**A Reconsideration of the 8 Phases of EMDR: A Personal Essay**

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For the last 30 or so years EMDR has been defined as an eight-phase method of psychotherapy. This paper is being offered because I think that there are problems in the way these 8 phases organize and present Shapiro’s revolutionary contribution to psychotherapy. The problems do not prevent EMDR from being effectively offered to clients, but they do make teaching EMDR more difficult. They also make it easier to be rejected by people who may be put off by the idea of a therapy that involves moving eyes back and forth, claims very rapid effects, and is still, unreasonably, not well accepted in academia in the US. Please remember the rejection deprives people in need of the potential benefits.

To further put this effort in context, let’s consider that there are three broad categories by which Shapiro’s contribution might be understood:

1) The novel (at the time) proposition that the reconsolidation of memory, rather than extinction/desensitization, is an important way to consider much of possible therapeutic change.

2) The discovery that voluntary sensory or sensory/motor activities can facilitate therapeutic information processing.

3) The invention of a therapeutic structure to effectively utilize this discovery.

Before getting to a methodical consideration of the problems and a suggestion for an alternative way of considering the 8 phases, as well as the 3-pronged protocol, allow me to offer the following imaginary dialogue that might occur as EMDR is taught in a PhD psychology program course on psychotherapy. I choose this particular setting to hold this dialogue because it might shed light on the profound difficulty EMDR has had in being accepted in such programs in the US.

*Instructor: EMDR is a comprehensive 8 phase method of psychotherapy that begins with the history phase, during which the client is assessed for candidacy for EMDR.*

*Student: Does comprehensive mean a complete method?*

*I: I believe Shapiro would think so.*

*S: Before we take history, shouldn’t we know things like the client’s goals for therapy, or even if there is some current crisis that need to be addressed? So, isn’t there something that should come before history? Maybe the term “assessment” would work?*

*I: Yes, but as you will see that term is reserved for identifying the elements of a specific memory to be processed. And, besides, technically, asking about anything that has already taken place is “history”.*

*S: (eyes roll)*

Later:

*S: So, you say in what is called the “Desensitization” phase desensitization is not the model of change, but what occurs is rather the further processing of memory (it “moving” from what has been called “non-declarative” to “declarative” memory), a process Shapiro calls ”****Re****-processing”. So,” It’s name is McGill, she called herself Lill, and everyone knew her as Nancy?” (Beatles, 1968)…Seriously, since hallmark of the eye movement is supposedly that it appears to frequently lead to more rapid processing, shouldn’t the phase be called “Accelerated Processing.”*

As many still know “accelerated processing” is how Francine originally labelled what happened with eye-movement. Discussion of the name change will have to wait for another time.

Let’s leave that fictional classroom and get into this from another angle.

**Change and EMDR**

“If I had it to do over again, I would name it simply ’Reprocessing Therapy.’”

(Shapiro 3rd edition p xii)

Experience can make the strengths and weakness of many of our standard practices in life better understood, and it is sometimes important to make changes. Francine, as quoted above recognized a problem with the name EMD and chose not to change it beyond adding “Reprocessing” to “EMD”. Having worked with her closely in the early years of EMDR I was privy to consideration of changing the name and did promote the decision not to change beyond adding the “R”.

With acknowledgement by Francine[[1]](#footnote-1) of at least one problem with the presentation of EMDR, allow me to offer another quote from her: “Effective use of EMDR therapy demands knowledge of both how and when to use it. The first phase of EMDR treatment (the History phase) therefore includes an evaluation of the client safety factors that determine client selection.” (3rd edition, p65)

A stickler for clarity might suggest that if taking the client history is the first phase of EMDR and EMDR can’t be used until the client is evaluated as being prepared, it is impossible to begin EMDR therapy, as the evaluation for being prepared is technically part of EMDR, which can’t start until the client is evaluated as appropriate.[[2]](#footnote-2)

This might seem to be obnoxious quibbling, but I don’t think it is. I think it is the entrée to reconsider Francine’s description of the 8 phases and the 3 pronged protocol, not with the purpose of denying the profound clinical value of their essence, but rather to organize them more rationally and give them language that is less confusing, especially to those first learning EMDR. Beside the confusion of the language, the attempt of the 8 phases to describe a complete psychotherapy in an orderly way, when it clearly does not do so, undermines the credibility of Shapiro’s work to those who have not seen first-hand how powerfully and uniquely effective it can be.

