

CLINICAL USE NOTE

This original guide is an educational reference for licensed clinicians who have completed, or are completing, formal EMDR basic training. It is not a replacement for EMDRIA-approved training, supervised practicum, consultation, clinical judgment, or the standard texts/protocols used in formal training. Use only within your scope of competence.

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1. Purpose, Scope, and Clinical Orientation

Eye Movement Desensitization and Reprocessing (EMDR) is a structured trauma-focused psychotherapy that uses an eight-phase framework. During reprocessing, the client briefly attends to disturbing material while also engaging in dual-attention bilateral stimulation (BLS), such as eye movements, tones, or taps. The goal is adaptive processing of distressing memories and associated beliefs, emotions, and body sensations.

This manual is designed as a field guide: what to assess, what to document, what to monitor, and how to organize the work. It intentionally does not reproduce proprietary training scripts or replace protocol-specific instruction.

Evidence context

APA describes EMDR as an eight-phase psychotherapy for PTSD and currently suggests it as a treatment option for adults with PTSD. The U.S. National Center for PTSD describes EMDR as a standardized trauma-focused psychotherapy and notes that it is recommended as a first-line PTSD treatment in multiple clinical practice guidelines.

Competence before technique

- Complete formal EMDR basic training before independently delivering full EMDR reprocessing.
- Use consultation/supervision for complex trauma, dissociation, severe instability, high-risk presentations, developmental adaptations, and protocol modifications.
- Practice within licensure, ethics, informed consent, documentation, and emergency-care requirements.
- Do not assume that every trauma-exposed client is ready for reprocessing simply because EMDR is clinically indicated.

The eight phases at a glance

Phase	Clinical purpose
1. History & Treatment Planning	Case conceptualization, readiness, resources, target map, treatment priorities.
2. Preparation	Informed consent, therapeutic alliance, stabilization, dual-attention orientation, coping resources.
3. Assessment	Activate and measure the target: image, negative cognition, desired positive cognition, VOC, emotion, SUD, body location.
4. Desensitization	Facilitate adaptive processing while monitoring distress, association, orientation, and safety.
5. Installation	Strengthen the selected adaptive positive cognition associated with the target.
6. Body Scan	Identify and process residual somatic disturbance linked with the target.
7. Closure	Return to present orientation and adequate stability whether processing is complete or incomplete.
8. Reevaluation	Review the previously processed target, interval changes, emerging material, and next treatment step.

2. The EMDR Treatment Map: Past, Present, Future

EMDR treatment planning commonly follows a three-pronged structure. The clinician uses the client's presenting symptoms and case formulation to identify relevant past experiences, current triggers, and future situations that require adaptive responding.

Prong	Questions for treatment planning
Past	Which earlier experiences appear to have laid the groundwork for the current symptoms, beliefs, emotional responses, or relational patterns?
Present	Which current situations, sensations, people, places, images, or relational cues trigger the disturbance now?
Future	What upcoming situations require a new response, belief, boundary, behavior, or sense of agency? What would adaptive coping look like?

Clinical principle

Target selection is not simply choosing the "worst memory." Select targets that fit the case formulation, current goals, readiness, and the client's capacity to remain oriented and engaged. Complex cases may require substantial work in Phases 1 and 2 before reprocessing.

Target map worksheet

Domain	Clinician notes
Presenting symptoms / treatment goals	
Key negative self-beliefs / themes	
Potential past targets	
Current triggers	
Future templates / desired responses	
Resources / strengths / supports	
Readiness concerns / consultation needs	

3. Readiness and Safety Gate Before Reprocessing

A readiness decision is broader than diagnosis. Before moving into Phase 3 and active reprocessing, confirm that the client can participate safely, understands the process, has sufficient present orientation, and has a workable plan for between-session distress.

Screen and conceptualize

- Current suicide risk, self-harm risk, violence risk, abuse exposure, or other acute safety concerns.

- Dissociation, depersonalization/derealization, amnesia, identity fragmentation, or rapid loss of present orientation. Use validated dissociation assessment when clinically indicated and seek consultation for significant dissociation.
- Substance intoxication/withdrawal or patterns that interfere with safe participation and post-session stability.
- Psychotic symptoms, severe mania, delirium, or other conditions that substantially impair reality testing or informed participation.
- Medical, neurological, visual, vestibular, migraine, seizure, pregnancy, or other considerations relevant to the selected BLS modality; coordinate with medical care when appropriate.
- Current environment: ongoing interpersonal danger, unstable housing, caregiving demands, court/legal stress, sleep deprivation, or limited support that may change pacing.
- Capacity to notice internal experience without becoming persistently overwhelmed or disconnected, and ability to use agreed stabilization strategies.

