

EMDR Therapy Quick Reference Card

A Clinical Guide for Trauma-Informed Practice

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The Adaptive Information Processing (AIP) Model

EMDR is based on the Adaptive Information Processing model, which proposes that:

Principle	Description
Natural Healing Capacity	The brain has an innate capacity to process experiences adaptively toward health and resolution.
Trauma Blocks Processing	Traumatic experiences can overwhelm this natural system, causing memories to be stored maladaptively with original emotions, sensations, and beliefs intact.
Memory Networks	Memories are stored in associatively linked networks; processing one memory can affect related memories.
Bilateral Stimulation	Alternating left-right stimulation facilitates access to and processing of maladaptively stored material.
Three-Pronged Approach	Treatment addresses past memories, present triggers, and future templates.

“The past is present.” — Francine Shapiro, Ph.D.

The Eight Phases of EMDR

Phase 1: History Taking & Treatment Planning

Purpose: Develop therapeutic alliance, assess history, identify targets

Key Activities:

- Develop secure working relationship
- Assess client history and presenting issues
- Identify target memories for processing
- Evaluate resources and readiness

Clinical Note: Assess both internal and external resources. Some clients need significant time in phases 1 and 2 before moving on.

Phase 2: Preparation

Purpose: Explain process, establish safety, develop coping skills

Key Activities:

- Explain EMDR process and terms
- Address concerns and questions
- Teach coping techniques (Safe Place, Container)
- Establish therapeutic safety

Clinical Note: Ensure client has adequate stabilization skills before proceeding. Never skip this phase.

Phase 3: Assessment

Purpose: Identify target and establish baseline measures

Key Activities:

- Identify target image (worst part of memory)
- Establish Negative Cognition (NC)
- Identify desired Positive Cognition (PC)
- Rate SUD (0-10) and VOC (1-7)
- Locate body sensations

Clinical Note: The NC should be an irrational, present-tense self-belief (e.g., “I am worthless”). The PC should be desired and realistic.

Phase 4: Desensitization

Purpose: Process the traumatic material until SUD = 0

Key Activities:

- Begin bilateral stimulation (BLS)
- Process emerging material without leading
- Check SUD periodically
- Continue until SUD reaches 0

Clinical Note: Follow the client's process with "Go with that." Trust the brain's natural healing capacity. Don't lead or interpret.

Phase 5: Installation

Purpose: Strengthen positive cognition until VOC = 7

Key Activities:

- Link PC to target memory
- Strengthen with BLS
- Check VOC
- Continue until VOC = 7

Clinical Note: If VOC doesn't reach 7, explore what prevents full belief. There may be blocking beliefs or additional material.

Phase 6: Body Scan

Purpose: Clear any remaining somatic disturbance

Key Activities:

- Scan body from head to toe
- Notice any tension or disturbance
- Reprocess remaining sensations
- Achieve clear body scan

Clinical Note: The body holds trauma. Complete processing requires clearing somatic residue.

Phase 7: Closure

Purpose: Return client to equilibrium, prepare for between-session processing

Key Activities:

- Return to calm state
- Debrief session
- Prepare for between-session processing
- Provide self-care instructions

Clinical Note: Never leave a client in distress. Use Safe Place, Container, or other stabilization techniques as needed.

Phase 8: Reevaluation

Purpose: Ensure processing held, address new material

Key Activities:

- Review previous targets
- Check SUD and VOC
- Address new material that emerged
- Plan next targets

Clinical Note: Always begin subsequent sessions with reevaluation to ensure gains are maintained.

Assessment Protocol

The Target Memory Components

Component	Question	Scale
Image	“What image represents the worst part of the incident?”	N/A
Negative Cognition	“What words go best with that picture that express your negative belief about yourself now?”	N/A
Positive Cognition	“When you bring up that picture, what would you like to believe about yourself now?”	N/A
VOC	“When you think of the incident, how true do those words [PC] feel to you now on a scale of 1-7?”	1-7
Emotions	“What emotion(s) do you feel now?”	N/A
SUD	“On a scale of 0-10, where 0 is no disturbance and 10 is the highest disturbance, how disturbing does it feel now?”	0-10
Body Location	“Where do you feel it in your body?”	N/A

Common Negative Cognitions

Category	Examples
Responsibility	“I should have done something,” “It’s my fault”
Safety	“I am in danger,” “I cannot trust anyone”
Control	“I am powerless,” “I am out of control”
Self-Worth	“I am worthless,” “I am not good enough,” “I am unlovable”
Defectiveness	“I am damaged,” “There is something wrong with me”

Corresponding Positive Cognitions

Category	Examples
Responsibility	"I did the best I could," "It's over; I survived"
Safety	"I am safe now," "I can choose whom to trust"
Control	"I am in control now," "I have choices"
Self-Worth	"I am worthy," "I am good enough," "I am lovable"
Defectiveness	"I am okay as I am," "I am whole"

Session Language

Assessment Phase

- "What image represents the worst part of the incident?"
- "What words go best with that picture that express your negative belief about yourself now?"
- "When you bring up that picture, what would you like to believe about yourself now?"
- "When you think of the incident, how true do those words feel to you now on a scale of 1-7?"
- "On a scale of 0-10, where 0 is no disturbance and 10 is the highest disturbance, how disturbing does it feel now?"
- "Where do you feel it in your body?"

