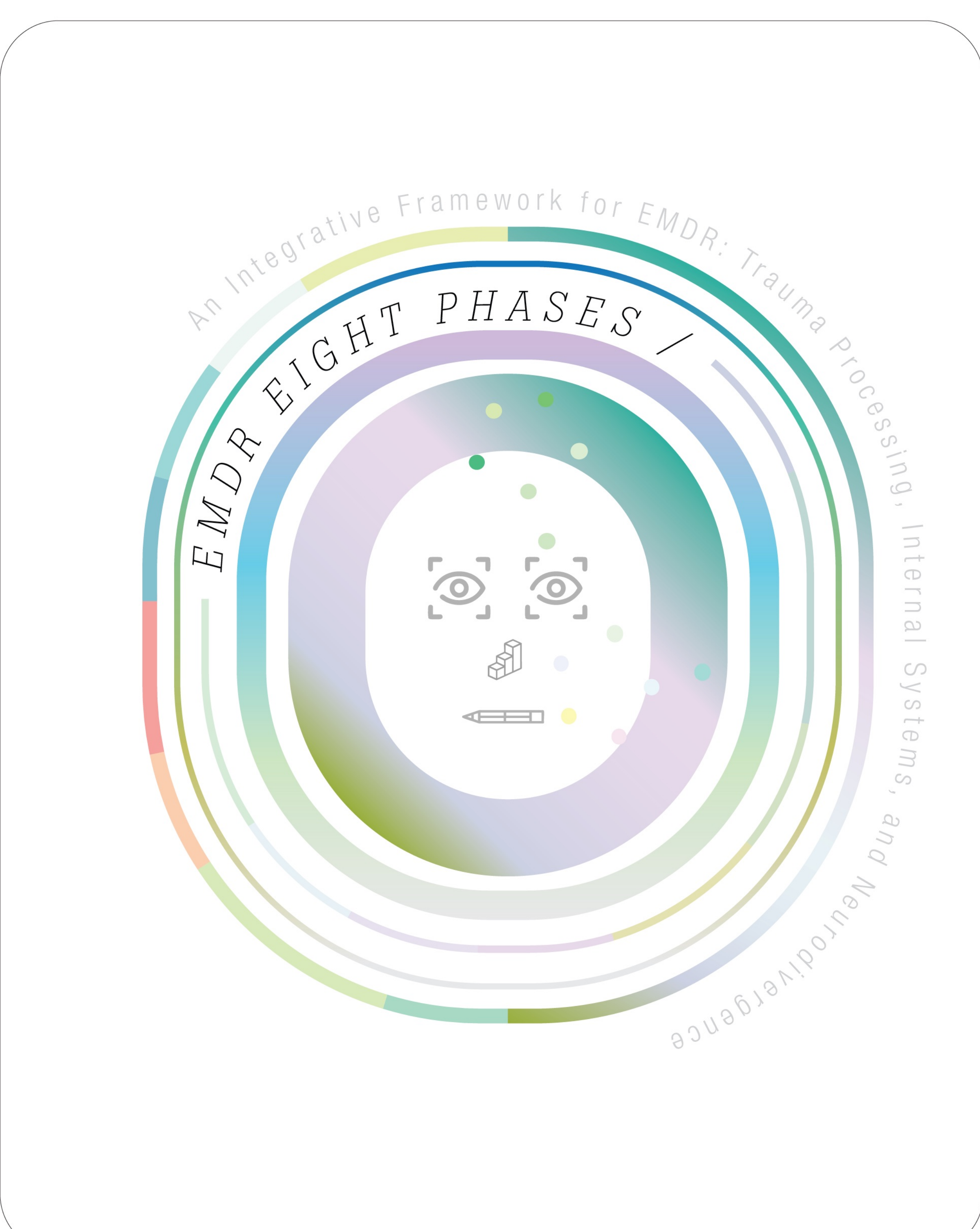

An Integrative Framework for EMDR: Trauma Processing, Internal Systems, and Neurodivergence
EMDR EIGHT PHASES /

An Integrative Framework for EMDR:

Trauma Processing, Internal Systems, & Neurodivergence

Eye Movement Desensitization and Reprocessing (EMDR) is an evidence-based psychotherapy originally developed by Francine Shapiro for the treatment of trauma and trauma-related disorders. Grounded in the Adaptive Information Processing (AIP) model, EMDR posits that psychopathology is often the result of maladaptively stored memories that remain insufficiently processed, contributing to persistent distress, dysregulated affect, and negatively held self-beliefs (Shapiro, 2018). Through structured protocols and the use of bilateral stimulation, EMDR facilitates the reprocessing of these memories, allowing for adaptive integration across cognitive, emotional, and somatic domains.

The standard EMDR protocol is organized into eight phases, history taking, preparation, assessment, desensitization, installation, body scan, closure, and reevaluation, which together provide a comprehensive framework for trauma treatment (Shapiro, 2018). As illustrated in this packet , these phases function not as rigid steps but as an interconnected system, supporting stabilization, processing, and integration over time.

Contemporary clinical perspectives increasingly recognize that traumatic memory networks are not experienced as singular, cohesive narratives, but rather as fragmented, state-dependent experiences that may be associated with distinct emotional, cognitive, and somatic patterns (van der Kolk, 2014). From an internal systems perspective, these patterns can be understood as adaptive "parts" of the self, protective or wounded aspects that carry specific memories, beliefs, and survival strategies (Richard C. Schwartz, 2021). While EMDR is not inherently a parts-based model, its focus on accessing discrete memory networks, shifting negative cognitions, and integrating previously unprocessed material aligns with the broader clinical goal of fostering internal coherence and self-leadership.

A growing body of empirical research supports the efficacy of EMDR in the treatment of posttraumatic stress disorder (PTSD) and related conditions. Meta-analyses and randomized controlled trials have demonstrated that EMDR is comparable to, and in some cases more efficient than trauma-focused cognitive behavioral therapies (World Health Organization, 2013; Bisson et al., 2013). EMDR has been recognized as a first-line treatment for PTSD by multiple international organizations, including the World Health Organization and the American Psychological Association.

In parallel, there is increasing recognition of the intersection between trauma and neurodevelopmental differences, particularly in individuals with attention-deficit/hyperactivity disorder (ADHD). ADHD is associated with differences in executive functioning, emotional regulation, and attentional control that can influence how individuals encode, store, and retrieve emotional experiences (Barkley, 2015; Brown, 2013). Emerging research suggests that individuals with ADHD may experience heightened sensitivity to stress, increased emotional reactivity, and difficulty with self-regulation, all of which may interact with trauma exposure and processing (Shaw et al., 2014; Sibley et al., 2021).

From a neurodivergence-affirming perspective, these patterns are understood not as deficits alone but as variations in cognitive and regulatory systems that require attuned, flexible, and strengths-based approaches to care. Within this context, EMDR offers a potentially adaptive framework for supporting individuals with ADHD and related neurodivergent profiles, particularly when modifications are made to pacing, preparation, and resourcing to account for attentional variability and nervous system activation.

Neurobiologically, EMDR is increasingly conceptualized as engaging memory reconsolidation processes and facilitating integration across neural networks (Solomon & Shapiro, 2008). Its emphasis on dual attention, somatic awareness, and present-moment orientation aligns with broader trauma-informed approaches that recognize the role of the body and nervous system in healing (van der Kolk, 2014). When integrated with parts-informed frameworks, EMDR may support not only symptom reduction but also increased internal differentiation, reduced polarization, and greater access to adaptive self-states.

This packet reflects both the foundational structure of EMDR as developed by Francine Shapiro and applied clinical learning through training with Kendal Hart. It is intended as a structured clinical resource that integrates core EMDR principles with a trauma-informed, relational, and neurodivergence-affirming perspective. While maintaining fidelity to the eight-phase model, this work also emphasizes the importance of attunement, pacing, and clinical flexibility in response to individual client needs.

In this way, the packet serves not only as a procedural guide but as an integrative framework, one that supports the reprocessing of memory, the reorganization of internal systems, and the restoration of adaptive functioning across mind and body.