Not a blanket contraindication list

Many complex presentations can receive trauma-focused treatment with appropriate assessment, pacing, adaptation, and consultation. The question is not simply "Does the client have condition X?" but "Can this client engage in this phase of EMDR safely and effectively right now, and what support is required?"

Pre-reprocessing readiness checklist

- ☐ Informed consent for EMDR and BLS obtained
- ☐ Target rationale is linked to case formulation
- ☐ Client can use a stop/pause signal and therapist will honor it immediately
- ☐ Client demonstrates adequate present orientation
- ☐ At least one workable regulation/grounding strategy is available
- ☐ Plan exists for incomplete processing and between-session activation
- ☐ Risk assessment is current
- ☐ Clinician is within competence; consultation obtained when needed

4. Phase 1 - History Taking & Treatment Planning

Phase 1 establishes the clinical map. Gather enough history to understand symptoms, developmental context, attachment/relationship patterns, trauma/adversity, strengths, medical and psychiatric factors, and current functioning without pushing for unnecessary detail before the client is ready.

Core tasks

- Clarify the client's goals in behavioral and functional terms: sleep, driving, intimacy, work performance, panic, avoidance, relationships, shame, anger, nightmares, etc.
- Identify trauma/adverse experiences and symptom-linked memory networks while pacing disclosure carefully.
- Assess protective factors, cultural/contextual meaning, coping history, values, spirituality, relationships, and external supports.
- Identify possible touchstone or feeder experiences only when clinically useful; avoid forcing a linear trauma narrative.
- Develop a preliminary past-present-future target sequence.

- Determine whether additional assessment, stabilization, referral, or interdisciplinary collaboration is needed.

Case conceptualization prompts

Area	Prompts
Trigger	What reliably activates the problem now?
Meaning	What does the trigger seem to say about the client or the world?
Pattern	What emotion, body sensation, urge, avoidance, or relational response follows?
Origin	When has the client felt something similar before?
Resource	When does the client feel capable, connected, safe enough, or effective?
Goal	What would be observably different if treatment worked?

5. Phase 2 - Preparation

Preparation is individualized. Some clients need brief orientation; others need extended work on stabilization, alliance, affect tolerance, dissociation management, or environmental safety before reprocessing.

Explain EMDR in plain language

Example explanation

"We will identify experiences that still feel emotionally 'stuck.' At certain points I may ask you to notice a memory, thought, feeling, or body sensation while also following a left-right stimulus. You remain awake and in control. You can pause at any time. We will regularly check what you notice rather than forcing a particular response."

Preparation tasks

- Establish a stop/pause signal and explicitly rehearse that it will be honored immediately.
- Orient the client to dual attention: one foot in the memory/material, one foot in the present therapeutic room.
- Select BLS modality collaboratively, considering comfort, accessibility, culture, medical/visual needs, and telehealth logistics.
- Teach and practice one or more present-orientation/regulation strategies appropriate to the client.
- Discuss possible after-session activation, dreams, memories, emotions, fatigue, or insights and how the client will respond.
- Create an after-session plan: hydration/food as appropriate, reduced high-stakes demands when possible, support contact, journaling/logging if useful, and crisis resources when indicated.

Useful preparation resources (examples, not requirements)

- Slow orienting to the room and five-senses grounding.
- Breathing or paced exhalation when it helps rather than becoming a safety behavior.

- Calm/safe-enough place imagery if appropriate for the client; do not insist on “safe place” language when safety imagery is difficult or invalidating.
- Container imagery or intentional “setting aside” practice for material that emerges outside session.
- Resource development focused on competence, protection, nurturance, connection, or future coping, when within the clinician’s training.

6. Phase 3 - Target Assessment

Phase 3 activates the selected target and establishes baseline measures. Use the exact assessment sequence taught in your formal training. The worksheet below is a documentation aid, not a replacement for the trained protocol.

Target component	Record
Target event / memory	
Representative image or worst part	
Negative cognition (NC) about self now	
Desired positive cognition (PC)	
Validity of Cognition (VOC, 1-7)	
Primary emotion(s)	
Subjective Units of Disturbance (SUD, 0-10)	
Body location / sensation	

NC/PC quality check

Keep cognitions self-referential and relevant to the target. The positive cognition should represent an adaptive belief the client wants to hold now, not denial of what happened. Examples of themes include safety, responsibility, choice/control, value/worth, and connection/belonging.

