# EMDR in Practice

THE TALKING THERAPIES UK PRACTITIONER SERIES



# EMDR in Practice

## Delivering the standard protocol and managing processing

Practitioner level · 10 hours of continuing professional development

**TALKING THERAPIES UK**

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First edition, 2026.

This manual accompanies the EMDR in Practice 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 intermediate practitioner course serves as the critical bridge between foundational EMDR knowledge and independent clinical competence, focusing on the delivery of the standard protocol with precision and clinical judgement. Learners will engage in a deep dive into the preparatory phases, mastering the nuances of history taking within the Social GGRRAAACCEEESSS framework and constructing robust resourcing plans that empower clients to manage distress. The curriculum emphasises the art of desensitisation, teaching clinicians how to judiciously adjust bilateral stimulation and set size to facilitate adaptive information processing without overwhelming the client's capacity for integration.

The training moves beyond basic mechanics to address the complexities of managing blocked processing, equipping practitioners with a sophisticated toolkit of cognitive interweaves to re-engage stalled targets. Participants will learn to navigate the delicate balance of abreaction, distinguishing between necessary affective release and potential re-traumatization, while effectively identifying and managing dissociation. The course concludes with a detailed examination of the final phases of the protocol, ensuring learners can competently guide clients through installation of positive cognition and the comprehensive body scan to verify the resolution of somatic markers.

By prioritising safety and the successful completion of the protocol, this training prepares clinicians to deliver EMDR with autonomy and confidence. It is intended for professionals who have completed EMDR foundations or equivalent training and are seeking to refine their practice, ultimately fostering the high-level competence required for independent, evidence-based trauma therapy.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at practitioner level and carries 10 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

- Set up phase-three assessment precisely: image, negative and positive cognitions, VoC, emotion, SUD and body location
- Conduct desensitisation sets and respond to channels of association productively
- Recognise blocked processing and apply interweaves judiciously
- Complete installation and body scan, and close every session contained
- Re-evaluate at each session and work the target plan systematically
- Apply the three-pronged protocol: past events, present triggers and future templates

PART 1

# Foundations of EMDR Desensitisation and Resourcing

*This module covers the core mechanics, bilateral stimulation optimisation, and arousal management required for effective EMDR target processing.*

CHAPTER 1

# Preparation and resourcing

Preparation is the phase that determines whether every later phase is therapy or misadventure, and the practitioner course begins here deliberately: the craft of making a person genuinely ready, not procedurally briefed. Its four movements, explaining and consenting, building the calm place, developing resources, and confirming readiness, look administrative on paper and are clinical to their bones.

Explaining the process well is a rehearsable skill with a known standard. The client should finish the conversation holding five things. The model, in one honest paragraph: distressing experiences can be stored unprocessed, keeping their original charge; the procedure helps the brain finish processing them; what changes is how the memory is stored, not whether you remember. The procedure, concretely: you will hold the memory in a specific way, follow my fingers or the taps in sets, and simply notice what happens; between sets I will ask what you notice; there are no right answers, and minds go where they go. The experience, previewed frankly: it can be intense; feelings and body sensations may rise before they settle; sessions sometimes end mid-process, and we will always land you safely. The control: your stop signal, agreed now, rehearsed now, honoured absolutely. And the evidence, at guideline level, offered without oversell. Consent given to that account is consent to the actual treatment, and the ten minutes it takes buys alliance that storms will later spend.

The calm place, the phase's minimum resource, is taught with more care than its gentle name suggests, because it is both a skill and a diagnostic. The client selects a place, real or imagined, associated with calm or safety, the word chosen carefully, calm rather than safe for clients whose histories make safety itself a trigger. It is developed multisensorily, what is seen, heard, felt, smelled, until the state arrives in the body, and then enhanced with short, slow sets of bilateral stimulation, the same stimulation that will later power processing here used to deepen a resource state, brief sets, six to eight passes, because long fast sets can pull association towards exactly the material we are not yet processing. A cue word is linked, practised, the state summoned by the word alone, and homework assigned: daily use in

minor stress, so the pathway is worn smooth before crisis needs it. Diagnostically, the exercise is quietly priceless: the client who cannot find any place, whose calm image floods with intrusion, whose body cannot soften anywhere, has just told you the preparation phase needs to lengthen, and better to learn it here than at SUD eight.