References

Barkley, R. A. (2015). Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment (4th ed.). Guilford Press.

Bisson, J. I., Roberts, N. P., Andrew, M., Cooper, R., & Lewis, C. (2013). Psychological therapies for chronic post-traumatic stress disorder (PTSD) in adults. Cochrane Database of Systematic Reviews, (12), CD003388. https://doi.org/10.1002/14651858.CD003388.pub4

Brown, T. E. (2013). A new understanding of ADHD in children and adults: Executive function impairments. Routledge.

Shapiro, F. (2018). Eye movement desensitization and reprocessing (EMDR) therapy: Basic principles, protocols, and procedures (3rd ed.). Guilford Press.

Shaw, P., Stringaris, A., Nigg, J., & Leibenluft, E. (2014). Emotion dysregulation in attention deficit hyperactivity disorder. American Journal of Psychiatry, 171(3), 276–293.

Sibley, M. H., Arnold, L. E., Swanson, J. M., Hechtman, L. T., Kennedy, T. M., Owens, E. B., ... & Molina, B. S. G. (2021). Variable patterns of remission from ADHD in the multimodal treatment study of ADHD. American Journal of Psychiatry, 178(6), 563–571.

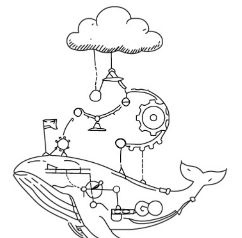
Solomon, R. M., & Shapiro, F. (2008). EMDR and the adaptive information processing model: Potential mechanisms of change. Journal of EMDR Practice and Research, 2(4), 315–325.

van der Kolk, B. A. (2014). The body keeps the score: Brain, mind, and body in the healing of trauma. Viking.

World Health Organization. (2013). Guidelines for the management of conditions specifically related to stress.

American Psychological Association. (2017). Clinical practice guideline for the treatment of posttraumatic stress disorder (PTSD) in adults.

Richard C. Schwartz. (2021). No bad parts: Healing trauma and restoring wholeness with the Internal Family Systems model. Sounds True.



CLOUDWHALE COLLECTIVE

CARRIE A. DYER

EMDR EIGHT PHASES

01. HISTORY

/ History Taking / Case Conceptualization, & Treatment Planning / Treatment Planning / Memory Selection & Ordering / Rapport / Track NC themes & narrow a NC target / When you have a NC prompt for a memory /

__ *"Tell me a little bit about what's going on that brings you in for therapy today. "*

__ *"When is the first time you remember thinking, feeling, believing that about yourself?"*
__ *"Who taught you that?"*
__ *"Where did you learn that?"*

Float Back Script: *"As you bring up the recent experience of ____________, notice the image that comes to mind, the negative belief you're having about yourself along with any emotions and sensations, and let your mind float back to an earlier time in your life when you may have felt this way before and just notice what comes to mind."*

Affect Scan Script: *"Bring up that experience, the emotions and the sensations that you're having now and allow yourself to scan back for the earliest time you experienced something similar…."*

02. PREPARATION

/ Client Preparation Resourcing Scripts / Safe/Calm Place + Container + Grounding skills (slow BLS) / Emotion regulation focus /

CALM SAFE PLACE EXERCISE:

Image: *"I'd like you to think about a place you have been or imagine being that feels very calm or safe. Perhaps being on a beach or sitting by a mountain stream. What image represents your place?"*

Emotions & Sensations: *"Focusing on that image, notice what you see, hear, and feel. Notice your emotions and where you feel that in your body. Describe what you're noticing."*

Enhancement: *"Focus on your calm/safe place—its sights, sounds, smells, and body sensations."*

EYE Movements: *"Bring up the image of that place. Concentrate on where you feel the pleasant sensations in your body and allow yourself to enjoy them. Concentrate on those sensations and follow my fingers. (6-12 slow passes of BLS) How do you feel now?"*

☐ *If Positive: "Focus on that. (6-12 slow passes of BLS) What do you notice now?" Repeat and enhance with BLS four to six times.*