7. Phase 4 - Desensitization / Reprocessing

During desensitization, the therapist facilitates repeated periods of dual-attention BLS while the client notices what arises. The therapist tracks processing without over-directing it, while continually monitoring orientation, distress, dissociation, physical comfort, and safety.

Basic clinician flow

1. Activate the target using the Phase 3 elements taught in training.
2. Begin BLS using the modality and parameters appropriate to the client and consistent with your training.
3. After a set, pause and invite a brief report of what is present now (image, thought, emotion, sensation, impulse, memory, or shift).
4. Use the client’s report to guide the next focus; avoid lengthy conversation that pulls the client away from processing unless clinically needed.
5. Continue while monitoring SUD, adaptive shifts, associative material, present orientation, and the client’s window of tolerance.

6. If processing stalls, first assess what is happening clinically rather than reflexively increasing intensity. Consider orientation, fear of change, blocking beliefs, dissociation, unmet information, secondary gain/protection, or an unaddressed feeder memory.
7. Use cognitive interweaves only within training and when processing is blocked; keep them brief and designed to restart the client's own processing rather than replace it.
8. Stop or shift to closure when time, safety, orientation, physiology, or clinical judgment indicates.

What to monitor continuously

Signal	Clinical response
Processing is moving	New associations, affect shifts, spontaneous adaptive perspectives, reduced disturbance, changed body sensation. Continue with minimal interference.
Client is overwhelmed	Slow down, orient to present, reduce intensity/length, increase distance, modify BLS, or return to stabilization as clinically indicated.
Client is disconnected / dissociative	Pause reprocessing, restore orientation, assess dissociation, and consult/adapt before continuing.
Processing is looping	Identify whether the client is repeating the same material without change. Consider blocking belief, incomplete information, feeder memory, or interweave within competence.
Sudden physical concern	Stop, assess, and address medical/physical safety. Change modality or refer for medical evaluation when indicated.

Therapist stance

Stay curious, non-leading, and regulated. EMDR is not a performance of eye movements; the clinical work is case conceptualization, pacing, dual attention, observation, responsiveness, and maintaining safety while adaptive processing unfolds.

8. Phase 5 - Installation

When the target disturbance has sufficiently resolved according to the trained protocol, return to the positive cognition and strengthen its association with the target.

- Check whether the original positive cognition still fits or whether a more accurate adaptive belief has emerged.
- Pair the target with the positive cognition using the installation procedure taught in training.
- Track VOC on the 1-7 scale and explore barriers if it does not strengthen as expected.
- Avoid pressuring the client to report a 7. A lower VOC can contain clinically meaningful information that may identify additional targets or blocks.

9. Phase 6 - Body Scan

After installation, ask the client to hold the target and positive cognition together and scan the body. Residual disturbance may indicate remaining processing needs even when cognitive distress has decreased.

- Invite a slow head-to-toe scan while maintaining present orientation.
- If neutral/positive, note completion according to protocol.
- If disturbing sensation remains, process it using the procedures taught in training and reassess.
- Distinguish trauma-linked activation from medical symptoms requiring separate assessment.

10. Phase 7 - Closure

Closure occurs at the end of every reprocessing session whether the target is complete or incomplete. The goal is adequate present orientation and stability - not pretending unfinished material has disappeared.

If the target is complete

- Confirm current orientation and emotional/physical state.
- Review what the client may notice between sessions and how to document new material if useful.
- Reinforce that new insights or dreams can be noted without deliberately analyzing or reactivating the target outside session.

If the target is incomplete

- Stop reprocessing with enough time for closure.
- Clearly state that the work is unfinished and will be reevaluated next session.
- Use stabilization/present-orientation strategies appropriate to the client.
- Confirm the after-session plan and crisis/safety plan when relevant.
- Document the level of disturbance, last material noticed, orientation, and how stability was restored.

Do not promise "nothing will come up."

Prepare clients realistically for continued processing or temporary activation. Encourage them to observe and record clinically useful changes while using agreed coping strategies and seeking urgent help if safety concerns arise.

11. Phase 8 - Reevaluation

Reevaluation begins the next session after reprocessing. It is not merely asking whether the client feels better. Reassess the target, symptoms, functioning, new associations, current triggers, and the treatment plan.

