HANDBOOK

EMDRAA
EMDR Association of Australia

EMDRAA CONSULTANT HANDBOOK

Whether you are an experienced EMDRAA Consultant, or have recently completed your Consultant Accreditation, we welcome you to utilise this handbook and hope that it is helpful for your practice in supporting developing EMDR therapists.

As an EMDRAA Accredited Consultant, you have proven your skills, experience and training at multiple junctures and demonstrated a significant commitment to the importance of the high-fidelity application of EMDR therapy. You will have also demonstrated high levels of clinical skills and experience with a range of clinical presentations and an awareness of when and how to apply appropriate clinically informed deviations from fidelity.

EMDRAA consultants represent the interests of the community with regards to the standards and quality of EMDR treatment provided in Australia. Therefore, it is your ethical responsibility to work with your consultees towards a level of knowledge and skill considered appropriate at each level of their training, and to support their accreditation once the required standard is met based on objective guidelines and your clinical assessment. Your work with consultees provides an important checkpoint between EMDR training and the experience of EMDR therapy by our community. EMDRAA is here to support and empower you in this process.

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BASIC TRAINING

Basic training programs accredited by EMDRAA are assessed to ensure they meet a standard curriculum. This curriculum outlines not only the minimum requirements for the structure of basic training (e.g. how many hours of training), but also the expected content inclusions. EMDRAA Accredited Consultants are strongly encouraged to review this curriculum and ensure they remain current with developments in the basic training process.

For a clinician to be eligible to undertake basic training accredited by EMDRAA, they must first meet the eligibility requirements outlined on the EMDRAA website. These criteria are designed to ensure an individual will have the required skills and knowledge necessary to both complete EMDR basic training, but also successfully implement this in their clinical practice.

As a means of expanding the availability of EMDR therapy in Australia, EMDRAA additionally provides an alternative pathway for individuals who may not directly meet these criteria. This process, the Exceptional Circumstances process, requires a clinician to outline how they may meet the eligibility criteria through alternative means, or to make a case for undertaking EMDR basic training for those early in their career. Importantly, there are some eligibility criteria which are not flexible in this regard. Consultants should familiarise themselves with this application form.

SUPPORTING CONSULTEES UNDER THE EXCEPTIONAL CIRCUMSTANCE'S APPLICATION

When a clinician makes an application under the exceptional circumstances process, they are required to ensure the **support of an EMDRAA Accredited Consultant** as part of their application. This support includes confirmation of availability for consultation from the outset of basic training, but also ensures the consultant is aware of the reasons an individual is not directly eligible.

Many clinicians in this circumstance will be well experienced and highly capable of engaging in the early stages of learning EMDR therapy, while others may require more intensive support. As an EMDRAA Accredited Consultant, it is important that you firstly ascertain the clinical skill and knowledge of a potential consultee, and then tailor your consultation to firstly upskill them in any gaps in training, and to then provide consultation to meet their basic training needs.

It is important that you make your own assessment of this and feel confident to support the consultee through both basic training, but also potentially through any additional needs they may have to ensure the success of their basic training.

As part of this application process, the applicant-clinician confirms that they will engage with the consultant promptly after beginning basic training. It is also important that you be mindful of this, so that new trainees are not left unsupported in the early stages of their EMDR training. There is no specific requirement to provide this consultation in an individual format. However, EMDRAA strongly recommends that at least the first session of consultation be individual to allow you to make your own assessment of the clinician's training needs.

Beyond this, consultation provided under this pathway is considered under the same standards as any other basic training consultation.

SUPPORTING CLINICIANS THROUGH BASIC TRAINING

An EMDRAA Accredited Basic Training Program requires completion of

- **40 hours** of workshop-based training, including
  - **20 hours** of didactic learning, and
  - **20 hours** of facilitated practicum experience implementing the EMDR standard protocol, and additional
- **10 hours** of individual or group consultation as an active participant.

It is recommended that some consultation hours occur after the initial workshop training.

All **10 hours** can be in a group setting if there is a ratio of **15 minutes of time allocated per person**.
For example, a maximum 4 participants for an hour consultation, with all 4 allocated 15 minutes to individually contribute within that time.

The date of completion of basic training is considered either the date of the trainee's 10th consultation session or the date of completion of all workshop components, whichever occurs later.

Consultation for basic training should focus on the fundamentals of the 8 phases of the standard protocol of EMDR therapy, and the implementation of the protocol in the clinician's clinical practice. This could include discussion of specific case examples and troubleshooting, but also general questions and information sharing regarding the standard protocol. The focus here should be extending the content of basic training into clinical practice.

EMDRAA provide a basic training log, where a consultee can document the EMDRAA accredited training completed, as well as the hours of consultation completed. As part of

this process, the consultee needs to provide the consultant evidence of completion of their workshop components of basic training.

Once completed and signed off by the consultant, a consultee can use this log to apply for EMDRAA full membership. Some training providers will coordinate this process, while many clinicians will work across multiple trainers and consultants to meet this requirement. For this reason, consultants should be familiar with the basic training log and ensure they review it and any supporting documentation before signing off. An example of the training log is provided as an appendix to this document.

CONSULTATION FOR ACCREDITATION PROCESSES

The following information provides an overview of the general requirements of Consultation for Accreditation and advice on how to structure and deliver it.

- From the outset of a new consultation relationship, the consultant should first confirm that the consultee has completed basic training, and that they meet the eligibility requirements outlined on the EMDRAA website. If these requirements are incomplete, please advise your consultee what is required and if unsure, please refer your consultee to accred@emdraa.org.

- Upon commencing consultation for accreditation, it is recommended that you contract with your consultee the expectations and requirements for the accreditation process. A sample agreement is included in the appendix of this booklet, but you are strongly encouraged to develop your own with the consultee.

