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EMDR Therapy Certification Packet

This packet is a collection of resources that are not my own creation. Most of these resources can be found on EMDRIA.ORG . I have collected them onto this document for your convenience.

Contents:

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Brief Description of EMDR Therapy

EMDR is an information processing therapy that uses an eight-phase approach. When something traumatic or negative occurs, sometimes people store this event in their brains in a dysfunctional manner and many of the elements of the event freeze or are stuck and remain unprocessed. When the person thinks about the event or trauma, or when the memory is triggered by similar situations, the person may feel like they are reliving it. This reliving can be in the form of thoughts, feelings, body sensations or flashbacks. A trauma can be described as a big T or a little t.

After identifying what is at the root of what is bothering the person the most, in the desensitization phase, using eye movement, auditory sounds or hand sensors, the bi-lateral stimulation serves to help release the dysfunctional, unprocessed material and integrate it with the more functional part of the brain. In other words, the person will not forget (memory erase) the trauma or negative experience but it will reduce the emotional charge attached to it and, in most cases, the person will no longer be triggered.

The GOAL of EMDR is to provide the most profound and comprehensive treatment in the shortest amount of time while maintaining a stable client in a balances system.

Necessary Criteria for Certification in EMDR

Case Conceptualization and Treatment Planning:

- Candidate understand how past experiential contributors' impact/inform present day disturbances and can be used to predict or inform positive outcomes.
- Candidate understands the AIP model.
- Candidate can state what a treatment plan is, what strategies are used to identify targets and triggers, and can identify the difference between memories, triggers, and symptoms.
- Candidate is competent at determining the past events and knows the utmost importance of reprocessing the past events first, unless there is a valid reason why not to reprocess the old material first (i.e., recent event or acute stress reactions). Candidate has thoughtful understanding and offers valid reasons for not proceeding in this manner.
- Candidate is competent at determining and carrying out the individualized treatment plan including the three-pronged approach (past events, present day triggers and future template).
- Candidate understands the treatment plan is a growing document that is the roadmap for treatment and is dictated by the client's level of affect tolerance.
- Candidate understands how the client's symptoms manifest behaviorally, emotionally, somatically, relationally, and cognitively.

- Candidate understands and knows how to determine the client's readiness for reprocessing. S/He knows how to adequately prepare the client for reprocessing. Candidate understands that positive memory networks are necessary for reprocessing and how to develop them.
- Candidate understands the complexity of multiple early trauma and disturbing materials and the influence or complications it causes to treatment planning. Candidate is able to demonstrate how to proceed with the reprocessing treatment plan, when blocking beliefs or feeder memories or other disturbing events surface.

Phase 1: History Taking

- Candidate appropriately gathers historical information both in general and EMDR specific (attachment and trauma history). In regards to the EMDR specific history gathering, the candidate appropriately identifies the earlier experiences (e.g., traumatic and disturbing live event) as well as negative themes or beliefs which influence and impact the present life experiences.
- Candidate understands timing of this phase is key and depends on the client's level of affect tolerance.
- Candidate appropriate identifies what earlier life events could have contributed to developmental deficits and maladaptive learning and is able to identify the earliest contributors to the client's pathology and behavioral/emotional dysfunction.

- Candidate understands the importance of the concepts of Fault/Responsibility, Safety, and Power/Control to determine treatment planning.
- Candidate understands the importance of assessing dissociative symptoms.

Phase 2: Preparation

- Candidate has appropriate therapeutic relationship before starting to reprocess memories
- Knows how to conduct multiple tools for stabilization
    1. Safe/Calm Place
    2. RDI
    3. Container
    4. Relaxation and other stress management strategies
- Candidates understands why and how to use stabilization tools not only in preparation for reprocessing, but also during history gathering and between sessions.
- Candidate understands the main elements of this phase: resourcing/skill building, education of process, psycho-education of the brain/ANS/dissociation etc., ensuring emotional/cognitive/somatic literacy.

- Candidate understands all the mechanics and procedures involved in resourcing and reprocessing.
- Candidate explains all these elements of EMDR to client as part of the explanation of EMDR.
    1. Seating
    2. Distance
    3. BLS – types to use chosen in this phase.
        1. Formats, with EM as the preferred
        2. Differences for resourcing verses reprocessing
    4. Stop Signal/Metaphors

Phase 3: Assessment

- Candidate understands that this phase is about accessing and activating the memory by "zooming in," which in turn provides a baseline to understand how the memory exists for the client (or an assessment of the memory)
- Candidate arranges seating position, determines distance, stop signal and preferred BLS method before proceeding with the Assessment. The candidate also provides explanation of the procedures and expectations of the client during reprocessing.
- The memory for reprocessing is adequately chosen and accessed by identifying all components of the traumatic memory:
    1. Target memory
    2. Image
    3. Negative Cognition (NC)

        - Negative/Irrational,
        - Self-referencing Statement,
        - Generalized to the whole self
        - Present-Tense, while re-experiencing the old memory now

    4. Positive Cognition (PC)

        - Positive, Self-referencing Statement
        - Present-Tense

    5. Validity of Cognition (VOC 1-7)
    6. Emotions/Feelings
    7. Subjective Units of Distress (SUDS 0-10)
    8. Location of Body Sensation

Phase 4: Desensitization

- Candidate understands the goal of this phase is to process and reduce the level of disturbance associated with the memory.
- Candidate understands DAS – Disturbance reduction, Assimilation, Synaptic connections.
- Candidate conducts BLS appropriately given clients presentation
- Candidate stays appropriately "out of the way"
- Candidate gives appropriate support, uses metaphor during a set of BLS, if necessary
- Candidate knows when and how to intervene when reprocessing is stalled or looping
- Candidate understands plateaus of information processing.
- Candidate appropriately manages client's abreactions
- Candidate appropriately knows when, why and how-to re-access target memory
- Candidate understands the difference between going back to target, when SUDS are needed, and when you have reached the end of a channel.
- Candidate knows the measuring scale and how to take a SUDs and what to do if it is >0
- Candidate knows what to do if SUDs = 0 (1, if ecologically sound)
- Candidate appropriately responds client's stop signal, if appropriate
- Candidate understands the difference between the end of a channel and end of phase.
- Candidate knows how to close down an incomplete session

Phase 5: Installation

- Candidate understands this phase is about strengthening positive memory networks and attaching a new meaning to the memory.
- Candidate understands the criteria for being a cognition.