Reevaluation prompts

- When you bring up the target now, what do you notice?
- What has changed since the last session - emotionally, physically, behaviorally, relationally, or in dreams/memories?
- Is the SUD still low? Does the positive cognition still feel true? Is the body clear?
- Did any new memory, trigger, belief, or "feeder" material emerge?
- Has real-world behavior changed in the direction of the treatment goal?
- Do we continue this target, move to another past target, address a present trigger, or develop a future template?

12. When Processing Becomes Difficult

Complex processing is a signal to conceptualize, not to force. When the client becomes stuck, first assess what is maintaining the block and whether the client remains within an appropriate window for processing.

Pattern	Consider
Repeated loop with no shift	Blocking belief, loyalty conflict, fear of consequences, missing information, feeder memory, secondary protection, insufficient preparation.
Sudden numbness / blankness	Dissociation, protective shutdown, fatigue, shame, fear of therapist judgment, overactivation followed by collapse.
Distress escalates without recovery	Insufficient dual attention, target too broad, inadequate preparation, current danger, complex trauma network, need for pacing/adaptation.
Client intellectualizes	Protective strategy, fear of affect, shame, therapist over-questioning, insufficient body/emotion access.
Positive cognition will not install	PC may be unrealistic, target not fully processed, conflicting memory network, present-day danger, entrenched shame, or another target needs attention.

Cognitive interweaves

Interweaves are advanced clinical interventions for blocked processing. Use them only as taught in EMDR training/consultation. They should be brief, strategically chosen, and followed by a return to the client's processing rather than turning EMDR into a therapist-led cognitive discussion.

13. Special Populations and Adaptations

Standard EMDR procedures may require developmentally, culturally, medically, or clinically informed adaptations. Adaptation should preserve the underlying treatment logic while remaining within competence.

- Children/adolescents: integrate caregiver involvement as appropriate, developmental language, shorter attention demands, play/creative methods, and safety/consent requirements.
- Complex trauma/dissociation: emphasize phased assessment, present orientation, parts-informed conceptualization when trained, pacing, and consultation. Do not use aggressive reprocessing simply to "break through."
- Telehealth: establish privacy, emergency location/contact procedures, technology backup, BLS method, screen fatigue considerations, and a plan if connection drops during activation.
- Recent/ongoing trauma: distinguish past memory processing from current danger and practical safety needs. Stabilization and environmental intervention may take priority.
- Medical/neurological conditions: select BLS modality thoughtfully and coordinate with medical providers when symptoms or risks warrant.
- Couples/family context: be clear about who the EMDR client is, confidentiality boundaries, treatment goals, and whether conjoint work creates safety or disclosure complications.

14. Suggested Session Structure

EMDR is phase-based rather than rigidly session-based. A single session may contain several phases, and Phases 1-2 may span multiple visits. The following structure is a workflow aid, not a fixed treatment dose.

Session segment	Clinician tasks
Opening / check-in	Risk/safety update, interval changes, current functioning, medication/substance/medical changes when relevant.
Reevaluation	Review prior target and between-session processing.
Treatment decision	Continue target, select new target, return to preparation, or address current trigger/future template.
Reprocessing work	Use Phases 3-6 as indicated and within available time.
Closure	Ensure present orientation and adequate stability; review after-session plan.
Documentation	Record target, measures, BLS modality, key shifts, completion status, safety, and next plan.

Example course of care - flexible

Stage	Possible focus
Early sessions	History, case formulation, risk/readiness, psychoeducation, preparation, target mapping.
Middle sessions	Reprocessing selected past targets; reevaluation; present triggers as indicated.
Later sessions	Remaining triggers, future templates, functional rehearsal, relapse/maintenance planning, termination.
Complex presentations	May cycle repeatedly through assessment, preparation, reprocessing, and stabilization over a longer course.

15. EMDR Session Documentation Template

Use the template below alongside your agency/EHR requirements. Document enough to show clinical reasoning, safety, progress, and continuity without unnecessarily recording graphic trauma details.