- An appropriate and sustainable schedule of consultation should be discussed at the outset. The suggested frequency is 1-2 hours per month. Consider with your consultee the level of support they need (this may vary across consultation), and also their expectations of the duration of an accreditation process.

- For practitioner accreditation, EMDRAA currently requires a minimum of 10 hours of consultation (post basic training). Importantly, this is a minimum requirement and does not mean all requirements can be fulfilled within this range of hours.

- At least 5 of the 10 hours of consultation required for accreditation as a practitioner must be individual consultation. Similarly, at least 10 out of the 20 hours of consultation required for consultant accreditation must be individual consultation.

- Any group hours counted for accreditation must have a ratio of 30 minutes per participant for the session duration to be counted. For example, if in a group of 4, the session of consultation must run for 2 hours, allowing 30 minutes per participant. In this case, all 4 participants can count the 2 hours, so long as the consultant can sign off that all 4 participants contributed appropriately.

- Up to two (2) hours of individual consultation for Practitioner accreditation and Consultant accreditation can be counted for asynchronous activities. This is designed to facilitate consultants conducting video reviews and fidelity ratings. Asynchronous consultation is not *required* – but is available as an option.

- Consultation should focus on clinical examples of the consultee's work to demonstrate use of all 8 phases and 3 prongs of the standard EMDR therapy protocol. This can include verbal reports, case presentations, review of session transcripts, in-vivo demonstrations and roleplays, and video or audio recorded sessions.

- The consultant will inform the consultee at the outset, of any fees for time spent viewing any recordings for this purpose, if applicable.

- If the consultee is unable to record direct examples of their work (e.g., due to working in a secure forensic setting) the consultant and consultee should initially identify other options to demonstrate a real-life application of EMDR therapy. If no alternative is found, the consultee should liaise with the Accreditation and Standards Committee to identify a suitable alternative.

- For consultant accreditation, a further 20 hours of consultation are required following practitioner accreditation, as well as a higher level of knowledge and expertise working with more complex presentations and additional protocols as demonstrated in the client log.

- For consultant accreditation, the content of consultation should broaden to include the consultee's skills and knowledge in providing consultation to other clinicians.

- For consultant accreditation, the consultant will review examples of the consultee providing consultation to an individual, and to a group of clinicians, to assess their consultation skills. It is recommended that comprehensive feedback is provided to the consultee upon review of these examples of their work. The consultant may need to see several examples of the consultees practice before they are able to sign off an application. The consultant will inform the consultee of fees for time viewing any recordings for this purpose, if applicable.

- Throughout any consultation process, the consultee should be encouraged to seek consultation from other consultants who may have expertise in areas that address their needs more specifically as required.

- If the consultee uses more than one EMDRAA accredited consultant as part of their accreditation, signed documentation of the hours of consultancy with the additional accredited consultant and the number of sessions the consultee has had with them, including in what format (i.e. individual vs. group), must be provided to the primary consultant supporting the application. It is important to obtain an agreement to discuss your consultancy with the other consultant to ensure any areas of concern have been addressed.

- Should a consultee engage with a new primary consultant after completing consultation elsewhere, it is at the discretion of the new consultant as to whether they need to see further examples of a consultees work – even if these have been demonstrated to a different consultant.

EXPECTATIONS OF CONSULTANTS

- The consultant will document the date, time, format, and brief session content for the consultation and store this information for five (5) years from the date of application.

- It is both the consultant and consultee's responsibility to store a copy of all final application documents, including any fidelity ratings, and the consultee's client log, as part of the consultation documentation for a period of five (5) years.

- The Accreditation and Standards Committee will conduct periodic audits of the client log in particular, to monitor the consistent and appropriate use of this.

- The consultant will complete all necessary parts of the application form and/or any letters of recommendation needed for the accreditation application, once all requirements and competencies are met and demonstrated. If the skills and knowledge have not been demonstrated, the consultant should instead provide written documentation of the time spent in consultation, the skills and knowledge demonstrated and areas for improvement, without providing sign off for an application. The consultant should address these areas during consultation as they arise, however this may be addressed through additional consultation with another consultant who should be provided copies of this documentation.

- The consultant will provide a safe and supportive learning environment. Should the consultee report any concerns regarding consultation, the consultant should firstly attempt to resolve these within consultation. Should a consultee have further concerns, the consultant should encourage the consultee to contact the Accreditation and Standards Committee to discuss their concerns and identify a path forward.

- The consultant will keep up to date with current research and changes within the field of EMDR Therapy, including relevant scientific and clinical literature, and maintain professional development as required. The consultant will provide information and accommodate the consultee's learning needs as long as the need is within the consultant's area of expertise and will refer the consultee to other resources and consultants if they fall outside their area of expertise.

- The consultant is expected to practice within the ethical and professional guidelines of their relevant professional registrations and/or memberships.

EXPECTATIONS OF CONSULTEES

1. The consultee is expected to come to each session prepared to present relevant material and clear questions for the consultant.

2. The consultee is expected to complete all required tasks between sessions.

3. The consultee is expected to practice within the ethical and professional guidelines of their relevant professional registrations and/or memberships.

4. The consultee is expected to keep and regularly update a client log, for regular review during consultation.

5. The consultee is expected to be prepared to submit recordings and other examples of their work for assessment by the consultant. It is the consultees responsibility to ensure appropriate informed consent is taken from any clients for this purpose.

6. For applications for consultant level, the consultee must provide videos of the provision of consultation to other consultees. The consultee similarly needs to obtain informed consent from these consultee-clients.

7. The consultee must ensure their recorded work examples are of reasonable enough quality that the consultant can sufficiently assess their work.

