EMDR Foundations

THE TALKING THERAPIES UK PRACTITIONER SERIES



EMDR Foundations

The adaptive information processing model and the eight phases

Foundation level · 7 hours of continuing professional development

TALKING THERAPIES UK

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First edition, 2026.

This manual accompanies the EMDR Foundations course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

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A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

Set in Poppins and Roboto, the Talking Therapies UK typefaces. Figures drawn by the Talking Therapies UK teaching-diagram engine.

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How to use this manual

This comprehensive foundation course offers a rigorous introduction to Eye Movement Desensitisation and Reprocessing (EMDR) for clinicians and trainees new to the approach. The curriculum is built upon the Adaptive Information Processing model, which provides the essential theoretical framework for understanding how EMDR facilitates the resolution of traumatic memories. You will examine the robust evidence base supporting EMDR within national trauma treatment guidelines, gaining clarity on its efficacy and appropriate application. The training proceeds through the eight-phase standard protocol, guiding you from the initial history-taking and case conceptualisation to the critical phase of preparation, where Resource Development and Installation are prioritised to ensure client safety. You will learn to identify targets using the Subjective Units of Disturbance (SUDs) scale and navigate the complex process of Desensitisation utilising Dual Attention Stimuli. The course concludes with detailed instruction on Installation, the Body Scan, Closure, and Re-evaluation, ensuring a complete understanding of the therapeutic journey. By mastering these phases, you will develop the professional and ethical competence required for client selection and readiness assessment, providing the vital conceptual grounding necessary before undertaking supervised skills practice. This seven-hour programme is designed to meet the standards of recognised EMDR training, equipping you with the knowledge to begin integrating this powerful trauma therapy into your practice.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at foundation level and carries 7 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the conventional form of a model you will meet in the literature and in supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

What this manual will leave you able to do

- Explain the adaptive information processing model and what it says trauma symptoms are
- Describe all eight phases of the standard EMDR protocol and each one's function
- Explain bilateral stimulation and the evidence on its role honestly
- Take a trauma history and build a target sequence plan
- Prepare clients properly: resourcing, safe place and informed consent
- State clearly what EMDR practice requires by way of accredited training and supervision

PART 1

The model and the evidence

Adaptive information processing and EMDR's place in trauma treatment.

CHAPTER 1

The adaptive information processing model

Eye Movement Desensitisation and Reprocessing rests on a claim about memory, and the claim must be understood before any technique makes sense: psychological difficulty, in this model, is substantially the result of unprocessed memory. The Adaptive Information Processing model, the framework Shapiro built beneath her clinical discovery, holds that the brain possesses an innate system for digesting experience, taking the day's events, linking them into existing memory networks, extracting what is useful and letting the affect discharge, the work done substantially in sleep, and that ordinary distress resolves because this system works. What we learn from a bad day integrates; the sting fades; the lesson remains. Trauma, in this account, is what happens when an experience overwhelms the system: encoded at high arousal, the memory is stored in state-specific form, isolated from the networks that would contextualise it, frozen with its original images, emotions, sensations and beliefs intact, and unable to link to anything that would update it.

The maladaptively stored memory then behaves exactly as the clinical picture describes. Triggered by cues that match its fragments, it fires whole: the affect of the original event, the body state, the belief, delivered into the present at original intensity, which is why a survivor does not remember fear so much as have it again. Because the memory cannot link, experience that should correct it never reaches it: twenty years of safety leave the frozen network untouched, the person knowing they are safe and feeling hunted, the two systems unacquainted. And because networks associate, the frozen material becomes a hub: later experiences that resemble it attach to it rather than to adaptive networks, symptoms generalise, and a present-day slight can draw its charge from a decades-old injury, the model's explanation for reactions that puzzle everyone including their owner. Pathology, in the AIP frame, is thus not disease but arrested digestion: the system that should have processed the experience was overwhelmed, and the material waits, intact, for processing to become possible.

Treatment follows with unusual directness: make processing possible. EMDR's procedures access the frozen network deliberately, bringing up the image, the belief, the emotion, the body sensation, the memory's full address, and then, with the network active, apply bilateral stimulation, classically side-to-side eye movements, alternatively taps or tones, in repeated sets, while the client is instructed simply to notice what happens. What happens, in successful processing, is linkage: the frozen material begins associating, spontaneously, to other memories, thoughts, feelings, perspectives, the adaptive networks finally reaching it, and across sets the memory transforms, distress falling, the image receding or changing, insight arriving unprompted, the person saying, with some surprise, it feels like a long time ago, or I was a child, it was not my fault, conclusions nobody suggested. The model's word for this is reprocessing: the digestion completed, the memory re-stored in integrated form, informative rather than intrusive.

