TRAINING PACKAGE APPLICATION

Applications must meet the EMDRAA Training Curriculum requirements set forth by EMDRAA.

The Accreditation & Standards Committee reviews EMDRAA Training Package Applications.

Please be prepared to allow approximately 120 days for the review process once it has been determined the application is complete. Please also complete the attached self-assessment for curriculum requirements and provide your curriculum materials for review, as outlined in the self-assessment form.

Provider Name:

Organisation or Business name (if applicable):

Mailing Address:

City:

State:

Postcode:

Phone:

Email:

TRAINING PACKAGE APPLICATION

EMDR TRAINING CURRICULUM MATERIALS

TRAINING MATERIALS REQUIRED FOR SUBMISSION

Please be sure to submit this completed application form along with the following training materials electronically (email preferred) as a Word document, although PDF documents will be accepted as well:

- ☐ Completed Self- check form with appropriate reference to all required content and materials
- ☐ Training syllabus or course summary with line numbers along the side of the document for the review process.
- ☐ Timeline of training content in 1- or 2-hour long segments including breaks and lunches. (The timeline can be incorporated into the training syllabus/course summary mentioned above). The timeline should include line numbers along the side of the document for the review process.
- ☐ Training manuals and any additional materials (handouts, slides, etc.) that will be provided to trainees with line numbers along the side of the document for the review process.
- ☐ Training Evaluation Forms for Training Instructor, Practicum Facilitator, and Consultant (if applicable).
- ☐ Grievance Procedure and Form for trainees.

Name:

Signature:

Basic Training Curriculum Requirements

1. Documents included to support this application:
   1.1. Curriculum Outline
   1.2. Slides
   1.3. Workbooks/manuals
   1.4. Any additional handouts
   1.5. Pre-reading materials
   1.6. Pre-workshop materials

Please complete the checklist below. For each item, please identify the document that contains the content and the page and line number if appropriate.

2. STRUCTURE AND ADMINISTRATION

	Requirement	Document/ Page and line number	(EMDRAA review) Met/ Not Met	(EMDRAA review) Comments/ Revision needs
2.1	Grievance process, cancellation and refund, equal opportunity and access		Select	
	Applicant response:			
2.2	Full disclosure of training costs		Select	
2.3	Information is consistent with EMDRAA policies regarding training and consultation		Select	
2.4	Provide access to the EMDRAA Basic Training log (copy or access link) https://emdraa.org/forms/		Select	

2.5	Training Evaluation Forms		Select	
	Applicant response:			
2.6	Information on trainers to be used		Select	
2.7	Timetable and structure - allocation of time (separate didactic and practicum time) - content and curriculum (extra notes below)		Select	
	Applicant response:			
2.8	Training materials (e.g., manual, slides etc) - Information is consistent across materials. - Information is cross-referenced for participants		Select	
	Applicant response:			
2.9	Pre-workshop Material:		Select	
2.10	Assessment tools and measures for inclusion:		Select	
	Fidelity checklist inclusion: (Cooper, R. Z., Smith, A. D., Lewis, D., Lee, C. W., & Leeds, A. M. (2019). Developing the Interrater Reliability of the Modified EMDR Fidelity Checklist. *Journal of EMDR Practice and Research, 13*(1), 32-50. doi:10.1891/1933-3196.13.1.32)		Select	

	Applicant response:
	Additional comments from reviewers:

3. CONTENT OF TRAINING

	Requirement	Document/ Page and line number	(EMDRAA review) Met/ Not Met	(EMDRAA review) Comments/ Revision needs
3.1 3.1.1 3.1.2 3.1.3	Three sections with a minimum time and content requirement: Instructional (20 hours) – Up to 10 hours can be completed asynchronously. Supervised Practicum (20 hours) Consultation (10 hours) - information provided		Select Select Select	
	Applicant response:			
3.2 3.2.1 3.2.2 3.2.3	If online (please completed additional online training application): Three sections with a minimum time and content requirement: Instructional (20 hours) - Up to 10 hrs can be asynchronous didactic instruction. Practicum (20 hours) - all hours must be completed live (synchronously) Consultation (10 hours) - all hours must be completed live (synchronously)		 Select Select Select	
	Recommended Text: Shapiro, F. (2018). *Eye Movement Desensitization and Reprocessing, Basic Principles, Protocols and Procedures.* (3rd ed.). New York: The Guilford Press.			
3.3 3.3.1 3.3.2	**Supplemental material:** Access to the EMDRAA FAQ and Resources pages. Contact information for EMDRAA Approved Consultants can be found online at https://emdraa.org/accredited-consultants/			

	Applicant response:			
3.4	Specific explanation of the *Basic Training* and accreditation processes, including required workshops, consultation, and additional processes. Should the training in question have its own rules or processes for training which differ from those of EMDRAA, trainees must be provided clear information outlining the differing rules and which are related to the training company versus EMDRAA.		Select	
	Applicant response:			

4. INSTRUCTIONAL

The goal of the Instructional Section of the training is to provide information and understanding in each of the following areas. Although EMDRAA is not regulating the amount of time spent on any one portion, it is expected that the majority of time will be spent teaching the Method section as well as case conceptualisation and treatment planning. The curriculum developer may determine the order in which the material is presented.

Minimum Required Time: 20 hours (up to 10 hours can be pre-recorded/asynchronous didactic instruction).