Desensitization Phase

- "Bring up the picture, the words, and notice where you feel it in your body. Follow my fingers."
- "What do you get now?"
- "Go with that."

- “Notice that.”
- “Just notice.”
- “What comes up?”

Installation Phase

- “Do the words still fit, or is there another positive statement that would be more suitable?”
- “Think of the original event and hold it together with the words. How true do they feel now, 1-7?”

Body Scan

- “Close your eyes, concentrate on the incident and the positive cognition, and mentally scan your entire body. Tell me where you feel anything.”

Closure

- “The processing we’ve done today may continue after the session. You may or may not notice new insights, thoughts, memories, or dreams.”
- “If anything comes up, just notice it, write it down, and we can work on it next time.”

Complex Trauma Modifications

Extended Preparation Phase

Complex trauma survivors often need significantly more time in Phase 2.

- Build robust stabilization skills before any processing
- Develop multiple resources (Safe Place, Container, Resource Development and Installation)
- Ensure adequate window of tolerance

Fractionated Processing

Work with smaller pieces of traumatic material.

- Target specific moments rather than entire events
- Use “slice of the pie” approach
- Stop processing before overwhelm

Addressing Dissociation

Be alert to dissociative responses during processing.

- Establish grounding protocols before beginning
- Use “back of the head” scale (0-10) to monitor dissociation
- Stop and stabilize if dissociation increases

Working with Parts

Complex trauma often involves structural dissociation.

- Identify and work with protective parts
- Ensure all parts consent to processing
- Use ego state protocols when indicated

Pacing Considerations

- Shorter processing sets
 - More frequent check-ins
 - Extended closure procedures
 - Longer between-session intervals when needed
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Key Techniques

Safe Place

A visualization technique for stabilization where the client imagines a calm, peaceful place.

Use: Before processing, during closure, between sessions for self-regulation.

Container

A visualization technique for temporarily storing disturbing material.

Use: When processing is incomplete, to contain material between sessions.

Floatback

A technique where the client “floats back” to identify earlier memories connected to current disturbance.

Use: To identify touchstone memories, when current targets don’t fully resolve.

Cognitive Interweave

A strategy used when processing is blocked, where the therapist offers information to stimulate adaptive processing.

Use: When looping occurs, when client is stuck, when safety/responsibility/choice information is needed.

Future Template

Processing anticipated future situations to install adaptive responses.

Use: After past and present triggers are processed, to prepare for future challenges.

Key Glossary Terms

Term	Definition
AIP Model	Adaptive Information Processing—the theoretical foundation of EMDR
Bilateral Stimulation (BLS)	Alternating left-right stimulation (eye movements, taps, tones)
Negative Cognition (NC)	Irrational, negative self-belief connected to the trauma
Positive Cognition (PC)	Desired adaptive self-belief
SUD Scale	Subjective Units of Disturbance (0-10)
VOC Scale	Validity of Cognition (1-7)
Target Memory	The specific memory selected for processing
Touchstone Memory	Earliest/most significant memory in a network
Cognitive Interweave	Therapist-offered information to unblock processing
Looping	Stuck processing, returning to same material repeatedly

Founder & Historical Context

Dr. Francine Shapiro discovered EMDR in 1987 when she noticed that eye movements reduced the intensity of disturbing thoughts. She developed and refined the approach through rigorous research.

Key Insight: Traumatic memories are stored differently than ordinary memories, maintaining their original vividness and emotional charge. EMDR facilitates the brain’s natural processing system to integrate these memories adaptively.

Foundational Texts:

- *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures* (Shapiro, 2018, 3rd Edition)
- *Getting Past Your Past* (Shapiro, 2012)

Evidence Base: EMDR is recognized as an effective treatment for PTSD by:

- World Health Organization (WHO)
 - American Psychological Association (APA)
 - Department of Veterans Affairs/Department of Defense
 - International Society for Traumatic Stress Studies (ISTSS)
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Professional Organizations

- **EMDR International Association (EMDRIA)** - emdria.org
 - **Evergreen Certifications** - EMDR-C certification with complex trauma foundation
 - **EMDR Europe** - emdr-europe.org
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This quick reference card is intended as a clinical aid and does not replace comprehensive EMDR training. EMDR certification requires completion of an EMDRIA-approved training program.

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