What bilateral stimulation contributes is the model's most researched and most debated element, and honest teaching presents it honestly. The dominant mechanistic accounts: working-memory taxation, the dual task of holding the memory while tracking the stimulus degrades the memory's vividness and emotional charge, an effect replicated across many laboratory studies and indifferent to the modality of the second task; and an orienting-response account linking the stimulation to the physiology of REM sleep, the system in which ordinary consolidation runs. What the evidence supports with confidence is the treatment's efficacy as a whole package; what remains argued is the necessary contribution of the eye movements themselves, with meta-analytic support for an additive effect alongside a literature that keeps the question open. The clinical stance this course teaches: deliver the protocol as validated, hold the mechanism claims with scientific manners, and promise clients the outcome evidence, not a neurology lecture.

What reprocessing changes, concretely, is worth fixing before technique arrives, because it defines the treatment's targets and its endpoints. The memory's affective charge: distress ratings falling towards zero and staying there. Its cognitive residue: the negative self-belief encoded with the event, I am powerless, I am dirty, it was my fault, replaced by an adaptive alternative the client can hold as true. Its somatic footprint: the body scan clear, the clench and drop gone when the memory is deliberately summoned. And its

behavioural shadow: the avoidances and triggers organised around the memory losing their necessity. The past event is not forgotten, the model is emphatic, and grief where grief belongs remains; what changes is the storage, from present-tense wound to past-tense fact.

Two boundaries keep the model honest in teaching and in the room. First, AIP is a clinical working model, powerful as formulation and heuristic, and its neurological claims are hypotheses of varying maturity; the practitioner speaks of networks and linkage as the useful clinical language it is, without dressing it as settled neuroscience. Second, the model is not a claim that all suffering is trauma: grief, circumstance, biology and meaning have their own territories, and the AIP question is always specific, is there identifiable experience, stored and unintegrated, plausibly driving this presentation? Asked with that discipline, the model routes the right people towards the treatment; asked as ideology, it routes everyone, and treats the formulation's failure as the client's resistance.

Hold the model against one person to see its explanatory reach. A man of forty, competent and liked, collapses into disproportionate shame whenever a supervisor glances at his work without comment. In AIP terms the present cue, silent scrutiny, matches a network: a father at the kitchen table, red pen in hand, the boy's homework wordlessly corrected, the encoded belief nothing I do is good enough, stored at eight years old with its full affect and never updated by thirty years of contrary evidence, because frozen networks do not take deliveries. The supervisor is not the problem; the address the cue reaches is, and treatment that argued with the present, reassurance, appraisal work on the supervisor's actual opinion, would leave the network untouched. EMDR's wager is to go to the address: process the kitchen table, and the glance loses its power source. Close by writing one such pairing from your own caseload, the present trigger and the past address the AIP model would hypothesise beneath it, with the encoded belief named. The next lesson places the model inside the evidence and the guidelines, and teaches whom this treatment is for.

Going deeper: AIP as a working clinical instrument.

The AIP model does its best work when treated as an instrument rather than a creed. Its clinical claims are three. First, pathology is located in memory: present symptoms are the activation of inadequately processed memories held with their original affect, sensation and belief — which is why EMDR's

history-taking is really target-mapping, tracing today's trigger back along associative channels to the memories that taught the response. Second, the system is self-righting given access: like a wound that heals once debris is removed, the processing system moves material towards adaptive resolution when the memory is activated within dual attention — a claim with the practical corollary that the therapist's job during sets is to stay out of the way, following rather than steering. Third, resolution is linkage: a processed memory has connected with adaptive networks — 'it is over', 'I did survive', 'I was a child' — so the model predicts treatment ends not with erasure but with information rearranged: the event recalled, the charge gone, the belief updated.

Used diagnostically, AIP reframes case formulation as a memory audit: for this presentation, which experiences installed the negative cognition, which maintain it, and which future situations will test its replacement — yielding EMDR's three-pronged plan of past, present and future targets.

Hold the model's scientific status honestly, as the course's ethic requires: AIP is a fertile clinical heuristic whose treatment works robustly in trials, while the mechanism of bilateral stimulation (working-memory taxation being the best-supported account) remains under investigation. Practitioners can use the instrument confidently while reporting its evidence precisely.