Resource development and installation extends the same method to the capacities the coming work will need, and it is titrated to the person: for the resilient single-incident client, calm place may suffice; for complex presentations, preparation becomes a project in its own right. The standard repertoire: strength resources, memories of coping, competence, courage, evoked fully and installed with short sets; relational resources, figures, real, historical, fictional or spiritual, who embody protection, wisdom, nurture, assembled into what some protocols call a team, available in imagery when processing meets what a child faced alone; containment, the vault, the box, the practised imaginal shelf on which unfinished material is placed between sessions, rehearsed until it works; and state-shifting skills from the wider trauma toolkit, breath, grounding, orientation, borrowed unapologetically. The installation grammar is constant: evoke the state fully, body included, then brief slow sets to strengthen, then cue, then practise.

Confirming readiness closes the phase, and it is a checklist answered honestly rather than a feeling of momentum. Can the client shift states in session, distress deliberately raised a little and then lowered with their resources, demonstrated, not assumed? Is dual attention available, one foot here, tested with mildly uncomfortable material before the real thing? Is the stop signal rehearsed and trusted? Is the life platform stable enough this month, and the risk picture mapped against baseline? Is the dissociation screen done and its findings acted on? And is consent current for the specific first target the plan names? A no anywhere is not failure but sequencing: the phase continues, the reason named, the destination kept in view, because preparation without a destination drifts into the respectable avoidance every trauma therapy must guard against.

One more preparation craft belongs on the record: predicting the process's oddities before they arrive. Clients told in advance that minds wander to apparently unrelated material, that this is linkage rather than failure, that some sets feel empty and some overwhelming, that benefit often lands between sessions, meet those events as forecast weather rather than

alarming anomalies, and the mid-course crisis of confidence, this is not working, I am doing it wrong, is largely pre-empted in this phase, at the cost of five sentences. Preparation, done to this standard, also quietly builds the treatment's outcome measure: a client who can raise a disturbance and lower it with their own resources has already changed their relationship to their inner life, before a single target is processed, and some of the method's earliest clinical gains, better sleep, fewer escalations, arrive in this phase, banked and named as evidence of the system the treatment is about to put to heavier use.

A fragment shows the phase's quality bar. A woman preparing to process an assault cannot complete calm place, every image invaded, and the finding reroutes three sessions: containment built first, the vault rehearsed until intrusions can be shelved; a relational resource installed, her grandmother's kitchen, the one address her history offers where protection lived; state-shifting drilled until a deliberately evoked disturbance of four can be brought to two within minutes, in the room, twice. Only then is the target loaded, and when processing later storms, as it does, the storm is survivable precisely because these three sessions happened. That is preparation as this course means it: not delay, but the manufacture of the conditions under which the next lesson's engine, desensitisation itself, can run to completion. A phase-two file worth keeping: each client's tested modality, speeds, cue words and resource inventory on one page, because the details that make processing smooth are exactly the details a busy practice forgets between clients.

Going deeper: when the calm place is not calm, and other real-world preparation.

Standard preparation assumes machinery that trauma has often sabotaged, and the practitioner's craft is largely a repertoire of repairs. The calm place fails in predictable ways. For some clients every candidate scene turns hostile on entry, the beach acquires watchers, the childhood bedroom acquires footsteps, because for a person whose danger lived at home, safety-imagery itself is trauma-adjacent. The repairs run in order: change the frame from safe to calm or pleasant (safety claims too much); build a fictional or composite place with no autobiographical address; anchor in a sensory fragment rather than a scene (the exact weight of a sleeping cat, winter sunlight through a bus window); or set imagery aside and build the

resource in the body, through paced breathing with a cue word conditioned across sessions. A calm place that works is then stress-tested deliberately: invoked after mild activation in session, so both parties know it functions under load, not only in the calm in which it was built.