**What is problematic in the current construction of the 8 phases**

Briefly,

*Problems with the History phase*

- As mentioned above, the History phase as now construed, cannot be the beginning of EMDR if it is to be considered a comprehensive method. There are activities common to psychotherapy in general that must take place before the History phase, as Francine describes it. One is establishing client goals, which is not explicitly mentioned in Francine’s writing on the History phase until the Client History Form in Appendix A of the 3rd edition (p 431). There are also clearly other activities that must take place before trauma processing is considered. For example, stress management exercises[[3]](#footnote-3) that are part of the, later, EMDR Preparation phase or, sometimes, teaching some basic communication skills to help with immediate problems.

In Shapiro’s earliest published works (1989) she acknowledged the need for psychotherapeutic interventions that didn’t fall into the standard phases. She also acknowledges this in her texts (3rd edition, 232 – 233). If the 8 phases of EMDR are to be considered a comprehensive approach (p. ix), integrating other methods, room must be made for such things as assertiveness training and in vivo exposure in the therapeutic effort. (3rd edition pp. 232-234). These do not comfortably fit into the phases as constituted and would most properly be considered[[4]](#footnote-4) parallel to the phases just as termination of therapy, part of every method, seems only to fit outside (after) the 8 phases.

*Problems with the Assessment phase*

- The name Assessment phase is confusing because most therapist would reasonably consider assessment, as it is commonly used, to be part of what Shapiro is calling History.

- In the Assessment phase there is the “positive cognition”. Before the item was named, Francine (1989) referred to it as what the client would prefer to believe. This will most often be “positive” however in my work and from what is reported by clinicians referring to this preferred belief as positive can steer the client toward a judgmental path. I, and other clinicians and clients, can find a belief such “I don’t have to judge myself.” an even more beneficial path for the client, more easily found if the client is not steered toward “positive” So, therefore I am suggesting that the “positive cognition” be referred to as the “preferred cognition” In Francine’s earliest public descriptions of EMDR she would ask for a “present’ cognition that expressed the client’s “negative” view of themselves. I am not suggesting a change in the name of the “negative cognition”. When she asked for the “positive “cognition” she asked for what the client would “prefer” to believe.

*Problems with The Desensitization phases*

**-** The problem with name of the Desensitization phase is demonstrated **i**n the imaginary dialogue above. I will not be calling it “desensitization” because as Shapiro has long taught it is not. And, not calling it “reprocessing” because it is more akin to more fully processing or continuing processing than reprocessing.[[5]](#footnote-5)

- Installation and Body Scan get their own phases in the original 8, when they should have more properly be considered part of what has been called the Desensitization phase. There was never enough activity in these to stand on equal footing with Assessment or Desensitization. In addition, in these phases, sometimes “reprocessing” starts again as unprocessed material emerges.

- I think it could be argued that Closure of complete or incomplete processing of a target event are also part of the new Reprocessing phase. A little support for this comes from the fact that Shapiro does include Desensitization, Installation Body Scan and Closure in one chapter (6) when describing them in all editions of her text.

- Reevaluation as the final phase in Shapiro’s construction carries heavy load. As the last phase of a comprehensive approach, in addition to understanding the results of the previous session’s work, it must also include all that goes with considering termination of therapy, though that is not explicitly stated.

Another way to conceptualize the confusion is to consider that the phases of EMDR as now constructed do not all constitute the same class of activity. Some are phases of psychotherapy in general, some to the whole “reprocessing” effort, and others are specific to the processing of a single target.

If I am correct in my assertions, it might be wondered why Francine did not see problems herself and make modifications. Part of the reason might be that she had seen so many examples of trained clinicians making serious errors in practice that she wanted to publish a standard quickly, which did not leave time for adequate consideration. I can’t know for sure, but my guess is that she also to so quickly to standardize the method in a publicly available manual for treatment to respond to unreasonable and virulent criticism that threatened to undermine acceptance of EMDR in the academic community. There were many such criticisms, and not having a published standardized treatment protocol would leave her work more vulnerable. [[6]](#footnote-6) I must take some responsibility for what I am criticizing as, you can see in the Acknowledgement section of the first edition of her text, I was consulted as she wrote her text and in the process I did not make an issue of the problems described here.