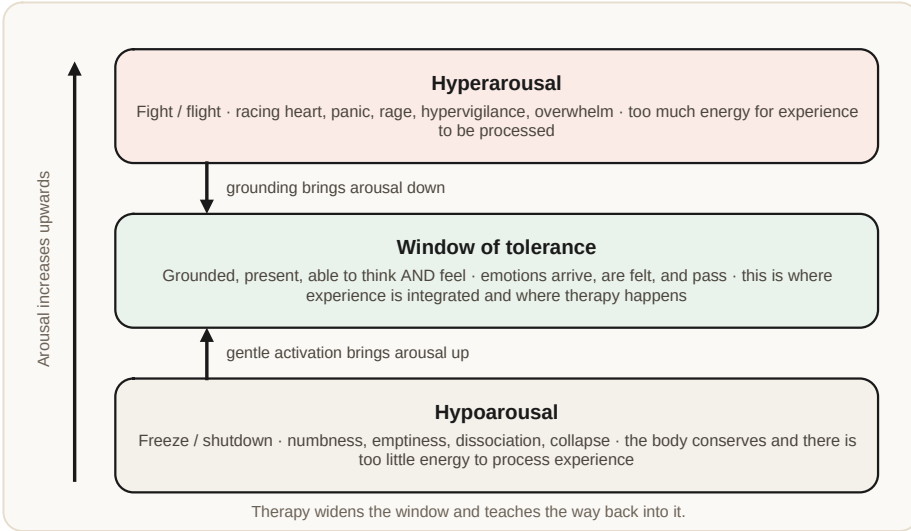


FIGURE 1.1 The window of tolerance

Siegel's window of tolerance describes the zone of arousal within which experience can be processed and integrated. Trauma narrows the window: survivors are thrown into hyperarousal (fight/flight) or hypoarousal (shutdown) by reminders. Therapy widens the window and teaches the return journey.

Points worth keeping

- Maladaptively stored memory
- The adaptive information processing model
- The role of bilateral stimulation
- What reprocessing changes

PRACTICE TASK

Explain the AIP model to a client in plain language.

CHAPTER 2

Evidence and indications

The journey of eye movement desensitisation and reprocessing (EMDR) from a novel observation to a guideline-endorsed treatment is a case study in how empirical rigour can transform clinical practice. The first systematic observation by Francine Shapiro in 1987, followed by the inaugural randomised controlled trial in 1989, placed EMDR on a research agenda that has since been populated by dozens of controlled studies, meta-analyses, and systematic reviews. Throughout the 1990s and early 2000s, EMDR was subjected to direct comparison with wait-list controls, with active comparators such as trauma-focused cognitive behavioural therapy (CBT), and with other exposure-based interventions. The accumulation of evidence was not linear; early trials were modest in size and sometimes suffered from methodological limitations, yet the overall pattern of effect sizes consistently favoured EMDR for the reduction of post-traumatic stress disorder (PTSD) symptoms as measured by instruments such as the Clinician-Administered PTSD Scale (CAPS-5) and the PTSD Checklist (PCL-5). Meta-analytic syntheses, for example those conducted by Bisson and colleagues (2007) and later by Lee and Cuijpers (2013), demonstrated that EMDR's pooled standardised mean difference was comparable to that of trauma-focused CBT, with the added observation that EMDR often required fewer sessions and did not demand between-session homework. These findings were sufficient for the National Institute for Health and Care Excellence (NICE) to issue its 2018 guideline recommending EMDR as a first-line psychological intervention for PTSD in adults, placing it alongside trauma-focused CBT and specifying a high strength of recommendation. The World Health Organization (WHO) echoed this endorsement in its 2013 mental health gap action programme, and the International Society for Traumatic Stress Studies (ISTSS) has listed EMDR among the evidence-based treatments for trauma-related disorders. The headline for commissioners and clinicians is therefore clear: EMDR is one of only two psychological treatments that enjoys first-line status for PTSD in major UK and international guidelines, with an evidence base that is both robust and clinically relevant.

Beneath this headline, however, lie important nuances that must be conveyed to trainees. Component analyses of the EMDR protocol have generated ongoing debate about the specific contribution of bilateral stimulation, whether in the form of eye movements, tactile taps, or auditory tones. Laboratory studies have shown that bilateral stimulation can reduce vividness and emotional intensity of recalled images, supporting the working memory hypothesis advanced by van der Kolk and colleagues (2002). Clinical dismantling studies, though fewer in number, have produced mixed results, with some suggesting that the core elements of the protocol—such as the eight-phase structure and the dual-attention stimulus—are sufficient for therapeutic gain, while others argue that bilateral stimulation adds incremental benefit. The quality of trials varies, and the strongest conclusions should be drawn from the most methodologically rigorous studies, typically those with adequate sample sizes, concealed allocation, and blinded outcome assessment. Beyond PTSD, the evidence for EMDR in other diagnostic categories such as major depressive disorder, anxiety disorders, chronic pain, and substance use disorders is emerging but less mature. Systematic reviews indicate promising effect sizes for depression and specific phobias, yet the confidence intervals are wider and the number needed to treat is higher than for PTSD. Clinicians must therefore adopt a gradient of confidence: high for PTSD, moderate for trauma-adjacent conditions, and exploratory for more distal applications. This gradient is not a limitation but a reflection of the ethical imperative to provide informed consent based on the current state of the evidence.