8. The consultee should be open to constructive feedback and engage in self-reflection about their work across consultation. The consultee should work to understand and address any concerns brought to the consultee's attention by the consultant.

A NOTE ON GROUP CONSULTATION

The consultant must ensure that each participant in a group is actively contributing as per the above requirements, and that the group duration is sufficient to accommodate this.

In a mixed group of basic trainees and consultees pursuing accreditation, this can be difficult. The below diagrams are designed to emphasise how this might take place over an hour session.

<table>
<tr><th>Standard Basic Training Hour</th><th>Standard Accreditation Hour</th><th>Mixed Hour</th></tr>
<tr><td>Participant #1 – 15 mins</td><td rowspan="2">Participant #1 – 30 mins</td><td>#1 Basic training – 15 mins</td></tr>
<tr><td>Participant #2 – 15 mins</td><td>#2 Basic training – 15 mins</td></tr>
<tr><td>Participant #3 – 15 mins</td><td rowspan="2">Participant #2 – 30 mins</td><td rowspan="2">#3 Accreditation – 30 mins</td></tr>
<tr><td>Participant #4 – 15 mins</td></tr>
</table>

TIPS FOR SUPPORTING APPLICATIONS

The following are tips and suggestions that will assist with the process of accreditation. These are compiled from common conversations that consultants have had with the Accreditation and Standards Committee, along with feedback from consultees.

Tip #1
Start consultation by clearly outlining requirements and reviewing required information (e.g., proof of professional membership/registration and basic training logs). While many consultees may make assurances about these, it is important that this is addressed from the outset.

Tip #2
Review the relevant application form in session, and ensure the consultee understands the specifics of the form – often consultees have second or third hand information which may not be accurate, or outdated information.

Tip #3
Obtain an example of the consultees clinical work (preferably a video recording) early in consultation. This can immediately help focus consultation to address specific areas.

Tip #4
Review the competency checklist early on to identify specific areas of need and use this to develop a plan for consultation.

Tip #5
Use the client log as a living document across consultation. Have consultees show the log routinely and ask about specifics of cases. Ideally, follow-up on this in subsequent sessions to assess implementation of new learning.

Tip #6
Explain and introduce the Modified EMDR Fidelity Checklist (Cooper et al., 2019) early in consultation. Speak through examples of the items and encourage consultees to immediately begin filming sessions and then reviewing and rating their own sessions. Do not use the fidelity rating as an exercise in perfection. Use this as an iterative process, whereby a consultee can improve their fidelity across a series of ratings.

Tip #7
Consider the strategic use of individual and group consultation. For each consultee, consider which competencies or issues may be best addressed in each modality of consultation

Tip #8
EMDR consultation does not substitute for the teaching of foundational psychotherapy skills, which are a prerequisite for safe and effective EMDR therapy. Should concerns in this area become evident, the consultant may require these be addressed and remedied prior to writing a recommendation for accreditation.

Tip #9
If as a consultant you have not seen something, you should not feel pressured to sign off on this. There are a myriad of examples where competency might be *assumed* based on verbal reports only or based on a consultee's clinical background. Be sure of competency, and do not feel pressured to accept prior learning, qualifications, etc as evidence.

Tip #10
Consider time – this includes recency of practice of your consultee, and also their progression over time. If a consultation relationship has extended across lengthy periods of time, it is important to ensure you reconsider recent work examples prior to any application.

Tip #11
Ensure the consultee is responsible for completing their application forms. Have consultees complete their relevant areas, and compile associated supporting documentation prior to sending this to you. Do not feel pressured to complete this for the consultee but do help them troubleshoot uncertainties with the application form itself.

USING THE COMPETENCY CHECKLIST IN CONSULTATION

For both practitioner and consultation accreditation, the application process includes consideration of a specific set of competencies.

The following is general guidance for considering these competencies and also for completing the final application form.

- For practitioner accreditation, the competency checklist should be reviewed early on to ensure both consultant and consultee are familiar with requirements.

- The practitioner competency checklist requires a self-assessment by the consultee, and then confirmation of this by the consultant.

- A practitioner may demonstrate these competencies in a variety of ways – this could include during verbal discussions in sessions, by providing work examples (recordings, transcripts, clinical documentation), through roleplay or demonstration, or through setting any writing or presentation tasks the consultant identifies.

- As a consultant, it is crucial that there must be certainty that the consultees self-assessment is consistent with what has been assessed during consultation.

- For consultant accreditation, the listed competencies are broader, and should be approached in a similar way to practitioner applications. For the purpose of the final application the primary consultant must document how each competency has been addressed across consultation. It is strongly recommended that this is completed *across* consultation – as a gradual process, and then this information compiled for the final application.

USE OF THE CLIENT LOG IN CONSULTATION

As a part of consultation, you, as a consultant are required to review and approve your consultee's client log. The core function of the client log is to provide a clear summary of the consultees ability to implement EMDR effectively and consistently. This document should be assessed qualitatively, within the context of the consultees work, and should not be used as a "race to 25 or 75 clients."

In reviewing the cases presented, consider carefully whether the consultee has been able to consistently implement all eight phases across all three prongs. In practice, the client log should reflect the vast majority (at least 80%) of cases having received all eight phases. Commonly reported concerns here are client logs that reflect a pattern of frequent premature client disengagement, large numbers of clients not progressing beyond Phase 2, or client logs that frequently rely on other therapies or interventions (e.g., most cases receiving Imagery Rescripting, but not demonstrating all eight phases). Regular review of the client log will allow the consultant to identify these issues early, and then focus consultation on addressing them.

For consultant accreditation, the client log may demonstrate appropriate deviations from standard protocol where clinically indicated (to other protocols or within the standard protocol). Importantly, consultation should carefully consider when, how, and why these deviations occur.