I think that, like with the name, even if she considered making changes later on she might not have because the model offered was serviceable and because of the confusion changes would cause. Also, changes would be interpreted in a way so as to add to the issues on which academic psychologists would continue their attacks. It should be mentioned that, unfortunately, her strategy was only partially successful. Academic psychologist in the US, at least, still seem to shun one of the few methods of treatment for the psychological effects of trauma that they have had to acknowledge is supported by experimental evidence.

**The reconstituted 8 phases**

In their original form the 8 phases could describe what happens in the complete processing of the first memory/event[[7]](#footnote-7) to be processed. Phases 5 -7 would only occur if the client was ready to move toward complete processing (e.g. no distress …) However, the next memory would begin at phase 3. Phase 8 could be applied in the next session no matter how far along the processing had gone in the previous session. While in her extensive discussions of the 8th phase Shapiro considers factors relevant for termination of therapy calling this “reevaluation”, but just does not describe all of what occurs.

I am proposing that what we call EMDR are the phases that are unique to planning for and processing target memories. Such activities as taking history, evaluation for medical problems and termination of therapy that are not specific to EMDR should not be considered part of EMDR proper. This is not to say that the insights developed in EMDR would not influence these activities. For example, what has been learned from the practice of EMDR might be useful in history taking even if one intended to engage in Imaginal Exposure.

**Beginning psychotherapy – ( Pre-EMDR?)**

(This is not intended to be **the** official description of what should happens at the beginning of psychotherapy for all therapists. It is just meant to be one possible example.)

Informed consent – especially rules of confidentiality

Assess client for crisis – respond to that if necessary

Teach (or encourage client who has them to use) stress management techniques

Finish discussion of the various aspects of the therapeutic endeavor

Understand client goals and teach about how to establish goals

Client history[[8]](#footnote-8)

Determine if intensive trauma work would be appropriate. If client is prepared for this, offer it. If not prepared, focus on what would be needed to engage in it.

**EMDR**

1. Describe to the client what happens in EMDR processing – if client consents, then:

2. Clarify the importance of stress management skills for trauma processing and work to support these skills.[[9]](#footnote-9)

3. Select a target for reprocessing (usually from the trauma history – taken before the EMDR phases begin)

4. Establish the various aspects of the mental associative network of the target event and the content of proposed elements (e.g. preferred cognition) that would be connected to it.[[10]](#footnote-10)

5. Process the selected event(s)

a. work toward complete processing of the target event[[11]](#footnote-11) – if and when the client is ready check for completion using installation[[12]](#footnote-12) of preferred cognition and body scan.

b. process event using the 3-pronged protocol

c. when the event is not completely processed in a session, close the event and prepare the client for the rest of their day

d. re-evaluation of work done on targets in the previous session (This is not to say that the following session(s) would only employ EMDR, there might be a variety of other necessary activities including sometimes providing education, giving direct advise, etc..)

6. If there are more events to process return to 3

7. Completion of formal EMDR phases of treatment – determine that all events are processed.

8. Incorporate use of EMDR principles in responding to ongoing life events that raise more distress than required or desired.

**Post-EMDR**

Since Eye movement can be employed even in conversational therapy, and the client might be using EMDR type sensory motor activities even alone, there really may not be a “post-EMDR” phase. Post-EMDR might mean engaging in other therapeutic activity such as career planning or termination of therapy.

**Conclusion**

Francine’s great discovery was that sensory or sensory/motor activities such as

the eye movement or tapping used in EMDR can facilitate/accelerate therapeutic information processing. Part of this discovery, that information processing could change how an event was held in memory, presaged the more recent research on memory reconsolidation. This was different from what was the standard understanding, that the psychotherapeutic solution to pathologically held memory (learning) was that a competing response overrode maladaptive response was previously established. Shapiro creatively[[13]](#footnote-13) constructed a therapeutic framework in which to apply this discovery relying on behaviorist and other extant psychotherapy concepts. Her framework, the 8 phases, has become the enforced standard for defining EMDR. I hope that what is offered above is a better way to consider and express the activities encompassed in the 8 phases. However, I do not think this offering adequately encompasses how I think of EMDR or even how Shapiro thought of it herself, in some contexts.