Indications for EMDR follow directly from the evidence hierarchy. The most unequivocal indication is PTSD and clinically significant post-traumatic stress symptoms in adults, particularly when the index trauma is a single, discrete event such as a motor vehicle collision, a physical assault, or a natural disaster. In these cases the standard EMDR protocol can be applied with minimal adaptation, allowing the therapist to follow the eight-phase sequence—history taking, preparation, assessment, desensitisation, installation, body scan, closure, and re-evaluation—without substantial deviation. The evidence also supports the use of EMDR for complex trauma presentations, where multiple or chronic traumatic experiences are present. Here the protocol is often employed in a phased manner, beginning with stabilisation and resource development before targeting the most distressing memories, a strategy that aligns with the Adaptive Information

Processing (AIP) model's premise that unprocessed memories can be stored in a dysfunctional network and that bilateral stimulation facilitates their integration. Children and adolescents with PTSD are another well-supported group; developmental adaptations such as shortened phases, the use of age-appropriate metaphors, and parental involvement have been validated in randomised trials and are reflected in the NICE guideline's recommendation for use with younger clients. Beyond the core PTSD population, clinicians may consider EMDR for trauma-adjacent conditions when a clear, memory-based formulation can be articulated. Examples include specific phobias that originated from a single frightening incident, complicated grief where the loss is intertwined with a traumatic element, and depressive episodes where intrusive memories of humiliation or failure appear to drive mood. In each of these scenarios the therapist must explicitly link the presenting problem to a target memory, describe the AIP hypothesis, and justify the selection of EMDR over alternative modalities.

Contraindications and cautions must be presented not as a binary exclusion list but as a readiness map that guides clinical decision-making. Absolute contraindications are few. Acute unmanaged psychosis, where reality testing is compromised, precludes the safe use of EMDR because the client may be unable to differentiate between internal imagery and external stimuli. Active severe substance dependence that is likely to interfere with the consolidation of new memory networks also warrants postponement of EMDR until a period of stability is achieved. Situations in which the client cannot be kept safe during high-affect work, such as an environment with ongoing interpersonal violence, constitute a hard stop until safety can be assured. Relative cautions are more common and require proactive management. Significant dissociation, identified through tools such as the Dissociative Experiences Scale (DES) or the Structured Clinical Interview for DSM-5 Dissociative Disorders, must be screened for in every assessment because the processing phase of EMDR demands sustained attention to both the target memory and the present moment. Unrecognised dissociative structures have historically led to adverse outcomes, prompting the development of the "safe place" resource phase and the use of grounding techniques before proceeding. Unstable risk, including acute suicidality, demands a separate risk-management plan that is implemented before any trauma work begins. Ongoing trauma, such as continued domestic abuse, requires that the therapist first address safety and stabilisation, often

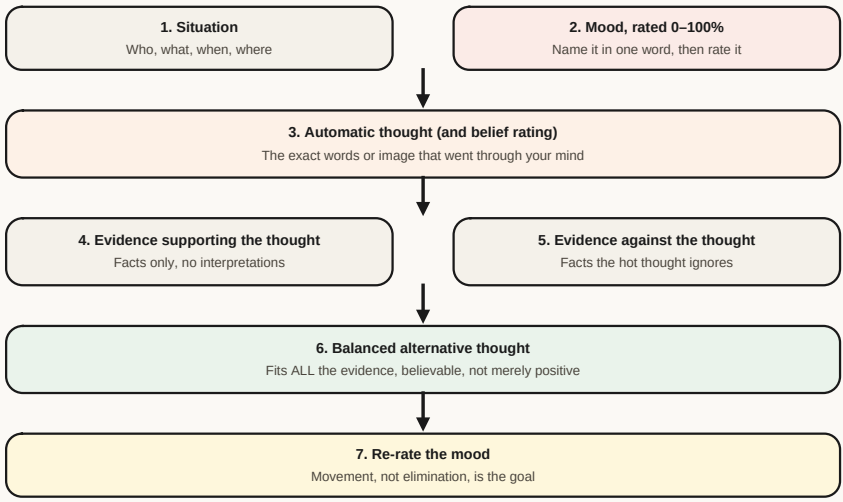
through phase-one interventions, before moving to memory desensitisation. Severe personality-level difficulties, particularly borderline personality disorder with marked affective instability, benefit from a phased approach that emphasises resource installation and affect regulation prior to targeting traumatic memories. Medical considerations such as pregnancy, cardiac conditions, or seizure disorders do not automatically preclude EMDR, but they necessitate titration of bilateral stimulation intensity, close liaison with medical providers, and careful monitoring of physiological responses. Practical considerations—such as a client facing imminent eviction or severe housing instability—may render the timing of EMDR inappropriate, as the client's capacity to tolerate the emotional load is compromised.