☐ *If Negative: Try to enhance the original image. If it remains negative, redirect the client to another calm/safe place or use another form of resource development such as the container exercise.*

Cue Word: *""Is there a word or phrase that represents your safe place? Think of ________ and notice the positive feelings that you have when you think of that word. Concentrate on those sensations and the word ___________ and follow my fingers. (6-12 slow BLS) How do you feel now?"*

Self-cueing: *"Now, on your own, want you to bring up the image and the word, noticing the positive sensations. How was that?"*

Cueing w/ Disturbance: *"Now, I want you to recall a recent minor annoyance (SUD 1-2) (wait until they have indicated they have found one) and notice the negative feelings. Now, turn your attention back to your calm place and word ______________ and notice any shifts in your body. What did you notice?"*

Self-Cueing w/ Disturbance: *""I'd like you to think of another mildly annoying incident (SUD 2-3); notice how you feel. Now, follow that same exercise on your own until you reach a relaxing conclusion.*

03. ASSESSMENT

/ Assessment / Negative & Positive Cognition List / TICES / Nervous system activation before processing /

__ **Image:** *"What picture represents the incident?"*

__ **NC:** *"What words go best with that picture that express your negative beliefs about yourself now?"*

__ **PC:** *"When you bring up that picture (or experience), what would you prefer to believe about yourself instead?"*

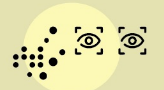
__ **VOC:** *"When you think of that incident, how true do those words (repeat P) feel to you now on a scale from 1 to 7 where 1 feels completely false and 7 feels completely true"*

__ **Emotions:** *"When you think of that incident, and the words [repeat NC], what emotions do you feel now?"*

__ **SUD** (Subjective Units of Disturbance): *"From zero, which is no disturbance or neutral to 10, which is the worst you can imagine, how disturbing does it feel to you"*

__ **Physical Sensation:** *"Where do you feel it in your body?"*

04. DESENSITTITATION



/ Desensitization / Challenges in Processing Feeder Memories / Blocking Beliefs / Cognitive Interweaves /

__ **Begin Desensitization:** *"Now remember, it is your own brain that is doing the healing, and you are the one in control. I will ask you to focus on the target mentally and to follow my fingers with your eyes. Just let whatever happens to happen, and we will talk at the end of the set. Just tell me what comes up, and don't discard anything as unimportant. Any new information that comes to mind is connected in some way. If you want to stop, just raise your hand."*

"I'd like you to bring up that image ______, those negative words ________ (repeat the negative cognition), notice where you are feeling it in your body, and follow my fingers."

__ **After each "set" of BLS**
[Immediately after phase 3, Add BLS
[25(+-) fast passes

"What are you noticing?"

"Go with that."
[If 3+ positive, neutral, off topic responses, return to target

"Let's go back to the original memory/experience, what comes up for you now?"

"Go with that."
[Process until SUD=0 °
[If SUD is low, ask "

"What keeps it a 1/2/3 & not a 0?"
[Add BLS to whatever the answer is
[Repeat until it's a 0
[If stuck at 1-3, likely blocking belief needs to be targeted
[See phase 7 to end sessions

EMDR EIGHT PHASES

05. INSTALLATION

Purpose of Phase 5

__Check the validity and applicability of the Positive Cognition (PC)
__ Enhance the Positive Cognition
__Connect it to the original target memory

Checking the Positive Cognition

"Do the words _____________ (repeat the PC) still fit, or is there another positive statement that feels better?"

Check the VOC

"As you think of the event/incident/memory, how do the words feel, from 1 (completely false) to 7 (completely true)?"

Link the PC and the Target and Add BLS

"Think of the event/incident/memory and hold it together with the words _________ (Repeat PC)."

__ Start BLS - (25 fast passes)
__ Continue to check the VOC after each BLS set until the client reports a VOC of 7.
__ If the client gets stuck at a number, ask, *"What prevents it f rom being a 7?"*
__ When the client provides an answer, say, *"Notice that,"* and add BLS.
__Continue to reprocess with BLS until it gets to a 7 (or less if ecologically sound) and then move on to Phase 6: Body Scan.