- If SUDs = 0 (1, if ecologically sound), candidate pairs original positive cognition with the targeted memory to check its appropriateness. If not, the candidate facilitates the client to determine a more suitable positive cognition.
- Candidate appropriately checks the VoC rating of the suitable positive cognition paired with the targeted memory.
- If VoC is <7, candidates knows how to determine what is preventing it from being a 7 and resume reprocessing.
- When VoC is = 7, candidate conducts a set of BLS to complete Installation.

Phase 6: Body Scan

- Candidate has client perform a Body Scan while pairing targeted memory with PC, requesting client to noticing any disturbing thoughts, emotions or body sensations.
- If necessary, candidate resumes reprocessing by having the client focus on disturbing material.
- Candidate understands the kind of BLS/DAS used.

- Candidate conducts another Body Scan, once disturbing material is reprocessed.

Phase 7: Closure

- Candidate understands that the goal of this phase is to preserve and maintain stability and balance in between sessions (bringing client back to emotional balance and homeostasis).
- Candidate knows not to check SUDS here and that every session ends here.
- Candidate knows that closing is based on individual client needs ex. Up or down regulation strategies
- If it is an incomplete EMDR session at the end of a therapy session:

    - Candidate appropriately conducts container and affect management exercises
    - Candidate does appropriate debriefing
        1. Explanations – i.e., reprocessing may continue
        2. Recommendation of the use of containers, safe place, and other affect management strategies between sessions
        3. Expectations of client, such as keeping a log

- If it is a completed EMDR session

    - Candidate does appropriate debriefing
        1. Explanations – i.e., reprocessing may continue
        2. Expectations of client, such as keeping a log
    - Containment for any disturbing materials which was activated during reprocessing but not directly related to reprocessed targeted memory

Phase 8: Re-Evaluation

- Candidate understands every session begins here.
- Candidate appropriately checks in with client about experiences since last session (general re-evaluation – any changes or new information, how they are managing and using their coping skills, symptoms worsening or better AND SUD/VOC specific)
- Candidate arranges seating position, determines distance, stop signal and preferred BLS method before proceeding with any further reprocessing or setting up the next target memory.
- In the event of an incomplete reprocessed EMDR target in previous session, candidate appropriately re-accesses target and continues with reprocessing.
- In the event of a completed EMDR target in previous session, candidate appropriately proceeds with the individualized treatment plan by choosing and reprocessing the next target memory.

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Future Template

- When past events and present-day triggers are adequately reprocessed, candidate continues with Future Template protocol.
- Candidate understands the procedural steps of future template around triggers and challenges.
- Candidate understands the difference between RDI future template, reprocessing anticipatory fears and triggers, and future template as a procedural step and the 3rd prong of the three-prong protocol.

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Certification Consultee Evaluation Form

This evaluation form is provided to Approved Consultants and Consultants in Training to support their evaluation of consultees working towards Certification. EMDRIA recommends that Consultants utilize this measure (or an equivalent tool) to assess a consultee's knowledge and skills in providing EMDR therapy and to identify areas to strengthen prior to recommending for the Certification credential.

No minimum/passing score is indicated due to the subjective nature of such an evaluation; however, the items below reflect content essential to the Certification process. Thus, if a consultee has not demonstrated the skill or practice described in each item, the consultant has reason to require that it be adequately demonstrated (in a manner determined by the Approved Consultant) prior to recommending for Certification.

Does the consultee gather an appropriate client history?

(Never) 1 2 3 4 5 *(Always)*

Is the consultee sensitive to different client populations?

(Never) 1 2 3 4 5 *(Always)*

Does the consultee utilize available resources for client support? (e.g. medical, family, social, community, religious, etc.)

(Never) 1 2 3 4 5 *(Always)*

Does the consultee adequately assess the client for appropriateness for EMDR therapy?

(Never) 1 2 3 4 5 *(Always)*

Does the consultee adequately screen the client for dissociation? (e.g. DES, MID, etc.)

(Never) 1 2 3 4 5 *(Always)*

Does the consultee adequately explain the EMDR therapy process to the client?

(Never) 1 2 3 4 5 *(Always)*

Does the consultee adequately prepare the client for EMDR therapy?

(Never) 1 2 3 4 5 *(Always)*

Does the consultee understand the mechanics of EMDR? (e.g. seating, distance, stop signal, etc.)

(Never) 1 2 3 4 5 *(Always)*

Does the consultee utilize the 'safe place' effectively?

(Never) 1 2 3 4 5 *(Always)*

Does the consultee utilize RDI effectively when needed?

(Never) 1 2 3 4 5 *(Always)*

Does the consultee 'stay out of the way' while processing with the client?

(Never) 1 2 3 4 5 *(Always)*

Does the consultee deal effectively with the 'looping' and 'stuck processing'? (e.g. change direction, speed or amount of eye movements; change modalities; cognitive interweave)

(Never) 1 2 3 4 5 *(Always)*

Does the consultee provide appropriate closure for incomplete sessions?

(Never) 1 2 3 4 5 *(Always)*

Does the consultee utilize standard EMDR therapy in a comprehensive treatment plan for clients?

(Never) 1 2 3 4 5 *(Always)*

Does the consultee demonstrate proficiency and fidelity in applying standard EMDR therapy?

(Never) 1 2 3 4 5 *(Always)*

Does the consultee demonstrate an understanding of when to use standard EMDR therapy versus when modifications are necessary in order to safely and effectively treat the client?

(Never) 1 2 3 4 5 *(Always)*

Does the consultee prepare adequate written case presentation material or recordings of their use of EMDR therapy with clients for consultation purposes?

(Never) 1 2 3 4 5 *(Always)*

Strengths & Weaknesses:

Example EMDR Case Presentation Form

The concept behind this EMDR Case Presentation Form is that the consultee can use this form to summarize the EMDR client case they choose to bring for discussion during the consultation process. Case presentation details can be outlined and summarized by the consultee so that the consultant can provide guidance and feedback on their use of EMDR with clients. Both consultants and consultees are welcome to use the form as is, make modifications, or use other resources for consultation process.