The following guidelines have been prepared by the Accreditation and Standards Committee, to inform use of the client log in consultation:

- Ensure client logs are appropriately de-identified for confidentiality.
- Review the client log regularly with your consultee to follow individual clients through the process with your consultee.
- Ensure a brief statement of presenting issues/ goals etc. is provided. This should not be a detailed background of the client, rather a snapshot summary of the key presenting issues and or client populations relevant to the case.
- Check all 8 phases are being used routinely by your consultee and if not, explore and make comment on reasons for this and/or areas for development for your

consultee.

- A majority of clients should have received all 8 phases. This should be 20/25 clients for practitioner, and 60/75 clients for consultation applications.
- Ensure that the applicant is using EMDR in working with a variety of presentations/client populations. Your consultee may work with one population but work with a variety of presenting issues (e.g., working only in a substance use treatment setting, but addressing multiple types of comorbidities such as depression, PTSD, grief, or recent events in addition to substance use issues).
- Consider which other protocols/ techniques are being used and consider the appropriateness of these and any deviations from the standard protocol.
- Review the treatment outcomes section for a brief statement of progress (related to objective or subjective treatment goals/ symptom reductions etc.).
- Consider each completed case for consistency and irregularities. For example, cases with significant treatment effects but only 1-2 sessions, or cases where very high session numbers are present but only Phases 1-3. Irregularities may be understandable but consider these in discussion with your consultee.
- Ensure the consultee includes the number of sessions of all 8 phases in their total work with the client, not just the number of sessions to reprocess one target memory, or only the number of sessions used for Phases 3-7.

Note: if due to client complexity, workplace issues or some extenuating circumstances, your consultee is unable to achieve the number of clients required for accreditation, some flexibility can be shown by the ASC when receiving applications for accreditation. Please contact the ASC by emailing accred@emdraa.org to discuss your consultees individual circumstances.

Please remember that it is your responsibility as the consultant to ensure the client log is complete at the time of submission. Ensure you have retained a copy of the client log with the other application documents. The ASC will conduct regular random audits of client logs to assess completion.

USE OF THE FIDELITY CHECKLIST IN CONSULTATION

As part of consultation, the consultant is required to observe a consultee who is applying for Practitioner Accreditation, providing individual therapy to a client. Using the fidelity checklist, the consultant then scores the consultee across phases 3-8. Your consultee must have a minimum of 1.4 as an average score across the scale, and for each individual phase.

It is preferable that the consultee presents this work sample in one video. However, the ASC acknowledges that not all phases may be covered in one video, so additional videos may require review. The committee also acknowledges that due to clinical need, an applicant may deviate from fidelity to an individual phase, and the phase may be scored lower than 1.4. This would not necessarily mean an applicant needs to resubmit, where the consultant is confident that:

- The consultee was aware of the deviation from fidelity
- The deviation was clinically informed and appropriate
- The consultee otherwise demonstrates high fidelity work and has provided evidence of this as their usual practice
- The deviation has been addressed within consultation – through review of other videos, roleplay or other activities
- The overall average fidelity rating is still above 1.4
- The consultant has commented on the particular phase not meeting the fidelity cutoff score in the final application, and indicated how this was otherwise assessed if not rated in another example of the consultee's work.

The fidelity checklist can be used during consultation as a learning tool, by watching parts of a recorded session with the consultee, and referring to the checklist during each phase, discussing how a session meets or does not meet the criteria; clinically informed reasons for deviating from fidelity can also be explored and highlighted in this context.

If you require any support in scoring the fidelity checklist, please contact the ASC via: accred@emdraa.org

Appendix 1 - Sample Contract for Consultation

The purpose of this agreement is to establish a clear understanding of your professional need and expectations for consultation. For what purpose are you seeking consultation currently?

- As part of an *Exceptional Circumstances to Train* application
- To complete EMDR Basic Training
- To achieve EMDRAA Practitioner Accreditation
- To achieve EMDRAA Consultant Accreditation
- For ongoing professional development – not for accreditation purposes

As our consultancy progresses, your needs and expectations may change, and you may want to change the focus of consultation. Please advise me of this and we can discuss our activities/consultation/ expectations at that time.

Consultee Information

Full name:
Relevant degree(s):
Professional Discipline/Registration type:
Phone:
Email:
Dates of EMDRAA basic training and trainer's name:
Work Setting:
Number of clients/weeks:
General type of client population: (e.g. adult/ child/ general presenting issues):

Goals for consultation for the next 12 months:

1.
2.
3.

Fees
The fee for individual consultation is $__/hour. Payment is expected at time of consultation via cash, direct deposit or EFTPOS. I have read and understand and agree to the above conditions and expectations.

Consultee Name	Consultee Signature	Date
Consultant Name	Consultant Signature	Date

Appendix 2 – Sample Basic Training Log

EMDR Basic Training Log

Your Basic Training in EMDR requires you to have completed:

- 40 hours of EMDRAA Accredited workshop-based training and
- 10 hours of Consultation with an EMDRAA Accredited Consultant.

This completed log will be required to show you have completed Basic Training, and thus **are** eligible for Full Membership of the EMDR Association of Australia.

Trainee details

Name:

Email:

Phone:

WORKSHOP BASED TRAINING

Show your consultant proof of your attendance at each training. The Consultant must sign that they have seen this.

Introductory/Level 1/ Part 1/ Weekend 1 Workshop	
Dates:	Trainer:
Proof of Attendance sighted by:	
Consultant Signature:	Date:

Advanced /Level 2/ Part 2/ Weekend 2 Workshop	
Dates:	Trainer:
Proof of Attendance sighted by:	
Consultant Signature:	Date:

Summary of Consultation

The Focus of Content should briefly summarise the areas covered during the consultation.