Resource development and installation follows the same logic at greater depth: brief, slow bilateral sets strengthening imagined states of competence, connection and protection, drawn from the client's own history where possible and from chosen figures where history offers nothing. The advanced subtlety is dosing: short sets, because long sets on a positive resource can associate their way into trauma material, which teaches the client the opposite of what preparation intends.

Readiness, finally, is confirmed by evidence rather than calendar. The working checklist: the client can down-regulate in session using the built resources, demonstrated, not reported; some between-session affect tolerance exists (the week survives feelings without major self-endangering behaviour); the stop signal has been rehearsed and, crucially, used once and honoured, because a stop signal that has never stopped anything is a rumour; life circumstances can absorb processing (not mid-eviction, not the week of the tribunal); and the client can state, in their own words, what processing will involve and why they are choosing it. Weeks spent earning that list are not delay before the therapy; with this population they are frequently the majority of the therapy's benefit.

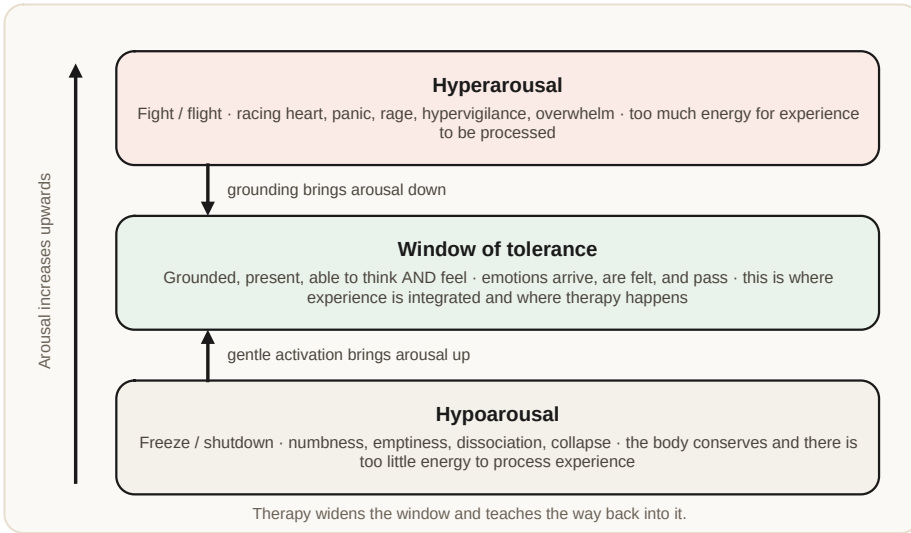



**FIGURE 1.1 The window of tolerance**

*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

- Explaining the process and gaining consent
- The calm/safe place
- Resource development and installation
- Confirming readiness

**PRACTICE TASK**

*Script an installation of a calm place with a client.*

CHAPTER 2

# Running desensitisation

The desensitisation phase of EMDR is where the therapeutic engine hums most quietly, and yet where the most decisive work occurs. It is the point at which the client's nervous system is invited to re-process a distressing memory while the therapist supplies the rhythmic bilateral stimulation that keeps the dual-attention task alive. The skill of the therapist lies not in overt interpretation but in the disciplined delivery of sets, the attentive following of the client's associative channels, the systematic return to the target memory, and the careful tracking of Subjective Units of Disturbance (SUD) until resolution is achieved.