Describe the focus area or question for this consultation session (case transcript needed/included?):

Relevant Consultee Areas:

- Describe therapist relationship with client (sensitivity to client differences?):
- EMDR appropriateness for client assessed:
- Adequate preparation for EMDR therapy (explanation issues, hesitations from consultee or client?):
- Informed consent for EMDR therapy:

Phase 1: Client History (be mindful of client confidentiality/HIPAA requirements)

- Why did client seek treatment?
- Relevant historical, cultural, family, medical, emotional, social support, or attachment information:
- Relevant dissociative assessment (ie. DES, MID) and/or other assessment information:
- Relevant current life stressors and resources:
- Relevant trauma history and target possibilities:
    - Past memories, present triggers, future goals? Complex trauma?
- Case conceptualization using AIP:
    - Identify memory networks for presenting problem:
    - Relevant clinical themes (responsibility, self-worth, safety, control, choices):
- EMDR Treatment Plan (indicate reasoning):
    - Stabilization/resource development sufficient prior to reprocessing?
    - Symptom reduction or comprehensive treatment? ○ Three prongs addressed? Future goals? Observations?
    - Target sequencing plan and why? (ie. Problem Driven, Present Trigger first, Timeline, Single Event, Other)

Phase 2: Preparation

- Logistical preparations such as distance, BLS speed, stop signal:
- Safe/Calm Place:
- Are additional stabilizing resources needed (Resource Development Installation (RDI), Container, skills to stay present, etc):

Phase 3: Assessment

- Target selected (Past memory or present trigger?):
- Picture/image/worst part:
- NC, PC & VOC:
- Emotions:
- SUD:
- Body Sensations:

Phase 4: Desensitization

- Describe relevant parts of the desensitization process. How did it go? Observations?
- BLS type and why (BLS changes?):
- SUD 0 or ecological?
- Stuck points, insights, shifts?
- Feeder memories, following new material:
- Interweaves needed:

Phase 5: Installation

- Describe installation process. How did it go? Observations?
- PC same or change:
- VOC to 7?
- Blocks? Feeder memories?

Phase 6: Body Scan

- Describe body scan process. How did it go? Observations?
- Clear:
- Unclear:
- Blocks? Feeder memories?

Phase 7: Closure

- Describe process. Was target reprocessing incomplete/complete?
- If incomplete, where was client getting stuck? How was client stabilized?
- What was client experience?

Phase 8: Reevaluation

- Describe client self-report during follow-up at their next session. How did it go? Observations?

Present Triggers

- Were all present triggers processed? How did it go? Observations?
- What was client experience?
- Blocks? Feeder memories?

Future Template

- Describe setting this up after present triggers are resolved. How did it go? Observations?
- What was client experience?
- Blocks? Feeder memories?

Additional relevant notes or questions:

emdria
EMDR International Association

CHECKLIST

*Use this checklist to organize everything you need before submitting your Certification application!

EMDRIA Certified Therapist

- [ ] Filled out Certification Application Form
  - ◯ Correct contact information listed
- [ ] EMDRIA Approved EMDR Training Certificate
  - ◯ Name and completion date is listed on certificate
- [ ] Current License to Practice Independently in Your State or Province
  - ◯ Name, license type, license number, and expiration date listed
- [ ] Notarized Document with the Two Statements
  - ◯ Signed/ stamped by notary
- [ ] Completed 20 Hours of Consultation
  - ◯ At least 10 individual consultation hours required
  - ◯ Documentation from Approved Consultant(s) / CIT includes number of hours attained, if they were individual vs group hours, and the time frame they were attained
- [ ] Recommendation Letter From Approved Consultant
  - ◯ CIT recommendation letter does not fulfill this requirement
- [ ] Two Recommendation Letters From Peers
  - ◯ Have two separate peer letters
  - ◯ Both peer letters are different from AC / CIT recommendation letters
- [ ] Completed 12 EMDRIA CE Credits
  - ◯ Have certificate, not just an email that says attended
  - ◯ Certificate(s) have EMDRIA program number and number of credits it is approved for
- [ ] Payment
  - ◯ Sending check along with application
  - ◯ Providing credit card information along with my application

Note, this is NOT the form you will submit to EMDRIA when you apply for certification

Access the application at https://cdn.ymaws.com/www.emdria.org/resource/resmgr/ct_ac_forms_2017/cert.app_2019.pdf

5 WAYS TO GET THE MOST OUT OF YOUR EMDR CONSULTATION

TO BECOME AN EMDRIA APPROVED CONSULTANT

1

KNOW THE APPROVED CONSULTANT CRITERIA

Get familiar with the Approved Consultant application process! Familiarize yourself with what consultation-of-consultation is. Know what you are responsible for and what you'll need from your consultant. (www.emdria.org/page/51)

2

COMPLETE THE CIT DECLARATION

Declare your Consultant-in-Training status. This lets EMDRIA know you intend to become an Approved Consultant and educates you on the terms and conditions of the CIT process. In addition, you will be included on our CIT search so that consultees seeking consultation for EMDRIA Certification can find you.

3

INTERVIEW APPROVED CONSULTANTS

Set yourself up for a good working relationship. Before entering a contractual agreement for consultation-of-consultation services, get a feel for the consultant by calling or interviewing them first. Ask yourself 'Will I feel comfortable working with this person?'

4

ENTER A CONTRACTUAL AGREEMENT

Clarify what each party will receive from this relationship. Put this in writing. An important step in this process is understanding what you are agreeing to in the consultation of consultation relationship. What will you receive out of the relationship? What is expected of you? Does it fulfill what you need for your Approved Consultant application?

5

COMMUNICATE THROUGHOUT THE PROCESS

Transparency fosters trust. Be sure to communicate concerns and expectations throughout your relationship. Sincere and honest communication sets you up for success.

KEY TERMS AND DEFINITIONS

FOR EMDR CONSULTATION

CONSULTANT:

The person providing the consultation. For the purposes of this document, the term consultant may refer to either an Approved Consultant or Consultant in Training.

CONSULTEE:

The person receiving the consultation.