Date of Consultation:		Length of Time (hours)	
Focus of Content:			
Approved Consultant Name			
Consultant Signature			

Date of Consultation:		Length of Time (hours)	
Focus of Content:			
Approved Consultant Name			
Consultant Signature			

Date of Consultation:		Length of Time (hours)	
Focus of Content:			
Approved Consultant Name			
Consultant Signature			

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Date of Consultation:		Length of Time (hours)	
Focus of Content:			
Approved Consultant Name			
Consultant Signature			

Date of Consultation:		Length of Time (hours)	
Focus of Content:			
Approved Consultant Name			
Consultant Signature			

This completed form is required to be produced when applying for Full Membership of EMDR Association of Australia.

Appendix 3 – Sample Accreditation Client Log

Client #	Presenting Problem	Date First Seen	Number of Sessions	Which of the 8 Phases were used?	Outcomes/comments
1					
2					
3					
4					
5					
6					

Appendix 4 - Example Case Note Sheet

Client *i*dentifier:		
Session Date:		
Target:		
Image/Perceptual:		
Negative Cognition:	**VOC:**	
Positive Cognition:		
Emotion:	**Body location:**	**SUDS:**

1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	

(**TC**) Target Check (**B/L**) Block/ loop (note strategy used) (**CI**) Cognitive Interweave

Final Positive Belief/Cognition:	**VOC:**
Body Scan outcome:	
Closure summary:	

Appendix 5 – The Cooper et al (2019) Modified Fidelity checklist

Items sourced initially from "A guide to the standard EMDR Protocols for clinicians, supervisors and consultants" (Leeds, 2009) and adapted by Australian researchers (Cooper, Smith, Lewis, Lee, & Leeds, 2019)

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

Re-evaluation 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):	
Re-evaluation Phase	

Re-evaluation 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 – Clinician never or minimally elicited subject's progress on these areas. 1 – Clinician elicited subject's progress on these areas in an incomplete or fundamentally flawed manner (e.g., spending an hour on this activity, eliciting lots of irrelevant information, failing to fully explore relevant issues). 2 – Clinician elicited subject's progress on these areas well.	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 – Clinician checks neither SUD nor VoC. 1 – Clinician checks either SUD or VoC. 2 – Clinician checks both SUD and VoC.	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.*) Examples include: “When you think of that image, what's the worst part of it now?” or “Has that image or any related thoughts or feelings been bothering you since we last met?” 0 – Clinician never explored this. 1 – Clinician explored this in an incomplete or fundamentally flawed manner (e.g., asked “Have you been getting any flashbacks?”) 2 – Clinician explored this well.	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. If the client has multiple traumas and after reprocessing the SUDS is a 2 or even a 3, it may be more appropriate to target a more disturbing or related memory or earlier memory, then select this as the next target.)* 0 – Reprocessing was evidently incomplete but the clinician did not remain focused on this target (i.e., chose a new target, ended the session). 1 – Reprocessing was evidently incomplete but clinician chose to focus on an associated memory. 2 – Reprocessing was evidently incomplete and clinician chose to remain focused on this target.	0	1	2
Re-evaluation 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 – No target was selected. 1 – Selected target was irrelevant to presenting problems and case formulation OR was fundamentally flawed in some way (e.g., was not a sensory event). 2 – Selected target was relevant and appropriate.	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 – Clinician did not elicit a sensory representation of the event. 1 – Clinician elicited a sensory representation of the event in a fundamentally flawed way (e.g., selected multiple representations at once, chose the most tolerable sensory representation). 2 – Clinician elicited and chose an appropriate sensory representation of the event.	0	1	2
7	Did the clinician elicit an appropriate negative cognition (NC)? 0 – NC is not obtained or is suggested by clinician and does not appear to resonate with subject. 1 – NC is missing a couple of essential elements. 2 – NC is derived from the subject and is self-referencing, presently held, accurately focuses on presenting issue, generalizable, is a true cognition (i.e. not a feeling, like “I am frustrated”) and has affective resonance.	0	1	2
8	Did the clinician elicit an appropriate positive cognition (PC)? 0 – PC is not obtained or is suggested by clinician and does not appear to resonate with subject. 1 – PC is missing a couple of essential elements. 2 – PC is derived from the subject and is self-referencing, in the same theme as the NC, accurately focuses on desired direction of change, generalizable, is a true cognition (i.e. not a feeling, like “I am happy”), is realistically adaptive and 1 < VoC < 5.	0	1	2
9	Did the clinician assure that the NC and PC address the same thematic domain: responsibility, safety, choice? 0 – NC and PC are in different thematic domains. 1 – NC and PC did not clearly address the same thematic domain. 2 – NC and PC clearly addressed the same thematic domain.	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 –VoC is absent or invalid (i.e., VoC =1 or VoC > 5). 1 – Valid VoC obtained but not while focused on image or other sensory memory OR invalid VoC obtained while focusing on image or other sensory memory. 2 – Valid VoC obtained while focusing on image or other sensory memory.	0	1	2
11	Did the clinician elicit the present emotion by linking the picture and the NC? 0 – Did not elicit the present emotion (or physiological response). 1 – Elicited present emotion (or physiological response) from the image or the NC but not both. 2 – Elicited present emotion (or physiological response) from both the image 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) NB SUD rating is on the entire target experience. 0 – Did not obtain a SUD. 1 – SUD obtained but not valid (i.e., SUD <= 2 during a 1st processing session, although continuing with a SUD <= 2 may be appropriate during a reprocessing session). 2 – Valid SUD obtained on present emotion (or physiological response).	0	1	2
13	Did the clinician elicit a body location for current felt disturbance? 0 – Did not elicit a body location for current disturbance. 1 – Elicited a vague body location for current disturbance. 2 – Elicited body location for current disturbance.	0	1	2
14	Did the clinician follow the standard assessment sequence listed above? Note: Although some leeway on the standard sequence is acceptable during this phase, the sequence of eliciting the Image → NC → PC → VoC → Emotion → SUD → Location is essential because the subject may find it difficult to elicit a PC after eliciting the current emotion associated with the traumatic event. 0 – Did not follow the essential sequence of Image → NC → PC → VoC → Emotion → SUD → Location 1 – Mostly followed the essential sequence of Image → NC → PC → VoC → Emotion → SUD → Location. 2 – Followed the essential sequence of Image → NC → PC → VoC → Emotion → SUD → Location.	0	1	2
Assessment Phase average score (items 5–14): **Total of 10 items.**				