The mechanics of delivering bilateral stimulation must become second nature. In preparation the therapist selects the modality that best matches the client's needs – eye movements are the default, supported by a robust evidence base that includes the randomised controlled trials of Lee and Cuellar (1999) and the meta-analysis of van der Kolk et al. (2007). When visual tracking is impractical, tactile taps or auditory tones are employed, each maintaining the essential alternating pattern that taxes working memory and facilitates the adaptive information processing (AIP) model proposed by Shapiro (1995). The speed of stimulation is calibrated to a brisk tempo, typically between 30 and 120 beats per minute, sufficient to engage the client's attentional system without causing fatigue. Sets are usually comprised of twenty to forty bilateral movements, though the therapist remains flexible, extending the set when material is still moving and shortening it when intensity requires titration. The rhythm of the therapist's voice is constant: a brief pause after each set, a gentle invitation such as "take a breath; what do you notice now?" followed by a moment of silence, then the next set. This disciplined cadence prevents the therapist from slipping into a counselling stance that could redirect the client's own associative flow.

Following the client's associative channels is the navigational craft of the desensitisation phase. Once the target memory is activated, the client's mind often drifts along familiar pathways. These pathways can be categorised, though not rigidly, as follows. Along the event, the client may revisit earlier

moments of the trauma or later consequences, producing a temporal sweep through the scene. Across the network, memories that share the same negative belief, bodily sensation, or affect may surface – the so-called "float-back" phenomena described by Shapiro (2001). Upward channels lead toward higher-order cognition, re-appraisal, or adult perspective, while downward channels descend into somatic sensation, often manifesting as tension, heat, or a feeling of heaviness. Occasionally, seemingly irrelevant images appear – a supermarket queue, a childhood game – which later reveal a thematic link to the original disturbance, such as helplessness or loss. The therapist's role is to stay out of the way while the client follows these streams, maintaining the bilateral sets and allowing the associative material to unfold. When the flow of new material diminishes, the client may experience a period of neutrality or calm; at this point the therapist gently returns the client to the original target memory, asking "what do you notice now?" and thereby re-engaging the processing loop.

Returning to the target is also the moment when the therapist utilises the SUD scale with precision rather than ritual. SUD is re-rated only at the end of a set of processing, not after every bilateral movement, because frequent interruption can disrupt the very dual-attention mechanism that underpins EMDR. The trajectory of SUD scores – for example, a decline from eight to six to four – is more informative than any single rating. A plateau, where the SUD remains unchanged across two or more returns, signals either a blockage that may require a different protocol (e.g., a resource installation or a cognitive interweave) or a deep channel that still requires patience. The ultimate aim is to reach a SUD of zero, but the therapist must respect the ecological floor of the client's experience. In bereavement or ongoing adversity, a residual SUD of one or two may reflect a realistic level of grief rather than an incomplete processing. The therapist therefore asks, "Is there anything that still disturbs you about this memory?" and, if the answer is negative, proceeds to identify any remaining fragments – a lingering sound, a specific image – that can be targeted as micro-targets.

The language used between sets is deliberately minimal. The therapist's repertoire consists of a handful of phrases that reinforce the dual-attention focus without steering the content: "take a breath; what do you notice now; go with that; notice that." When intensity needs acknowledgement, the therapist may add a permissive statement such as "it is old stuff; you are safe now; just notice it," which serves to reassure without imposing

meaning. More specific instructions, such as “watch the image as if it were on a screen, further away,” are employed for titration when the client’s affect is overwhelming. Interweave techniques, which will be explored in a later lesson, are reserved for genuine blocks. All other conversation is deferred to the phases of preparation, installation, and integration, where the therapist’s role is more overtly collaborative.