CONSULTANT IN TRAINING (CIT):

A Consultant in Training is an EMDRIA Certified Therapist who has completed the CIT declaration process, upholds the terms and agreements and is actively working towards becoming an Approved Consultant. The CIT is expected to work with at least five different consultees, three of whom have already completed the EMDR basic training. The CIT can provide a maximum of 15 hours of consultation to any one single consultee who is working towards EMDRIA Certification.

CONSULTATION:

Consultation is a collaborative relationship between mental health clinicians in which the consultant reviews the consultee's EMDR client case material and provides feedback to the consultee regarding their use of standard EMDR therapy with clients. The consultation is expected to be consultee-centered which means the focus is on the skills and knowledge of the consultee's use of standard EMDR therapy with clients. The consultation should be structured in format and consultees are expected to provide examples of their clinical work as part of the consultation process. This may include video recordings, audio recordings, near verbatim transcripts, and/or EMDR case presentation forms. The consultant is expected to review and evaluate the consultee's work as part of the consultation process.

- EMDR basic training consultation: The EMDR basic training consultation hours are focused on implementation and initial application of standard EMDR therapy and the AIP model in work with actual client cases.
- EMDRIA Certification consultation: The certification consultation hours are focused on demonstrating proficiency and fidelity to the standard EMDR therapy and also demonstrating an awareness of situations in which modifications to standard EMDR therapy are necessary in order to safely and effectively treat the client.

NOTE: Consultation is not equivalent to clinical supervision. Hours accrued toward EMDRIA Certification are not recommended to co-occur with supervision (for licensure). Consultation is also not equivalent to provision of psychotherapy services, which poses an ethical issue of dual relationship.

CONSULTATION-OF-CONSULTATION:

Consultation-of-consultation is a collaborative relationship between mental health clinicians in which a consultant provides feedback and guidance to a Consultant in Training (CIT). The feedback is focused on the CIT's skills and ability to provide consultation to other clinicians based on material presented by the CIT, direct observation, or recorded observation. The consultation-of-consultation should be structured in format and the CIT is expected to provide examples of their ability to provide consultation to others. The CIT is expected to work with at least five different consultees, three of whom have already completed the EMDR basic training. The consultant is expected to review, evaluate, and determine the readiness of the CIT as part of the process. Although co-leading consultation groups and shadowing (which is defined as being present while a consultant provides consultation) are significant and valuable for the CIT process, these activities themselves do not directly count as consultation-of-consultation hours. (In other words, consultation-of-consultation does not occur during the training event.)

NOTE: Only Approved Consultants can provide consultation-of-consultation to Consultants in Training.

KEY TERMS AND DEFINITIONS

FOR EMDR CONSULTATION

INDIVIDUAL CONSULTATION:

Individual consultation includes a total of two individuals, the consultant and consultee (1:1). Individual consultation hours can be accrued in a group setting under certain conditions (see group consultation below).

GROUP CONSULTATION:

Group consultation includes at least two consultees in a formalized setting which is led by a consultant in a structured group format. All consultees in the group are expected to participate and be prepared to bring their own EMDR case presentation material content for discussion. As a general guideline, groups should allow a ratio of 15 minutes per individual participant.

- EMDR basic training consultation: Group consultation size for basic training cannot exceed 10 consultees (1:10). When group time is not equally divided among consultees, each participant is expected to present case material, so that all consultees in the group both demonstrate and observe their peer's demonstration of standard EMDR therapy.
- EMDRIA Certification consultation: Group consultation size for certification cannot exceed 8 consultees (1:8). When group time is not equally divided among consultees, each participant is expected to present case material, so that all cosultees in the group both demonstrate and observe their peer's demonstration of proficiency and fidelity to the standard EMDR therapy. Consultees in this setting should also be able to demonstrate an awareness of situations in which modifications to standard EMDR therapy are necessary in order to safely and effectively treat the client.
- Consultation-of-consultation: Group size for consultation-of-consultation cannot exceed 4 CITs (1:4).

Individual consultation hours can be accrued in a group setting under certain conditions and the following examples are provided to outline the conditions and limitations:

- If there are 2 consultees participating in a group consultation session, the meeting time would be 60 minutes and each consultee would spend 30 minutes presenting their case for consultation. This means both consultees would receive 30 minutes of individual consultation and 30 minutes of group consultation.
- If there are 3 consultees participating in a group consultation session, the meeting time would be 90 minutes and each consultee would spend 30 minutes presenting their case for consultation. This means each consultee would receive 30 minutes of individual consultation and 60 minutes of group consultation.
- If there are 4 consultees participating in a group consultation session, the meeting time would be 120 minutes and each consultee would spend 30 minutes presenting their case for consultation. This means each consultee would receive 30 minutes of individual consultation and 90 minutes of group consultation.

As outlined in the examples above, the ratio would be 30 minutes of meeting time multiplied by the number of consultees in the group (30 minutes x each consultee = length of group consultation meeting) in order to calculate the duration of the group consultation meeting. The duration of the group consultation session would depend on the number of consultees participating in the group. A maximum of 30 minutes of individual consultation can be accrued per session and the remaining time is counted as group consultation. While 8 consultees could potentially participate in group consultation and accrue individual consultation hours, this situation would not be ideal as that group would have to meet for 4 hours.

NOTE: Consultation groups are distinct from study groups or groups focused on special populations and alternative procedures/protocols, which may not be structured and may enrich the practices of those attending, but do not count for consultation hours toward EMDRIA Certification.

STANDARD EMDR THERAPY:

Standard EMDR therapy means maintaining fidelity to EMDR therapy's eight phase, three-pronged approach (Shapiro, 2018).

Appendix A: Fidelity Checklists

Few clinicians look forward to having their work evaluated. However, such evaluations are often essential to advancing scientific knowledge or to enhancing clinical skills. The degree to which a manualized method is applied as intended is referred to as a fidelity rating. A system for fidelity rating is a fundamental component of the "gold standard" (Foa & Meadows, 1997) for evaluating the strength of treatment outcome studies of posttraumatic stress disorder. In addition, EMDR International Association (EMDRIA)-Approved Consultantsneed to have an objective set of criteria for evaluating the clinical work of those seeking the designation of EMDRIA Certified in Eye Movement Desensitization and Reprocessing (EMDR) therapy. Training supervisors may also be called on to assess the work of prelicensed clinicians in applying EMDR therapy.