Selecting suitable clients therefore involves a structured judgement that integrates formulation fit, stability, capacity, and willingness. Formulation fit refers to the plausibility of an AIP-based explanation for the client's presenting problems, requiring the therapist to identify at least one target memory that can be linked to the current symptomatology. Stability encompasses the assessment of dissociation, risk, and environmental safety, ensuring that the client can engage in the dual-attention task without being overwhelmed. Capacity is evaluated through a brief test of dual attention, often conducted during the preparation phase, where the client is asked to hold a simple visual or auditory stimulus while recalling a mildly distressing image, thereby demonstrating the ability to maintain the required split focus. Willingness is secured through a transparent consent conversation that outlines the nature of EMDR, the potential intensity of sessions, the client's right to signal a stop, and the evidence base supporting the intervention. Alternatives, particularly trauma-focused CBT, should be discussed openly, allowing the client to weigh the differing demands of homework, narrative exposure, and the less verbally intensive nature of EMDR. The final decision is then documented, reflecting the balance of evidence, client preference, and clinical judgement.

To illustrate the application of these principles, consider the case of Maya, a 34-year-old teacher who presents with intrusive memories, hypervigilance, and avoidance following a violent robbery that occurred two years ago. Maya scores 48 on the PCL-5, indicating severe PTSD, and reports that the memories are triggered by the sound of breaking glass. In the initial assessment, the therapist conducts a thorough risk evaluation, noting no current suicidality, no substance dependence, and a stable home

environment. The Dissociative Experiences Scale yields a score of 12, well below the threshold for clinically significant dissociation. The therapist formulates an AIP hypothesis linking Maya's hyperarousal and avoidance to the unprocessed memory of the robbery, identifies the flashback as the primary target, and confirms that Maya is motivated to engage in treatment after a clear explanation of EMDR's evidence base and procedural steps. During the preparation phase, Maya successfully demonstrates dual attention by tracking a moving dot while briefly recalling the sound of breaking glass, indicating sufficient capacity. The therapist then proceeds with the eight-phase protocol, using eye movements as the bilateral stimulus, and after eight sessions reports a reduction of Maya's PCL-5 score to 22, with the intrusive memories becoming less vivid and less distressing. This case exemplifies a clear indication, a thorough safety and capacity assessment, and an informed consent process that aligns with guideline recommendations.

In summary, the evidence supporting EMDR is anchored in a robust body of randomised trials, meta-analyses, and guideline endorsements that collectively position it as a first-line treatment for PTSD. The indications for EMDR are strongest for PTSD and trauma-related presentations where a memory-based formulation can be articulated, while the contraindications are limited to acute psychosis, severe uncontrolled substance dependence, and unsafe environments. Relative cautions such as dissociation, suicidality, ongoing trauma, and certain medical conditions require proactive management through stabilisation, resource installation, and collaborative care. Client selection rests on a four-component judgement—formulation fit, stability, capacity, and willingness—each of which must be documented and discussed with the client in the context of alternative evidence-based options. By integrating the evidence base, guideline recommendations, and a nuanced assessment of indications and cautions, clinicians can responsibly offer EMDR as a powerful tool for trauma recovery, ensuring that the therapeutic promise is matched by ethical and evidence-informed practice.



A 90% belief falling to 60% is a success; disqualifying the change is itself a thinking habit to name.

FIGURE 2.1 Working through a thought record

The classic seven-column thought record as a sequence: capture the situation and mood, catch the automatic thought, weigh the evidence on both sides, build a balanced alternative, and re-rate the mood. The learning is in the discipline of evidence before reassurance.

Points worth keeping

- The evidence base and guidelines
- Indications for EMDR
- Contraindications and cautions
- Selecting suitable clients

PRACTICE TASK

List two indications and two cautions for EMDR.