Desensitisation 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 – Did not instruct subject to focus on any of these areas. 1 – Clinician instructed subject to focus on 1 or 2 items (image or sensory memory, NC and body location). 2 – Clinician instructed subject to focus on all 3 items (image or sensory memory, NC and body location).	0	1	2

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 – Did not administer any bilateral eye movements or alternate bilateral stimulation (EM/ABS) or offered a speed of stimulation that was significantly too slow or far too few repetitions, e.g. only 4-8 saccades. 1 – Most times, most sets missing an essential element of EM/ABS, somewhat too slow or somewhat too few saccades. 2 – Most times, most sets were at least 24 EM/ABS of relatively constant and sufficient speed, width and direction.	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 – Gave no nonspecific verbal support or was overly directly with specific feedback or excessive dialogue during most sets (i.e. spoke during >50% of the set). 1 – Gave limited nonspecific verbal support or only slightly overly specific feedback or excessive dialogue during some of the sets (i.e. <50% of the set). 2 – Most time, most sets, avoided excessive dialogue and specific feedback and did offer nonspecific verbal support (i.e., if subject is not emotional, at least 1 comment per set. If subject is emotional, then more frequently).	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 – Used inappropriate phrases after most sets (i.e. >50% of the set). 1 – Used inappropriate phrases after some sets (i.e. <50% of the set). 2 – The clinician used appropriate phrases for all three items after most sets, most of the time (i.e., deep breath instruction, general inquiry, avoided specific inquiry).	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 – Permitted or encouraged excessing verbal reports or needlessly repeated subject’s comments after some sets (i.e. >50% of the sets). 1 – Often resumed EM/ABS without repeating the subject’s verbal report and without promoting excess verbiage (i.e. <50% of the sets). 2 – Completed the above most of the time, after most sets.	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 – Subject was never asked a question similar to "Recall the original incident. What do you notice now?" after reaching a neutral or positive end without evidence of strengthening. 1 – After five or more consecutive sets of EM/ABS reporting neutral or positive experiences without evidence of strengthening, only then was the subject asked a question similar to "Recall the original incident. What do you notice now?" 2 – After two consecutive sets of EM/ABS reporting neutral or positive experiences without evidence of strengthening, subject was asked a question similar to "Recall the original incident. What do you notice 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 – After 3-4 consecutive sets of eye movements reporting no change in a memory, belief, emotion, or body location, clinician never made a valid variation of the EM/ABS. 1 – After 3-4 consecutive sets of eye movements reporting no change in a memory, belief, emotion, or body location, clinician made a valid variation of the EM/ABS. 2 – After two consecutive sets of eye movements reporting no change in a memory, belief, emotion, or body location, clinician made a valid variation of the EM/ABS.	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.) • Explore for an earlier disturbing memory with similar affect, body sensations, behavioural responses, urges, or belief. • Explore for a blocking belief, fear or concern disrupting effective reprocessing, and then identify a related memory. • Explore target memory for more disturbing images, sounds, smells, thoughts, beliefs, emotions, or body sensation. Invite subject to imagine expressing unspoken words or acting on unacted urges. Offer one or more interweaves. 0 – After two consecutive sets of eye movements reporting no change in a memory, belief, emotion, or body location, clinician did not try any of these strategies. 1 – After two consecutive sets of eye movements reporting no change in a memory, belief, emotion, or body location, clinician didn't persist in using one of the above strategies (i.e., tried one strategy but subject still blocked, and didn't try a second strategy). 2 – After two consecutive sets of eye movements reporting no change in a memory, belief, emotion, or body location, clinician effectively used one or more of these strategies.	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.) Note: Intense, extended emotion includes a single behaviour (e.g., crying, hyperventilating, trembling, turning red, or other more subtle signs as determined by the therapist) that is present for an extended time (i.e., >6 minutes). Ineffective processing is when the subject reports exactly the same experience (e.g., emotion, thought, image, or body disturbance) OR a repetitive set of responses (i.e., looping) after two or more successive sets. 0 – Clinician did not use an interweave where appropriate. 1 – Interweave was offered in an incomplete or fundamentally flawed manner (e.g., interweave took ten minutes to deliver, interweave was not from domains of responsibility, safety, choice). 2 – An interweave from the domains of responsibility, safety or choice was offered in an appropriate way.	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.) Note: Intense, extended emotion includes a single behaviour (e.g., crying, hyperventilating, trembling, turning red) that is present for an extended time (i.e., >6 minutes). 0 – Clinician did not increase repetitions per set or give calm, compassionate, and encouraging verbal cueing. 1 – Clinician either increased repetitions per set until emotional behaviour noticeably decreased OR gave limited calm, compassionate, and encouraging verbal cueing (but not both). 2 – Clinician increased repetitions per set until emotional behaviour noticeably decreased AND gave multiple calm, compassionate, and encouraging verbal cueing per set.	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 client back to the selected target memory within one or two sets of bilateral eye movements or alternate bilateral stimulation? *(Skip if not applicable.)* 0 – A recent memory emerged and clinician did not acknowledged its significance or offer to return to it later, but merely continued with many sets (more than 4 or 5) of EM/ABS focused on the recent memory without returning to check the original target memory. A significant portion of the remaining portion of the session continued with this new focus of attention. 1 – A recent memory emerged and clinician either acknowledged its significance while offering to return to it later OR redirected subject's attention to target memory (but not both) within two or three sets of EM/ABSs. Alternatively, recent memory emerged and clinician both acknowledged its significance while offering to return to it later AND redirected subject's attention to target memory, but did so after more than three but fewer than 6 sets of EM/ABS. 2 – Recent memory emerged and all components of this item (i.e., acknowledgment, redirection to target, responding within two EM/ABS) were achieved completely.	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, and if this earlier memory becomes resolved then did the clinician redirect the subject back to the target memory. Alternatively did the clinician make a clinically informed decision to help the subject to contain this material until a later date due to concerns that the subject was not ready to confront this material? *(Skip if not applicable.)* If earlier memory *did not* require immediate containment: 0 –Clinician did not offer EM/ABS until earlier memory was resolved. Instead the clinician immediately redirected the subject to the original target even though time remained to process the earlier memory. 1 – Clinician offered EM/ABS for a series of sets after which the subject reported neutral or positive experiences, but they never redirected subject's attention back to the original target. 2 – Clinician offered EM/ABS until the subject reported neutral or positive experiences and if time remained then redirected the subject's attention to back to the original target. If earlier memory *did* require prompt containment (this may not be evident immediately): 0 – Clinician never advised the subject to about the option to contain this material and did not explore with the subject whether to address this earlier material now or wait until a later date when they feel more ready to confront it. 1 – Clinician delayed their advice to the subject to contain this material until a later date and the subject subsequently requested to stop reprocessing after confronting the earlier memory. Alternatively, they promptly advised the subject to contain this material without giving the subject the option of continuing, or may not have stated when they would return to it or the reasons for doing so. 2 – Clinician explored with the subject the option to contain this material until a later date when they are able to confront it and the subject elected to contain it.	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.*) Note: Clinicians should make this decision within 10 minutes of the session ending. This decision is informed partly by clinical judgment and partly by the subject's reported SUD upon rechecking the target after two sets of their reporting positive or neutral experiences. The aim is to ensure that subjects are oriented to the present and are given enough time to regain full orientation to the present, and to diminish any residual anxiety and distress before leaving the session. Reprocessing evidently could not be completed in this session and: 0 – The clinician never made any decision in order to end the session effectively and continued reprocessing right up to the end of the session. 1 – The clinician made some decisions in order to end the session effectively, however these were delayed, incomplete, rushed, or otherwise fundamentally flawed. (e.g., beginning part of the installation phase first and then going directly to closure; not reserving sufficient time for closure based on the client's needs). 2 – The clinician went directly to closure phase without returning the subject's attention to the residual disturbance in target.	0	1	2