Until the 2008 publication of an "EMDR Fidelity Questionnaire" for children (Adler-Tapia & Settle,2008), there were no published fidelity rating scales for assessing the application of EMDR therapy. Six fidelityrating scales were developed for the first edition of this book. For the second edition, these fidelity scales were carefully reviewed and revised. The following resources were reviewed as potential sources of relevant standards: "EMDR Fidelity Questionnaire"(AdlerTapia & Settle, 2008), EMDR Readiness Questionnaires (Sine &Vogelman-Sine, 2004), the "EMDR Implementation Fidelity Rating Scale" available from the EMDRIA Research Committee (Korn, Zangwill, Lipke, & Smyth,2001), the EMDRIA Consultation Packet (Standards and Training Committee, EMDR International Association, 2001),the EMDR Europe Accredited Practitioner Competency-Based Framework (EMDR Europe, 2015), and "Clinical Competencies for the Six Core Competencies: An Update on the Work of the EMDRIA Professional Development Subcommittee"(EMDRIA Professional Development Subcommittee, 2015b).

This set of rating scales can be used by clinicians for self-rating. They can be used in clinical supervision by supervisees and clinical supervisors to clarify the use of EMDR therapy. They can be used in conjunction with consultation as part of the basic training in EMDR and to help prepare clinicians for the advanced designation of EMDRIA certification. Researchers should be aware that in addition to the scales in this chapter, the "EMDR Implementation Fidelity Rating Scales" (Korn et al., 2001) are available from the EMDRIA Research Committee as described on the EMDRIA website (EMDRIA, 2015e). What follows is an overview of the six fidelity rating scales developed for this manual.

1. There is one fidelity scale covering history taking, case formulation, and treatment planning.

2. There are three fidelity scales for the Preparation Phase. The first scale covers general preparation issues including informed consent issues. A second fidelity scale covers the use of calm place exercise. A third scale addresses the use of Resource Development and Installation(RDI)—including both appropriate use and avoiding excessive or inappropriate use. This scale can be skipped as not applicable in many treatment situations. When applicable, it can be used repeatedly if necessary to cover installation of resources during more than one treatment session.
3. A single reprocessing session rating scale is used repeatedly as necessary for as many targets as there are to be rated. It includes a reevaluation section at the start that is skipped and not scored for the first reprocessing session for the patient.
4. The sixth rating scale provides an assessment of overall treatment including adjust ments to the treatment plan based on previous reprocessing sessions and reevaluation of the patient; whether targets related to past, present, and future were identified and reprocessed appropriately; and whether treatment goals were achieved.

Each of the six scales in this system uses a 3-point numeric rating:

a. "0" signifies missing or no adherence.
b. "1" signifies adherence is identified but is weak or flawed.
c. "2" signifies adherence is good.

Average rating scores are to be calculated for each scale as a whole and for each of the six sections of the reprocessing scale. Note that because some items are only scored when applicable, the total number of items to be averaged has to be counted for sections containing such items. There are a few critical items that, when applicable, are counted as two items. These doubled items contain two sets of rating numbers for ease in counting the number of items to be averaged.

Finally, there is a summary chart where average ratings from each applicable fidelity rating scale can be listed and a global fidelity score can be computed. There is space on this summary chart for up to three applications of RDI and up to eight EMDR reprocessing sessions. The interpretation of the average ratings is as follows. An average rating of less than 1 signifies inadequate adherence. An average rating of more than 1 signifies weak adherence. An average rating of more than 1.25 signifies adequate adherence. An average rating of more than 1.5 signifies good adherence. An average rating of 1.75 signifies superior adherence.

From: A Guide to the Standard EMDR Therapy Protocols for Clinicians, Supervisors, and Consultants, Second Edition DOI: 10.1891/9780826131171.ap01

EXHIBIT A.1

EMDR Therapy Fidelity Rating Scale for History Taking, Case Formulation, and Treatment Planning			
Subject Code:		Date of Session:	
Rater:		Date of Review:	
Comments:		Average Rating:	

Rating Scale: No Adherence: 0, Weak: 1, Good: 2

1	Did the clinician obtain a list of presenting complaints and symptoms?	0	1	2
2	Did the clinician identify the subject's treatment goals regarding desired behavioral, somatic, affective, and cognitive changes as well as any treatment-related concerns or fears?	0	1	2
3	Did the clinician identify current external and internal stimuli and patterns of response associated with symptoms?	0	1	2
4	Did the clinician obtain a life history of adverse and traumatic events?	0	1	2
5	Did the clinician identify childhood and current attachment patterns?	0	1	2
6	Did the clinician rule out medical and other risk issues for EMDR reprocessing?	0	1	2
7	Did the clinician identify nature and degree of structural dissociation (primary, secondary, or tertiary) using standard tools and thorough clinical assessment?	0	1	2
8	Did the clinician identify specific and co-occuring diagnoses including any personality disorders?	0	1	2
9	Did the clinician assess history and current substance abuse?	0	1	2
10	Did the clinician assess history and current danger to self and others?	0	1	2
11	Did the clinician assess history and current tension reduction, self-injurious, and therapy interfering behaviors?	0	1	2
12	Did the clinician assess coping skills and affect tolerance and provide a Preparation Phase of appropriate length (i.e., long enough while not needlessly delaying or avoiding reprocessing)?	0	1	2
13	Did the clinician develop a collaborative treatment plan and sequence of targets appropriately clustered and prioritized by symptom severity and treatment goals?	0	1	2
14	Did the clinician develop an overall case formulation informed by the AIP model?	0	1	2
	History-Taking Phase average score: Total divided by 14 items.			

