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1.0 – EMDR 8 phases description

1. Phase 1: History-taking and Treatment Planning

This phase involves obtaining a full history and conducting appropriate assessment with a focus on current issues and the past experiential contributors underlying present problems. The therapist and client work together to identify targets for treatment that include past memories, present triggers, and future challenges related to the presenting problem(s).

2. Phase 2: Preparation

Clients deemed appropriate for EMDR therapy treatment are prepared for memory processing. The goals in this phase include: a) establishing a therapeutic alliance; b) educating the client about symptoms according to the Adaptive Information Processing model (e.g. current problems are the result of past maladaptively stored memories); c) explaining the EMDR process and procedures, its effects, and what to expect; and d) teaching the client, according to their needs, affect regulation and management methods that increase stability and enable a sense of self-mastery and control.

3. Phase 3: assessment

The assessment introduces the reprocessing phases of EMDR. The memory (termed the "target" memory) to be treated is accessed through eliciting the client's current experience of the past event by identifying the components of the client's experience. The client figures out:

a) The image (most often is a visual element but can be of any sensory modality) that represents the worst part.
b) A negative, irrational, and self-referencing belief (in relation to the memory), termed the Negative Cognition (NC). The negative self-referencing belief that arises when the disturbing experience is brought to mind might be something like, "I am not good enough", "I am vulnerable", "I am powerless".
c) A Positive Cognition (PC) – A preferred, constructive cognition (or positive, adaptive belief) is identified to ascertain and verbalize the client's desired outcome, like, "I am good enough, I am safe now, I have some control/choices".
d) Validity of Cognition (VoC) – How true the PC feels in relation to the memory, in a scale from 1 to 7, with 1 being completely false and 7 being completely true.

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e) The emotion associated with the recall of that experience.
f) Subjective Units of Disturbance (SUDs - How distressing the memory is, on a 0-10 scale, with 0 being calm and feeling no distress and 10 being worst it could be (terms Subject Units of Disturbance (SUD).
g) The location of the associated bodily sensations.

4. Phase 4: Desensitization

This phase initiates the reprocessing of the targeted memory, and the associated negative memories that are maladaptively stored. The client focuses on the image, negative belief, and physical sensations associated with the disturbing memory, while simultaneously engaging in sets of bilateral stimulation. The bilateral stimulation initiates an associative process, with each new set evoking new associations such as new images, thoughts, feelings, and/or sensations about the targeted memory, and eliciting other events that are in the memory network.

5. Phase 5: Installation

The Installation Phase builds resilience. In the Desensitization Phase adaptive information links into the memory networks holding the maladaptively stored information. Processing continues in the Installation Phase, with positive belief about himself regarding the traumatic memory.
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6. Phase Six: Body Scan

The body scan is the final opportunity for any residual negative elements associated with the targeted disturbing memory to be identified, reprocessed, and transmuted into adaptive learning experiences. the client is instructed to pair the original memory with the desired positive cognition and scans for bodily discomfort (e.g., tension, tightness, unusual sensation).

7. Phase 7: Closure

During and after a session (i.e., complete or incomplete), the client may feel like they have run a marathon, and be physically tired and emotionally drained. Integration of negative memories often involves the release of a tremendous amount of tension. This is also true when working with grief-related memories. In other words, the client should leave feeling grounded, safe, and stable. Therefore, it is imperative the therapist leave adequate time at the end of the session for grounding, if needed, and debriefing. A safety check also should be completed as to the client's

ability to function (e.g., drive a car, go to work) with stabilization/affect management techniques and strategies can be implemented as needed.

8. Phase 8: Re-evaluation

Francine Shapiro stated, “The term ‘reevaluation’ reflects the need for the precise clinical attention and follow-up that frame any EMDR therapy session targeting disturbing material” (2018, p.192). General functioning: The subsequent session should begin with an evaluation about global functioning as well as specifically about the memory that was previously targeted.