Field	Documentation prompt
Clinical focus / diagnosis	Symptoms and functional target addressed.
Phase(s) used	1 / 2 / 3 / 4 / 5 / 6 / 7 / 8.
Target identifier	Brief, non-graphic label and approximate age/time if relevant.
NC / PC	Negative cognition; desired/installed positive cognition.
Baseline measures	VOC, SUD, emotion, body sensation/location.
BLS modality	Eye movements / taps / tones / other; note clinically relevant adaptation.
Processing summary	Key shifts/associations in concise clinical language;

Field	Documentation prompt
	blocks/interweaves if used.
End-state measures	SUD, VOC, body scan, complete vs incomplete.
Closure / stability	Present orientation, regulation strategy, client response.
Risk / safety	Changes in SI/HI/self-harm/abuse risk or other relevant concerns.
Plan	Next target/phase, homework/logging if any, consultation/referral needs.

Sample concise note

Example

EMDR Phase 8 reevaluation and Phases 3-7 used for a trauma-linked driving target. Client reported target remained distressing at start; target image, NC/PC, affect, SUD, VOC, and somatic activation assessed. Dual-attention BLS used per trained protocol. Processing included reduced physiological activation and emergence of a more adaptive sense of present-day control. Session ended with target incomplete; client was fully oriented, used grounding successfully, denied acute safety concerns, and reviewed between-session coping/monitoring plan. Will reevaluate target next visit.

16. Quick Reference: Phase-by-Phase Clinician Checklist

Phase	Checklist
Phase 1	☐ Goals ☐ History/context ☐ Risk ☐ Resources ☐ Target map ☐ Readiness
Phase 2	☐ Consent ☐ Explain EMDR ☐ Stop signal ☐ BLS orientation ☐ Regulation ☐ After-session plan
Phase 3	☐ Target ☐ Image ☐ NC ☐ PC ☐ VOC ☐ Emotion ☐ SUD ☐ Body
Phase 4	☐ Dual attention ☐ BLS ☐ Notice/track ☐ Orientation ☐ SUD ☐ Blocks/safety
Phase 5	☐ Confirm PC ☐ Install ☐ VOC
Phase 6	☐ Body scan ☐ Process residual disturbance
Phase 7	☐ Complete/incomplete status ☐ Present orientation ☐ Stability ☐ Between-session plan
Phase 8	☐ Recheck target ☐ Interval processing ☐ Function ☐ Next target/phase

17. Client Handout: What to Expect After an EMDR Session

After an EMDR session, some people notice little change right away; others notice new thoughts, dreams, emotions, body sensations, memories, or shifts in perspective. These experiences can vary. Your therapist will help you decide what is clinically important to track.

Between sessions

- Notice what comes up without forcing yourself to analyze or re-live the memory.
- If useful, briefly write down a new memory, dream, trigger, thought, body sensation, or insight so you can discuss it next session.
- Use the grounding or regulation strategies you practiced with your therapist.
- Continue basic care: sleep routine, meals, hydration, movement, medication as prescribed, and supportive connection when possible.
- Avoid deliberately testing yourself with major trauma triggers unless that is part of a treatment plan you and your therapist developed together.
- If you feel unsafe, have thoughts of harming yourself or someone else, or experience a medical emergency, use your safety plan and seek urgent/emergency help rather than waiting for your next appointment.

Remember

You remain in control during EMDR. You can ask to slow down, pause, change the stimulation method, or stop. Treatment should be collaborative and paced to your needs.

18. Training, Consultation, and Evidence Resources

Clinicians should use this guide together with formal EMDR training materials, consultation, and current clinical practice guidelines. Key resources used to inform this original guide include:

- EMDR International Association (EMDRIA). “Language of EMDR” - eight phases and phase descriptions. https://www.emdria.org/glossary/language-of-emdr/
- EMDRIA. “EMDR Basic Training” - curriculum, practicum, and consultation expectations. https://www.emdria.org/emdr-training/
- EMDRIA. “8 Phases of EMDR Therapy Infographic.” https://www.emdria.org/resource/8-phases-of-emdr-therapy-infographic/
- American Psychological Association. “Eye Movement Desensitization and Reprocessing (EMDR) Therapy.” https://www.apa.org/ptsd-guideline/treatments/eye-movement-reprocessing
- American Psychological Association. 2025 Clinical Practice Guideline for the Treatment of PTSD in Adults. https://www.apa.org/ptsd-guideline
- U.S. Department of Veterans Affairs, National Center for PTSD. “Eye Movement Desensitization and Reprocessing for PTSD.” https://www.ptsd.va.gov/professional/treat/txessentials/emdr_pro.asp
- Shapiro, F. (2018). Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols, and Procedures (3rd ed.). Guilford Press. Standard reference text; obtain through publisher/library.

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