EXHIBIT A.2

EMDR Therapy Fidelity Rating Scale for Preparation Phase Session			
Subject Code:		Date of Session:	
Rater:		Date of Review:	
Comments:		Average Rating:	

Rating Scale: No Adherence: 0, Weak: 1, Good: 2

1	Did the clinician provide psychoeducation on trauma and recovery?	0	1	2
2	Did the clinician provide psychoeducation on subject's role in sessions?	0	1	2
3	Did the clinician obtain and record informed consent to treatment with EMDR therapy?	0	1	2
4	Did the clinician encourage the use of bilateral eye movements (rather than taps or tones) and assess subject's tolerance for bilateral eye movements?	0	1	2
		0	1	2
5	Did the clinician have subject rehearse a stop signal?	0	1	2

6	Did the clinician provide an appropriate metaphor to enhance mindful noticing?	0	1	2
7	Did the clinician assess, teach, and reevaluate anxiety-reduction skills as needed?	0	1	2
8	Did the clinician assess, teach, and reevaluate dissociation reduction skills as needed?	0	1	2
9	Did the clinician use calm (safe) place or RDI before reprocessing?	0	1	2
	Preparation Phase average score: Divide total by 10. Nine items and item 4 is doubled.			

EXHIBIT A.3

EMDR Therapy Fidelity Rating Scale for Calm Place—Safe Place Exercise			
Subject Code:		Date of Session:	
Rater 1:		Date of Review:	
Comments:		Average Rating:	

Rating Scale: No Adherence: 0, Weak: 1, Good: 2

1	Did the clinician provide an explanation and purpose for the calm place exercise?	0	1	2
2	Did the clinician assist in identifying an appropriate memory or image?	0	1	2
3	Did the clinician elicit additional sensory details?	0	1	2
4	Did the clinician add brief sets (4–12 cycles) of bilateral eye movements (or alternate bilateral stimulation)?	0	1	2
5	Did the clinician ask subject to report feelings and observations after each set of stimulation?	0	1	2
6	Did the clinician ask subject to identify a cue word or phrase and rehearse it with the imagery and additional sets of bilateral stimulation?	0	1	2
7	Did the clinician ask subject to rehearse the imagery and cue word(s) without guidance?	0	1	2
8	Did the clinician ask subject to remember a disturbing incident or situation and then rehearse the exercise again with guidance?	0	1	2
9	Did the clinician ask subject to remember another disturbing incident or situation and then rehearse the exercise again without guidance?	0	1	2
10	Did the clinician ask subject to identify an alternate memory or image if the first led to negative associations? *(Skip if not applicable.)*	0	1	2
	Calm (safe) place exercise average score: One item can be skipped. Possible total of 10 items.			

EXHIBIT A.4

EMDR Therapy Fidelity Rating Scale for Resource Development and Installation			
Subject Code:		Date of Session:	
Rater:		Date of Review:	
Comments:		Average Rating:	

Rating Scale: No Adherence: 0, Weak: 1, Good: 2

1	If RDI was used for stabilization, did the clinician identify the presence of one of the following four criteria before using RDI? (*Skip if RDI was not used for stabilization*. ***Counts as two items if applicable.***) a. The subject shows impaired self-regulation skills, engages in angry outbursts, maladaptive tension reduction behaviors, dangerous or impairing substance abuse, self-injurious behaviors, or therapy interfering behaviors, or has expressed fears of starting EMDR reprocessing, and standard methods for self-control (progressive relaxation, breathing exercises, or calm place exercise) have proven insufficient. b. The clinician identified a substantial risk the subject would terminate treatment prematurely if EMDR reprocessing were started because of borderline shifts from idealizing to devaluing the clinician; weak ego strength; intolerable shame over acting out or tension reduction behaviors; or inability to cope with reexperiencing incompletely reprocessed or other intrusive, painful memories. c. The subject has episodes of being overwhelmed by affect, is confused, and is unable to express thoughts, concerns, or affects about events in a coherent narrative. d. EMDR reprocessing has led to chronically incomplete treatment sessions or to adverse impacts on subject's day-to-day functioning.	0 0	1 1	2 2
2	Did the clinician provide an explanation and purpose for the RDI exercise?	0	1	2
3	Did the clinician identify an appropriate, current, challenging target situation from a behavioral chain analysis or a chronically incomplete reprocessing target?	0	1	2
4	Did the clinician assist in identifying one or more qualities or skills needed for the target situation?	0	1	2
5	Did the clinician assist in identifying one or more appropriate memories or images for the qualities or skills needed for the target situation?	0	1	2
6	Did the clinician prompt the subject (if needed and appropriate) to consider mastery memories, role models, supportive others, and symbols as potential sources for adaptive responses? *(Skip if not applicable.)*	0	1	2
7	Did the clinician elicit additional sensory details?	0	1	2
8	Did the clinician repeat these sensory details to enhance recollection and vividness of the memory or image?	0	1	2
9	Did the clinician add brief sets (4–12 cycles) of bilateral eye movements or alternate bilateral stimulation?	0	1	2
10	Did the clinician ask the subject to report feelings and observations after each set of stimulation?	0	1	2
11	If needed, did the clinician repeat the sensory details to restore access to the resource memory or imagery before subsequent sets of stimulation?	0	1	2
12	Did the clinician ask subject to identify cue words or linking imagery and rehearse with the resource and additional sets of stimulation?	0	1	2
13	Did the clinician ask subject to identify an alternate memory or image if the first led to negative associations? *(Skip if not applicable.)*	0	1	2
14	Did the clinician verify the subject was able to mentally rehearse making use of one or more resources with adequate confidence in a future occurrence of the target situation?	0	1	2
15	Did the clinician verify in a follow-up session that the subject was better able to manage the target situation? *(Skip if not applicable.)*	0	1	2
	Resource Development and Installation average score: Up to four items can be skipped. Fifteen items, one can be doubled.			

