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EMDR Target Sequence Planning

The Ultimate Clinician's Guide

A defensible TSP: clustering by negative cognition, touchstone identification, sequencing rules, three-pronged integration, dissociation-aware adaptations, and worked cases.

WHAT'S INSIDE

- ✓ What a TSP is — and what it isn't
- ✓ The NC-cluster method
- ✓ Touchstone identification (Float-Back & Affect Scan)
- ✓ Sequencing within and across clusters
- ✓ Past · Present · Future integration
- ✓ Worked examples + one-page template

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1 · What a Target Sequence Plan is — and what it isn't

A Target Sequence Plan (TSP) is the case-conceptualisation document that organises which memories you will reprocess, in what order, and why. It is the operational bridge between Phase 1 (history & treatment planning) and Phase 3 (assessment) — without it, Phase 4 desensitisation tends to drift, loop, or destabilise.

A well-built TSP has four properties:

- Organised around negative-cognition (NC) clusters, not chronology.
- Identifies a **touchstone** — the earliest related node — for each cluster.
- Sequences within each cluster (earliest → worst → most recent).
- Carries the work into the **present** (triggers) and **future** (templates) prongs.

A TSP is not a chronological trauma list, a problem list, or a goal list. It is a memory-network map that tells you which node to touch next so the AIP system can do the work.

2 · The five inputs you need before drafting

Input	What you capture
Life-history timeline	0–5, 6–12, 13–17, 18–25, adult. One line per noteworthy event.
Symptom-cluster checklist	PCL-5, PHQ-9, GAD-7, DES-II (always for complex presentations).
Presenting issue in client's words	Verbatim; this is what the work has to move.
Current triggers list	What activates symptoms in daily life right now.
Somatic pattern	Where the activation lives in the body — clusters often share a body signature.

3 · The NC-cluster method

Most clients show 2–4 dominant negative-cognition clusters. Sort candidate memories into columns headed by these clusters; within each column, sort chronologically.

Cluster	Representative NCs
Defectiveness / shame	I am defective · I am not good enough · I am worthless · I am unlovable
Safety / danger	I am in danger · I am not safe · the world is dangerous
Responsibility / guilt	It's my fault · I should have done something · I am bad
Control / powerlessness	I am powerless · I have no control · I am trapped
Connection / belonging	I am alone · I don't belong · I will be abandoned

Clustering is the single biggest efficiency gain in target selection: memories that share an NC are usually associatively linked in the AIP network. Processing the earliest member often generalises through the cluster, collapsing 8–12 candidate targets into 2–4 that actually need direct reprocessing.

4 · Touchstone identification: Float-Back & Affect Scan

For each cluster, identify the **touchstone** — the earliest known memory carrying that NC, body sensation and affect.

Float-Back: hold the recent activating image, the NC, the body sensation. Ask: *'When you let yourself go back as far as you can, what's the earliest memory that comes up with this same feeling and this same thought?'*

Affect Scan: hold the body sensation only (no image, no NC). Ask: *'Let your mind float back — what's the earliest time you remember feeling exactly this in your body?'*

Use Float-Back when the NC is verbal and well-formed. Use Affect Scan when the NC is hard to articulate or the client intellectualises. Affect Scan is also the default for preverbal / early-attachment material.

5 · Sequencing rules

Within a cluster: process the touchstone first. Then the worst (highest SUD) memory. Then the most recent. This sequence is conservative — the touchstone often generalises across the cluster and reduces SUD on the others before you reach them.

Across clusters — use the decision tree below.

Decision tree — which cluster first?

Is one cluster directly driving the presenting symptom? Yes → start there, if affect tolerance and a working resource for the touchstone are in place. If not — stabilise first.

Multiple clusters look equally active? Is there a developmental hierarchy (one cluster precedes and feeds the others)? Start with the earliest/most-foundational. Otherwise start with the lowest-charge cluster to build mastery.

Client requests a specific cluster? Honor it if (a) they have affect tolerance for it AND (b) it is clinically reasonable. Otherwise educate and re-negotiate.

Complex trauma / dissociation present? Do not start with the worst memory. Begin with a more recent, lower-charge node in a stabilised cluster. See section 8.

6 · The three prongs: past · present · future

Every TSP must include all three prongs — incomplete plans are the most common reason gains don't generalise.

Prong	Targets
Past	Touchstone + 2–4 representative memories per cluster (worst, most recent, plus any developmental nodes that emerge).
Present	Current triggers — the people, places, sensations, internal cues activating the same network today.
Future	Future templates — anticipated situations the client wants to be able to handle. Often a behavioural milestone (driving, disclosure, boundary conversation).

7 · Worked examples

Example A — Single-incident PTSD (MVA, 14 months ago)

Diagnosis: PTSD, single incident. NC cluster: powerlessness / I am in danger. Touchstone via Float-Back: trapped in a stuck elevator at age 7.

TSP: T1 worst image of the MVA (impact). T2 trapped in the wreckage. T3 the elevator memory (touchstone). T4 first attempt to drive after the accident. T5 future template: driving the route to her parents' house.

Order processed: T3 (touchstone) → T1 (worst) → T2 → T4 (present trigger) → T5 (future). 12–16 sessions estimated.

Example B — Complex trauma (CSA + chronic neglect)

Two clusters identified: defectiveness/shame ('I am dirty / I am bad') and connection/belonging ('I am alone / I don't matter'). DES-II = 28 — clinically significant dissociation. Extended Phase 2 required.