28	If it appeared from spontaneous subject reports that 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.)* Target was checked (e.g., by asking, "Recall the original incident. What do you notice now?") AND: 0 – Appropriate SUD was not obtained before moving onto Installation Phase. 1 – Appropriate SUD was obtained but not rechecked after a second set of EM/ABS before moving onto Installation Phase. 2 – Appropriate SUD was obtained and rechecked after (at least) a second set of EM/ABS before moving onto Installation Phase.	0	1	2
Desensitization Phase average score (items 15–28): **Up to eight items can be skipped. Fourteen items, plus four can be doubled.**				

Installation Phase				
If the Desensitization Phase was completed (and item 28 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 – Clinician did not check to see if a better PC could be elicited and merely began Installation with the original PC from Phase 3. 1 – Clinician inquired about the a better PC but began the Installation Phase with a final PC that did not match full criteria for a PC or that was not a good fit for the subject. 2 – Clinician checked to see if a better PC could be elicited began the Installation Phase with a final PC that the subject agreed was suitable and that fully matched criteria for a PC.	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 – Subject was never prompted for a VoC. 1 – Subject was not instructed to think about the target incident before providing a VoC for the PC. Alternately, EM/ABS began before subject gave a valid VoC. 2 – Subject was instructed to think about target incident before providing a VoC for the PC (and before being administered the EM/ABS).	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 – Subject was not given a series of EM/ABS or alternately, subject was never instructed to focus on both the target incident and the PC between each set of EM/ABS. 1 – Subject was instructed to focus on either the target incident or the PC (but not both) between sets EM/ABS. 2 – Subject was instructed to focus on both target incident and PC between sets of EM/ABS.	0	1	2
32	Did the clinician obtain a valid VoC after each set of bilateral eye movements or alternate bilateral stimulation? 0 – Clinician failed to obtain a valid VoC after more than half of all EM/ABS sets. 1 – Clinician obtained a valid VoC after more than half but not all EM/ABS sets. 2 – Clinician obtained a valid VoC after all EM/ABS sets.	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.)* VoC was struggling to rise to a 7 after several sets of eye movements and: 0 – Clinician did not make the inquiry as per above. 1 – Clinician made an inquiry and accepted the subject's rationale for the VoC remaining below a 7 without targeting the rational with further EM/ABS. 2 – Clinician made the inquiry as per above and appropriately targeted the thought or moved to Body Scan / Closure.	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 – The completion of the Installation Phase did not involve the use of VoCs. 1 – The completion of the Installation Phase involved the incomplete or fundamentally flawed use of VoC's (e.g., ending with a single VoC of 7, ending with two successive VoC's of 5). 2 – The completion of the Installation Phase occurred via obtaining VoCs of 7 (or "ecological" 6's) after two successive sets of EM/ABS.	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 – No body scan was conducted. Or the subject was asked to think about negative details from the sensory memory, emotions or physical sensations in Phase 3. 1 – A body scan was conducted, but subject was not instructed to focus on *both* the final PC and the target incident. 2 – Subject was instructed on all major components of body scan.	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.)* Unpleasant sensations were reported and: 0 – No additional sets of EM/ABS were offered and no appropriate clinical rationale was present. 1 – Additional sets of EM/ABS were offered and were discontinued before the subject reported neutral or positive experiences after two successive sets. 2 – Additional sets of EM/ABS were offered and were discontinued after the subject reported neutral or positive experiences after two successive sets. Alternatively, No additional sets of EM/ABSs were offered but an appropriate clinical rationale was present.	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.)* Note: The new memory must be an eligible target (i.e., it must relate to presenting problems and have some distressing content). A new memory emerged and: 0 – The clinician neither targeted it in session (i.e., starting from Phase 3) nor explained to the subject that it may be best to target it later in treatment. 1 – The clinician either targeted it in session (i.e., starting from Phase 3) or explained to the subject that it may be best to target it later in treatment, however the decision made was not well-informed by the session's remaining time or the nature of the memory. 2 – The clinician either targeted it in session (i.e., starting from Phase 3) or explained to the subject that it may be best to target it later in treatment. This decision was well-informed by the session's remaining time and the nature of the memory.	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 – The Closure Phase was omitted. 1 – The Closure Phase began prematurely or was delayed. 2 – The Closure Phase was begun in a timely manner from either the successful completion of the Body Scan Phase or an appropriate premature discontinue from an earlier phase due to time or distress management constraints.	0	1	2