EXHIBIT A.5

EMDR Therapy Fidelity Rating Scale for Reprocessing Session			
Subject Code:		Date of Session:	
Rater:		Date of Review:	
Comments:		Average Rating:	

Rating Scale: No Adherence: 0, Weak: 1, Good: 2

	Reevaluation Phase average score (items 1–4):			
	Assessment Phase average score (items 5–14):			
	Desensitization Phase average score (items 15–28):			
	Installation Phase average score (items 29–34):			
	Body Scan Phase average score (items 35–38):			
	Closure Phase average score (items 39–45):			
	Reevaluation Phase			
1	Did the clinician reevaluate the subject's experience since the last session with attention to feedback from the log, presenting complaints, responses to current stimuli, and additional memories or issues that might warrant modifications to the treatment plan? (This is crucial after history-taking sessions as well as after stabilization and reprocessing sessions.)	0	1	2
2	Did the clinician check the SUD and VoC on the target from the last session? (*Skip if this is the first reprocessing session.*)	0	1	2
3	Did the clinician check for additional aspects of the target from the last session that may need further reprocessing? (*Skip if this is the first reprocessing session.*)	0	1	2
4	If the target from the last session had been incomplete or if in this session the subject reported the SUD were now a 1 or above or the VoC were a 5 or below, did the clinician resume reprocessing on the target from the last session? (*Skip if this is the first reprocessing session or if a more appropriate, disturbing, earlier or related memory was identified and selected as the next target.*)	0	1	2
	Reevaluation Phase average score (items 1–4): Possible total of four items. Three items (2, 3, and 4) can be skipped before reprocessing sessions have begun.			
	Assessment Phase			
5	Did the clinician select an appropriate target from the treatment plan?	0	1	2
6	Did the clinician elicit a picture (or other sensory memory) that represented the entire incident or the worst part of the incident?	0	1	2
7	Did the clinician elicit an appropriate negative cognition (NC)?	0	1	2
8	Did the clinician elicit an appropriate positive cognition (PC)?	0	1	2
9	Did the clinician assure that the NC and PC address the same thematic domain: responsibility, safety, choice?	0	1	2
10	Did the clinician obtain a valid VoC by referencing the felt confidence of the PC in the present while the subject focused on the picture (or other sensory memory)?	0	1	2
11	Did the clinician elicit the present emotion by linking the picture and the NC?	0	1	2
12	Did the clinician obtain a valid SUD (i.e., the current level of disturbance for the entire experience—not merely for a present emotion)?	0	1	2
13	Did the clinician elicit a body location for current felt disturbance?	0	1	2
14	Did the clinician follow the standard assessment sequence listed above?	0	1	2
	Assessment Phase average score (items 5–14): Total of 10 items.			
	Desensitization Phase			

15	Before beginning bilateral eye movements or alternate bilateral stimulation, did the clinician instruct subject to focus on the picture, NC (in the first person), and the body location?	0	1	2

(*continued*)

EXHIBIT A.5 (*continued*)

EMDR Therapy Fidelity Rating Scale for Reprocessing Session				
16	Did the clinician provide bilateral eye movements or alternate bilateral stimulation of at least 24 to 30 repetitions per set as fast as could be tolerated comfortably? (*Note*: Children and adolescents and a few adult subjects require fewer passes per set, e.g., 14–20.)	0	1	2
17	During bilateral eye movements or alternate bilateral stimulation, did the clinician give some periodic nonspecific verbal support (perhaps contingent to nonverbal changes in subject) while avoiding dialogue?	0	1	2
18	At the end of each discrete set of bilateral eye movements or alternate bilateral stimulation, did the clinician use appropriate phrases to have the subject, "Rest, take a deeper breath, let it go"(while not asking the subject to "relax") then make a *general* inquiry ("What do you notice now?") while avoiding narrowly *specific* inquiries about the image, emotions, or feelings?	0	1	2
19	After each verbal report, did the clinician promptly resume bilateral eye movements or alternate bilateral stimulation without excessive delay for discussion and without repeating subject's verbal report?	0	1	2
20	If verbal reports and nonverbal observations indicated reprocessing was effective, after reaching a neutral or positive channel end, did clinician return attention to the selected target and check for additional material in need of reprocessing (i.e., "What's the worst part of it now?")?	0	1	2
21	If verbal reports or nonverbal observations indicated reprocessing was ineffective, did the clinician vary characteristics of the bilateral eye movements or alternate bilateral stimulation (speed, direction, change modality, etc.)? (*Skip if not applicable*. Counts as two items if applicable.)	0 0	1 1	2 2
22	If verbal reports or nonverbal observations indicated reprocessing was ineffective, did the clinician do any of these? *(Skip if not applicable.* Counts as two items if applicable.) 1. Explore for an earlier disturbing memory with similar affect, body sensations, behavioral responses, urges, or belief. 2. Explore for a blocking belief, fear or concern disrupting effective reprocessing, and then identify a related memory. 3. Explore target memory for more disturbing images, sounds, smells, thoughts, beliefs, emotions, or body sensation. 4. Invite subject to imagine expressing unspoken words or acting on unacted urges. 5. Offer one or more interweaves.	0 0	1 1	2 2
23	If subject showed extended intense emotion, or if reprocessing was ineffective, did clinician show appropriate judgment in selecting and offering one (or if necessary more) interweave(s) from among the categories of responsibility, safety, and choices while avoiding excess verbiage? *(Skip if not applicable.* Counts as two items if applicable.)	0 0	1 1	2 2
24	If subject showed extended intense emotion, did the clinician continue sets of bilateral eye movements or alternate bilateral stimulation with increased repetitions per set, remain calm, compassionate, and provide verbal cueing paced with the bilateral stimulation to encourage the subject to continue to "just notice" or "follow"? *(Skip if not applicable.* Counts as two items if applicable.)	0 0	1 1	2 2
25	If a more recent memory emerged, did the clinician acknowledge its significance, offer to return to the more recent memory later, and redirect the subject back to the selected target memory within one or two sets of bilateral eye movements or alternate bilateral stimulation? *(Skip if not applicable.)*	0	1	2
26	If an earlier (antecedent) memory emerged, did the clinician continue bilateral eye movements or alternate bilateral stimulation on the earlier memory until it was resolved before redirecting the subject back to the selected target memory (or make a clinically informed decision to help the subject contain this material until a later date due to concerns the subject was not ready to confront this material)? (*Skip if not applicable.*)	0	1	2
27	If it became clear it was not possible to complete reprocessing in this session, did clinician show appropriate judgment to avoid returning subject's attention to residual disturbance in target, skip Installation and Body Scan Phases, and go directly to closure? (*Skip if not applicable*.)	0	1	2

28	If it appeared the Desensitization Phase may have been complete, did clinician show appropriate judgment to return subject's attention to target to confirm the SUD was 0 (or an "ecological" 1) by offering at least one more set of bilateral eye movements or alternate bilateral stimulation on the target before going to the Installation Phase? (*Skip if not applicable.)*	0	1	2
	Desensitization Phase average score (items 15–28): Up to eight items can be skipped. Fourteen items, plus four can be doubled.			