TSP draft (initial): Phase 2 first — 8–12 sessions of stabilisation, parts mapping, resource development. Then begin with the connection cluster (lower current activation) using a recent, contained node (a recent moment of isolation). Touchstone work deferred until affect tolerance and parts cooperation are established.

Example C — Attachment-focused (no discrete event)

Client presents with relational anxiety, no identifiable 'big-T' trauma. Dominant NC: I am unlovable. Affect Scan locates touchstone: age 4, locked in bedroom while mother screamed at father downstairs.

TSP: T1 touchstone (age 4 bedroom). T2 age 9 — being teased and parent dismissing it. T3 most recent — partner not texting back. T4 future template: a difficult conversation she's been avoiding.

8 · TSP for complex trauma & dissociation

Screen before you sequence. Administer the DES-II at intake. Using the commonly cited screening banding (Carlson & Putnam, 1993), a mean score in the 20–29 range indicates clinically significant dissociative symptoms and warrants extended Phase 2 before reprocessing; a mean ≥ 30 indicates a high probability of a dissociative disorder and calls for formal assessment (MID or SCID-D) plus a structural-dissociation, parts-informed frame (Van der Hart, Nijenhuis & Steele, 2006; ISSTD, 2011). Cutoffs are screening guides, not diagnoses — confirm against the source instruments.

Modified sequencing rules:

- Do not lead with the touchstone. Begin with a recent, contained, lower-charge node in a stabilised cluster.
- Do not lead with the worst memory. Build mastery first.
- Get parts buy-in. Before processing any target, check that protective parts agree (or at minimum will not actively interfere).
- Shorter BLS sets, more frequent check-ins, slower cadence. Closure to baseline every session, even if the target is incomplete.
- Title-only targeting for highly activating memories — process the 'movie title' rather than the worst image initially.

9 · The one-page TSP template

Field	Detail
Client (initials)	
DOB year / Date	
Presenting issue (client's words)	
Diagnosis + brief AIP formulation	
Screening scores	PCL-5 ___ · PHQ-9 ___ · GAD-7 ___ · DES-II ___
Cluster 1 — NC / Touchstone / Worst / Most recent	
Cluster 2 — NC / Touchstone / Worst / Most recent	
Present triggers	1. _____ 2. _____ 3. _____
Future templates	1. _____ 2. _____
Phase 2 status	Calm Place [ ] · Container [ ] · Stop signal [ ] · Parts mapped [ ]
First target / planned session	
Re-evaluation	Every 6–8 sessions; repeat PCL-5 / DES-II.

10 · Re-evaluation — how the TSP evolves

The TSP is a living document. Re-evaluate every 6–8 sessions, and any time new material surfaces that doesn't fit the existing clusters.

- **New touchstone surfaces during processing.** Stop, note it, and decide whether to redirect or complete the current target first. Usually: complete current, then re-sequence.
- **SUD won't move on a planned target.** Check for a blocking belief, a feeder memory, or an unmet developmental need. Re-run Float-Back from the stuck point.
- **Cluster collapses early.** If processing the touchstone generalises through the cluster, drop the redundant targets and move to the next prong.
- **Symptoms shift to a different cluster.** Re-screen (PCL-5, GAD-7) and reorder.

11 · Common pitfalls

- Chronological lists instead of clusters — wastes sessions on redundant targets.

- Skipping the touchstone in pursuit of the ‘worst’ memory — the touchstone is what holds the cluster together.
- No present or future prong — gains don’t generalise; clients improve in session but symptoms persist in daily life.
- Treating the TSP as fixed — it is a hypothesis; re-evaluate.
- No dissociation screen in complex presentations — DES-II is mandatory.
- Front-loading the worst target in a dysregulated client — builds destabilisation, not mastery.
- One cluster, one target — insufficient sampling; you can’t tell whether processing generalised.

12 · FAQ

Q. How many targets should a TSP contain?

A. Usually 6–12 across 2–4 clusters, plus 2–4 present triggers and 1–3 future templates. Complex trauma plans are often shorter to start (one cluster, 3–4 targets) and expand as work progresses.

Q. How long does it take to build a TSP?

A. 1–3 sessions of focused Phase 1 work for most cases. Complex trauma cases take longer because parts mapping and stabilisation are interleaved with target identification.

Q. Do I have to use the standard NC list?

A. No — the standard list is a starting point. Clients often phrase the cognition idiosyncratically; honor their language and check that it is genuinely a negative self-referential belief, not a fact.

Q. Can the TSP change mid-treatment?

A. Yes — it should. New material surfaces, clusters collapse early, touchstones reveal themselves only during processing. Re-evaluate every 6–8 sessions.

Q. What if the client refuses to identify a touchstone?

A. Don’t push. Begin with a recent, contained target in the same cluster. The touchstone often surfaces spontaneously during processing once the cluster is engaged.

Q. How does the TSP relate to the treatment plan?

A. The TSP is one section of the broader EMDR treatment plan, which also includes diagnosis, AIP case conceptualisation, goals, Phase 2 milestones, and risk/safety. The TSP is the operational part.

Session-count and target-count figures in this guide are illustrative planning heuristics drawn from clinical practice, not evidence-derived norms.

References

Every clinical claim in this resource is traceable to the sources below. Instruments are public domain or used under their published terms.

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