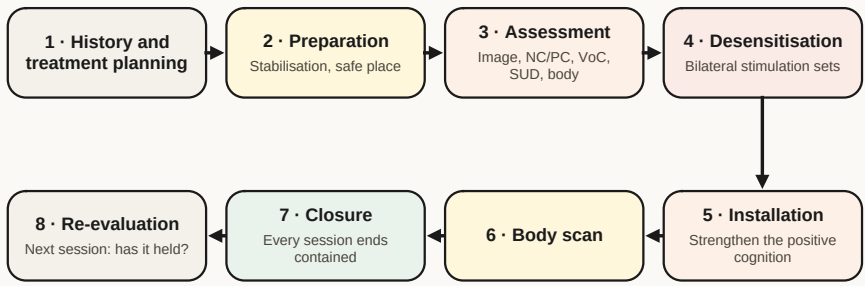
The numbers, particularly SUD, belong to the client, not the therapist. A client who consistently rates a SUD of two when processing a loss may be signalling an ecological floor – a healthy, realistic level of sadness that should not be forced to zero. Similarly, a high Validity of Cognition (VoC) rating that remains stubbornly at five may reflect cultural or personal beliefs about the truth of the cognition, not a procedural failure. The therapist’s craft is to inquire gently about the meaning behind the remaining number, distinguishing disturbance that still requires processing from meaning that the client wishes to retain. Forcing a reduction of the number without this distinction is a common source of protocol violation and can lead to iatrogenic harm.

Silence is a powerful therapeutic tool in this phase. The therapist must become comfortable with extended periods of non-verbal presence, observing the client’s breathing, facial expression, and subtle shifts in posture while maintaining the bilateral rhythm. This silence is not a void but the space in which the client’s nervous system reorganises the memory trace. In many other talking therapies, silence functions as a prompt for verbal response; in EMDR desensitisation, it is the substrate of change.

A concrete worked example illustrates the integration of these elements. The client, a 34-year-old woman, presents with a vivid memory of a motor-vehicle collision that occurred three years prior. The target image is the oncoming headlights, the negative cognition is “I am going to die,” and the initial SUD is rated at seven. The therapist begins with eye-movement sets, each consisting of thirty rapid left-right movements. Set one intensifies the brightness of the headlights; the therapist pauses, breathes, and asks, “what do you notice now?” The client reports a sensation of heat behind the eyes. Set two amplifies the sound of screeching brakes; after the set the client notes a tightening in the chest. Set three introduces a shaking sensation, and the client describes a feeling of being thrown forward. Set four brings an unbidden image of the client standing outside the wreckage, looking at the

scene from a distance. The therapist continues the sets until the client's affect begins to shift, at which point the therapist returns to the original target: "what do you notice now?" The client rates the SUD at five and reports that the headlights appear farther away. A new channel emerges – the hospital corridor, the face of the client's mother, a rising grief. Two sets of bilateral stimulation are delivered, during which the client's tears flow and the corridor gradually empties, leaving a sense of quiet. The therapist again returns to the target, and the SUD is now two. The client spontaneously remarks, "I keep thinking I walked away from the crash." Two more sets are administered, during which the image of the headlights transforms into a calm night road. The client rates the SUD at zero and reports a sense of relief. The therapist notes only a handful of words spoken over the course of the session, yet the memory has been re-encoded, its emotional charge dramatically reduced, and the client's narrative has been updated.

In sum, the desensitisation phase is a dance of precision and restraint. The therapist delivers bilateral stimulation with a rhythm that becomes invisible, follows the client's associative pathways without interference, returns to the target at appropriate intervals, and monitors SUD scores to gauge progress while honouring the client's ecological limits. Mastery of this phase emerges from repeated practice, attentive listening, and a deep respect for the client's internal processing system. The next lesson will explore how to respond when the system resists, introducing interweave techniques and resource installation to support continued movement towards resolution.




Phases 3–6 repeat per target memory; the client's own processing does the work.

**FIGURE 2.1 The eight phases of EMDR**

*Shapiro's standard protocol moves through eight phases. Preparation and history-taking do the stabilising groundwork; assessment activates the target memory with its image, cognitions and body sensation; desensitisation applies bilateral stimulation until distress falls; installation and body scan consolidate; closure and re-evaluation keep every session safe and cumulative.*

## Points worth keeping

- Delivering sets of bilateral stimulation
- Following associations
- Returning to target
- Tracking SUD towards resolution

**PRACTICE TASK**

*Describe how you would adjust a set that is producing little movement.*