(*continued*)

EXHIBIT A.5 (*continued*)

EMDR Therapy Fidelity Rating Scale for Reprocessing Session				
Installation Phase				
If the Desensitization Phase was completed (and item 27 was scored) proceed to score Installation Phase items. If the Desensitization Phase was incomplete, skip both the Installation and Body Scan Phases and proceed to score the Closure Phase. However, if the desensitization was incomplete and the clinician incorrectly proceeded to the Installation or Body Scan Phases, these phases should be scored and down rated accordingly.				
29	Did the clinician confirm the final PC by inquiring whether the original PC still fit or if there were now a more suitable one?	0	1	2
30	Before offering bilateral eye movements or alternate bilateral stimulation, did the clinician obtain a valid VoC (i.e., by having subject assess the felt confidence of the PC while thinking of the target incident)?	0	1	2
31	Did the clinician offer more sets of bilateral eye movements or alternate bilateral stimulation after first asking each time that the subject focus on the target incident and the final PC?	0	1	2
32	Did the clinician obtain a valid VoC after each set of bilateral eye movements or alternate bilateral stimulation?	0	1	2
33	After sets of bilateral eye movements or alternate bilateral stimulation, if the VoC did not rise to a 7, did the clinician inquire what prevents it from rising to a 7 and then make an appropriate decision to target the thought or move to body scan or closure? (*Skip if not applicable.)*	0	1	2
34	Did the clinician continue sets of bilateral eye movements or alternate bilateral stimulation until the VoC was a 7 and no longer getting stronger (or a 6 if "ecological")? *(Skip if not applicable.) (Note either item 33 or 34 should be scored unless there were [a]insufficient time to complete the Installation Phase or [b]a new issue emerged that prevented completing the Installation Phase.)*	0	1	2
	Installation Phase average score (items 29–34): Up to two items can be skipped. Possible total six items.			
Body Scan Phase				
35	Did the clinician obtain a valid body scan (asking subject to [a] report any unpleasant sensation while focusing on [b] the final PC and [c] the target incident with eyes closed)?	0	1	2
36	*If any unpleasant sensations were reported,* did the clinician continue with additional sets of bilateral eye movements or alternate bilateral stimulation until these sensations became neutral or positive? If unpleasant sensations were reported and bilateral stimulation was not offered, was there an appropriate clinical rationale (i.e., linkage to a different memory)? *(Skip if not applicable.)*	0	1	2
37	*If a new memory emerged*, did the clinician make an appropriate decision to continue by targeting the new memory in the session or later as part of the treatment plan? *(Skip if not applicable.)*	0	1	2
38	*If pleasant sensations were reported*, did the clinician target these and continue with additional sets of bilateral eye movements or alternate bilateral stimulation as long as these sensations continued to become more positive? *(Skip if not applicable.)*	0	1	2
	Body Scan Phase average score (items 35–38): Up to three items can be skipped. Possible total of four items.			
Closure Phase				
39	Did the clinician make an appropriate decision to move to closure?	0	1	2
40	Did the clinician assure subject was appropriately reoriented to the present by (a) *assessing* subject's residual distress and need to change state and to enhance orientation to the present and (b) *if needed* then offer appropriate and sufficient structured procedures (such as guided imagery, breathing exercises) for decreasing anxiety, distress, dissociation, and for containment?	0	1	2

41	Did the clinician support mentalization by inviting subject to comment on changes in awareness, perspective, and self-acceptance related to the target experience?	0	1	2
42	Did the clinician offer empathy and psychoeducation where appropriate, and statements to normalize and help to put into perspective the subject's experience? *(Skip if not applicable.)*	0	1	2
43	Did the clinician brief the subject on the possibility between sessions of continuing or new, positive or distressing thoughts, feelings, images, sensations, urges, or other memories or dreams related to the reprocessing from this session?	0	1	2

(*continued*)

EXHIBIT A.5 (*continued*)

EMDR Therapy Fidelity Rating Scale for Reprocessing Session				
44	Did the clinician request that the subject keep a written log of any continuing or new issues or other changes to share at the next session?	0	1	2
45	Did the clinician remind the subject to practice a self-control procedure daily or as needed?	0	1	2
	Closure Phase average score (items 39–45): Total of seven items. One item #42 may be skipped.			

EXHIBIT A.6

EMDR Therapy Fidelity Rating Scale for Overall Treatment			
Subject Code:		Date of Session:	
Rater:		Date of Review:	
Comments:		Average Rating:	

Rating Scale: No Adherence: 0, Weak: 1, Good: 2

1	Did the clinician assess the degree to which subject achieved treatment goals regarding desired behavioral, somatic, affective, and cognitive changes?	0	1	2
2	Did the clinician assess the degree to which adverse and traumatic events from subject's history were resolved and offer further EMDR reprocessing as indicated?	0	1	2
3	Did the clinician assess the degree to which maladaptive patterns of response to current external and internal stimuli were resolved and offer further EMDR reprocessing as indicated?	0	1	2
4	Did the clinician assess the degree to which the subject could benefit from exploring new behavioral choices (such as overcoming previous avoidant behaviors) or integrating new skills or a new self-image for the future and offer further EMDR reprocessing with a future template or RDI to consolidate a new self-image as indicated?	0	1	2
	Overall treatment average score: Total of four items.			

EXHIBIT A.7

EMDR Therapy Fidelity Summary Chart		
Fidelity Rating Scales	**Average Scores Rater 1**	**Average Scores Rater 2**
History-Taking Phase		
Preparation Phase		
Calm (safe) place Exercise		
RDI 1 (optional)		

RDI 2 (optional)		
RDI 3 (optional)		
Reprocessing session 1		
Reprocessing session 2		
Reprocessing session 3		
Reprocessing session 4		
Reprocessing session 5		
Reprocessing session 6		
Reprocessing session 7		
Reprocessing session 8		
Overall treatment		
Average across all charts		
Rater 1 comments		
Rater 2 comments		

Average rating	Adherence interpretation
0–0.99	Inadequate
1.0–1.25	Weak
1.26–1.50	Adequate
1.51–1.75	Good
1.76–2.00	Superior