In the early 1990s Francine came to the VA hospital where I worked. In casual conversation she suggested that we might pair the eye movement with the content of a client nightmare. She was clearly not suggesting that the full assessment phase would be conducted. She also clearly seemed to think this would still be EMDR. And, in fact, her discovery has been dropped into dream work as part of a therapy not-named EMDR as it has been paired with thoughts of addiction in other both named and not-named therapies. One intervention, I have found particularly helpful is to have a client engage in in vivo exposure while engaging in eye movement or tapping.[[14]](#footnote-14)

While I have offered the above reconsidered 8 phases of EMDR as an improvement, I think it is still some distance from adequate psychotherapy integration. This is not the place for it, but my attempt at the broader understanding is available elsewhere.

**Post conclusion**

The gap between what is taught about something and how it exists in the world outside the classroom, journal articles, or the formal rules of its practice is often ignored when teaching that subject. The sentence “Textbook examples only occur in textbooks.” is one way of putting this. Since I believe the official 8 phases have serious weaknesses in understanding how to actually think about and practice EMDR, and think there is a better way to do so, I must reconcile my beliefs with the official EMDRIA position on EMDR if I am going to continue to teach EMDR with their important acceptance. I plan to teach EMDR as required, and comment on aspects of it as outlined above as appropriate. I hope that as EMDR continues to be officially described, the ideas expressed in this paper will be considered.

**Finally**

When considering if EMDR, which I think is the most important contribution to the field of psychotherapy at least in my lifetime, is a comprehensive psychotherapy one can’t help notice that you could not teach a beginning psychotherapy course from Shapiro’s text. Beyond that, Francine and EMDRIA have never offered EMDR training, or even considered doing so to anyone who is not already a licensed psychotherapist or a student working on becoming one under the supervision of a faculty member.

1. I will sometimes refer to Dr. Shapiro as Francien because this is a personal essay and this is how I knew her and think of her at the times I use it. [↑](#footnote-ref-1)
2. There was early discussion of EMDR as a “technique”, “method” or “approach” If this distinction cannot be used to refute my point, as Francine came to explicitly considers it an “approach”. [↑](#footnote-ref-2)
3. After several drafts of this essay I was fortunate to came across a research paper from African EMDR therapists (Mbazzi et al. 2021 ) in which they shared their and other therapists’ modifications of the 8 phases to be more appliable to their own clients. Among these modifications was moving the Preparation phase to become the first phase. I think it would be reasonable to consider that some of the Preparation phase activity is so universal to therapy that it should be first considered prior to consideration of whether or not EMDR would be formally offered to a client. Since Preparation includes both specific teaching about EMDR and stress management skills, as will be seen, I am going a step further in breaking up preparation into pre-EMDR and EMDR activities. [↑](#footnote-ref-3)
4. As my failure to a identify most of the problems described here early in EMDR development was acknowledged earlier, I will say that a few raised here were brought to attention in my 2000 book on EMDR. [↑](#footnote-ref-4)
5. However, it may be that there is some traditional desensitization taking place at times. [↑](#footnote-ref-5)
6. Such I believe was also part of the motivation for changing the meaning of the AIP from “Accelerated” to “Adaptive”. Adaptive did not sound like it was making the same kind of extraordinary claim as “Accelerated”, so there might be less resistance. By the time she was solidifying this change in the second edition I was no longer one of the people she relied on for advice in this kind of decision. (I would have opposed it, but that question that might be more fully addressed at another time.) [↑](#footnote-ref-6)
7. Memory is usually the term, however, since we may start with a possible future event this needed to be acknowledged. [↑](#footnote-ref-7)
8. In my practice this is the first time I employ what are currently called the Assessment phase questions, except for the visual image. [↑](#footnote-ref-8)
9. I’m not sure how well this fits, but I did want to keep it a 8 phases [↑](#footnote-ref-9)
10. This is the place to mention that I would add identifying a “preferred emotion”. In the standard 8 phases the preferred emotion is calm, or no emotion. I think this is a problem. I address it in a paper, “The Preferred Emotion..”, at my web site. [↑](#footnote-ref-10)
11. Since we may start with an imagined future event, the target is not always a memory [↑](#footnote-ref-11)
12. I would prefer another term , but have not yet come up with one. [↑](#footnote-ref-12)
13. I think her elegant condensing of cognitive therapy and positive psychology elements into the “Assessment” phase was a major contribution to psychotherapy. [↑](#footnote-ref-13)
14. Perhaps, it has been obvious that I have not referred to the sensory sensory/motor activity as either “dual attention” or “bi-lateral stimulation”. This is because although both may be accurate abstractions, I don’t think that is full supported yet. Again, a subject for another time. [↑](#footnote-ref-14)