40	Did the clinician assure subject was appropriately reoriented to the present by (a) *assessing* subject's residual distress and to enhance orientation to the present and (b) *if needed* then offer appropriate and sufficient structured procedures (such as guided imagery, breathing exercises, or containment exercise to decrease anxiety, distress, & dissociation, 0 – Subject was not assessed for distress and clinician continued immersive discussion of the memory. When needed, interventions were not used to diminish the subject's distress. 1 – Subject was assessed for distress, but attempts at orienting them to the present and diminishing their distress were incomplete or ineffective. 2 – Subject was assessed for distress and clinician began present-oriented discussion. When needed, interventions were used to diminish subject's distress and subject reported these to be effective.	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 session just completed? 0 – No discussion about the subject's in-session experiences, the treatment trajectory, or observed improvements occurred. 1 – Some comments about the session's in session experiences, the treatment trajectory, or observed improvements occurred. 2 – Considered discussion about the subject's in-session experiences, the treatment trajectory, or observed improvements occurred.	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 – Subject introduced information about their own experiences, the treatment trajectory, and/or presenting problems and clinician did not respond therapeutically. 1 – Subject introduced information about their own experiences, the treatment trajectory and presenting problems and clinician gave partially therapeutic responses. 2 – Subject introduced information about their own experiences, the treatment trajectory and presenting problems and clinician responded with empathy, normalising statements, or psychoeducation.	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 – Clinician did not brief the subject of this possibility. 1 – Clinician minimally briefed the subject of this possibility. 2 – Clinician fully (and concisely) briefed the subject of this possibility.	0	1	2
	Did the clinician request that the subject keep a written log of any continuing or new issues or	0	1	2

44	other changes to share at the next session? 0 – Clinician did not request that subject keep written notes of any between-session behavioral observations, insights, triggers, etc. 1 – Clinician requested that subject keep notes of between-session issues or observations in an incomplete or fundamentally flawed manner, i.e. without explaining the notes can be brief and/or without offering a written log form 2 – Clinician requested that subject keep notes of between-session issues in a complete manner, e.g. explaining that they could be about behavioral changes, responses to triggers, new insights, new memories, positive dreams or nightmares.			
45	Did the clinician remind the subject to practice a self-control procedure daily or as needed? 0 – Clinician did not remind the subject to practice self-control procedures. 1 – Clinician reminded subject to practice self-control procedures in an incomplete or fundamentally flawed manner. 2 – Clinician reminded subject to practice self-control procedures.	0	1	2
Closure Phase average score (items 39–45): **Total of seven items. One item #42 may be skipped.**				

Appendix 6 – EMDR Consultation Resources

Farrell, D., & Keenan, P. (2013). Participants' Experiences of EMDR Training in the United Kingdom and Ireland. Journal of EMDR Practice and Research, 7(1), 2-16. https://doi.org/10.1891/1933-3196.7.1.2

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Farrell, D., & Moran, J. (2023). EMDR Therapy and the Trident Model: Enhancing Competency through Clinical Supervision and Consultation. In D. Farrell, S. J. Schubert, & M. D. Kiernan (Eds.), The Oxford Handbook of EMDR (pp. C56P51–C56P146). Oxford University Press. https://doi.org/10.1093/oxfordhb/9780192898357.001.0001

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Leeds, A. (2016). A Guide to the Standard EMDR Therapy Protocols for Clinicians, Supervisors, and Consultants, Springer Publishing Company.

Logie, R. (2024). EMDR Supervision: A Handbook. Routledge.

Madere, J., Leeds, A., Sells, C., Sperling, C., & Browning, M. (2020). Consultation for EMDRIA Certification in EMDR: Best Practices and Challenges. Journal of EMDR Practice and Research, 14(2), 62-75. https://doi.org/10.1891/emdr-d-19-00052

Shapiro, F. (2018). Eye Movement Desensitization and Reprocessing (EMDR) Therapy Basic Principles, Protocols, and Procedures, Guilford Press.