At times, the client may not be able to get their VOC to a 7. The client will generally be able to report a blocking belief. If it is benign, the clinician should proceed to phase 6: body scan. If it is a dysfunctional belief (e.g., "I don't deserve to be healthy"), administer BLS. Still, if it doesn't remit, it will need to be reprocessed as a complete EMDR treatment on the associated memory driving the negative self-assessment (see 'Blocking Beliefs' for more information).

06. BODY SCAN

Purpose of Phase 6

__Target bodily sensations connected to the target memory and neutralize them.

Body Scan

"Close your eyes and keep in mind the original memory /event and the positive belief (state PC). Then bring your attention to the different parts of your body, starting with your head and working downward. Any place you find tension, tightness, or unusual sensations, tell me." (Clinicians should note this is without BLS).

If the client identifies any bodily sensations, ask them to *"notice it"* and add BLS.

The goal is for the client to report no negative bodily sensations. Continue to utilize BLS with the client's focus on body sensations until they report no tightness, tension, or unusual sensations.

If the client shares any positive bodily sensations, reinforce those by the clinician stating *"Notice that"* while administering BLS.

Once the Body Scan is clear (e.g., the client reports no tension, tightness, or unusual sensation), move on to Phase 7: Closure.

07. CLOSURE

Purpose of Phase 7

__Ensure stability
__Close a session

There are two scenarios where clinicians will use closure:

__1. Closing a session when a target is ENTIRELY REPROCESSED (e.g., SUD=0, VOC=7, & a clear body scan). In this instance, the clinician should tell the client it is time to stop, positively reinforce their work, debrief them about the experience.

__2. Closing a session when a target is UNFINISHED (e.g., SUD is above 0, or VOC is below 7, or the body scan is not yet clear.) In this instance, tell the client it is time to stop, do not take an additional SUD, VOC, or do a body scan.

__ Stabilize with safe or place, container, or other similar exercises.
__ Encourage, positively reinforce, and debrief.
__ Explain what they may experience or notice in between sessions and what to do if they feel overwhelmed or notice new material.

Example: "Processing may continue after our session. You may or may not notice new insights, thoughts, memories, physical sensations, or dreams. Please make a note of whatever you notice. We will talk about that at our next session. Remember to use one of the relaxation or grounding techniques as needed."

It is good to have a few final minutes for talk therapy to help ground the client. Ask them about present-day things they have going on, such as a work situation or weekend plans.

08. REEVALUATION

Purpose of Phase 8

__Check-in after EMDR processing session to ensure the changes are maintained
__Evaluate progress overall and with the specific target memory
__Review remaining targets within the client's treatment plan

Check the Results

__Assess symptoms
__Identify changes in behaviors
__Explore reactions to present triggers
__Explore any new thoughts, insights, or information

Issues Specific to Target Memory

__New parts of the target memory that may have emerged
__Other associated memories
__New present day triggers that have emerged
__Assess if the SUD remained 0 and VOC remained 7

Resuming Reprocessing of an Unfinished Target Memory

Therapy sessions usually end without complete processing of a targeted memory. Where a clinician should begin the next session depends on where the last session ended. Below are several examples:

When the SUD on the target memory is not yet a 0

Suggestion: access via a component of the memory (TICES)

IMAGE:
"Bring up the memory we have been working on. What is the image that represents the worst part of it as you think about it now?"

Emotions:
"What emotions are you experiencing now?"

SUD:
"On a scale from 0-10, how disturbing is it?"

Body Location:
"Where do you feel it in your body?"
Then, begin reprocessing:
"Focus on the experience where you feel the sensations in your body and follow my fingers." (BLS)

If the SUD = 0 and the Positive Cognition has a VOC of less than 7

Resume phase 5: Installation and focus on getting the VOC to 7.
Then, move on to body scan.

If the SUD = 0, the VOC = 7, but you did not finish the body scan

Complete the body scan.
Then, move on to Future Template.