History and Overview: The goal of this section is to review the historical evolution of EMDR therapy from its inception through validation by randomised controlled studies. This includes, but is not limited to:

	Requirement	Document/ Page and line number	(EMDRAA review) Met/ Not Met	(EMDRAA review) Comments/ Revision needs
4.1	**Traumatology Overview** overview of traumatology and neurological changes made by trauma and adverse experiences on psychopathology		Select	
	Applicant response:			
4.2 4.2.1 4.2.2	**Origin:** Description of the initial discovery and origins of EMDR therapy. Overview of early research and current evidence base with reference to current inclusion in treatment guidelines		Select Select	

4.3 4.3.1 4.3.2 4.3.3	**Switch from EMD to EMDR therapy:** Understanding the significance of the shift in name and model from EMD to EMDR therapy, both in terms of revised theoretical model and procedure. Switch from desensitisation model to adaptive information processing (AIP) model The effect of EMDR therapy is not desensitisation in and of itself, but includes the multifaceted impact of reprocessing all aspects of negative, maladaptive information to adaptive, healthy, useful resolution (e.g., change of belief, elicitation of insight, increase in positive affects, change in physical sensation, and behaviour).		Select Select Select	
4.4 4.4.1 4.4.2 4.2.3	**Current EMDR therapy-related Research:** The package owner must include information about the representative studies to give the trainees a general grasp of the EMDR therapy literature. A current annotated bibliography of EMDR therapy-related theory and research supporting your program's content that you deem foundational to a trainees' understanding of EMDR therapy's efficacy, model, mechanism, and method should be included in the handouts. This list need not be exhaustive. It should be reviewed no less than yearly, and updated when needed. Resource sites where this material can be located and updated on the internet should be provided – with website addresses verified and updated no less than yearly.		Select Select Select	

	Applicant response:

5. Distinguish Model, Methodology, Techniques, and Mechanism

This section of the curriculum explains these four aspects of EMDR therapy and distinguishes among them.
The adaptive information processing model (AIP) is the underlying explanatory **model** of EMDR therapy as a psychotherapeutic technique. It is important that trainers have a full understanding of this model as outlined in Shapiro (2018). The AIP model provides the theoretical foundation of EMDR therapy.

The **methodology** relates to EMDR as a structured treatment protocol. This section includes the eight- phase treatment procedures of the basic EMDR therapy protocol, plus safeguards, ethics, and validated modifications for specific clinical situations.

Techniques refer to procedures that used core elements of EMDR therapy, either as an adjunct to the standard protocol or as a stand-alone intervention.

The **mechanism** section includes current hypotheses regarding how or why EMDR therapy works on the neurobiological level, plus current research exploring mechanisms of action. Although hypotheses regarding the mechanism of action are speculative at present, an introduction of these hypotheses is important. With a clear understanding of the AIP model, the specific aspects of the method, and current thinking regarding mechanism, the participants should be well informed regarding the study and practice of EMDR therapy.

	Requirement	Document/ Page and line number	(EMDRAA review) Met/ Not Met	(EMDRAA review) Comments/ Revision needs
5.1	Adaptive information processing model (AIP): Shapiro adapted and applied the AIP model as the underlying explanatory model of EMDR therapy. EMDR therapy is based, therefore, on a distinct information processing model which incorporates specific principles and treatment		Select	

	procedures. The AIP model guides history taking, case conceptualisation, treatment planning, intervention, and predicts treatment outcome. (See Appendix A for information about antecedent information processing models.)			
5.2	**Key concepts of the AIP model:**			
5.2.1	The neurobiological information processing system is intrinsic, physical, and adaptive		Select	
5.2.2	This system is geared to integrate internal and external experiences		Select	
5.2.3	Memories are stored in associative memory networks and are the basis of perception, attitude and behaviour.		Select	
5.2.4	Experiences are translated into physically stored memories		Select	
5.2.5	Stored memory experiences are contributors to pathology and to health		Select	
5.2.6	Trauma causes a disruption of normal adaptive information processing which results in unprocessed information being dysfunctionally held in memory networks.		Select	
5.2.7	Trauma can include commonly recognised distressing events and/or the experience of neglect, abuse, or other adversities that undermine an individual's sense of self-		Select	

	worth, safety, ability to assume appropriate responsibility for self or other, or limits one's sense of control or choices.			
5.2.8	New experiences link into previously stored memories which are the basis of interpretations, feelings, and behaviours.		Select	
5.2.9	If experiences are accompanied by high levels of disturbance, they may be stored in the implicit/nondeclarative memory system. These memory networks contain the perspectives, affects, and sensations of the disturbing event and are stored in a way that does not allow them to connect with adaptive information networks.		Select	
5.2.10	When similar experiences occur (internally or externally), they link into the unprocessed memory networks and the negative perspective, affect, and/or sensations arise.		Select	
5.2.11	This expanding network reinforces the previous experiences.		Select	
5.2.12	Adaptive (positive) information, resources, and memories are also stored in memory networks.		Select	
5.2.13	Direct processing of the unprocessed information facilitates linkage to the adaptive memory networks and a transformation of all aspects of the memory.		Select	

5.2.14	Maladaptive perceptions, affects, and sensations are discarded.		Select	
5.2.15	As processing occurs, there is a posited shift from implicit/nondeclarative memory to explicit/declarative memory and from episodic to semantic memory systems.		Select	
5.2.16	Processing of the memory causes an adaptive shift in all components and qualities of the memory, including sense of time, beliefs, emotions, physical sensations, and sensory information.		Select	
5.3	**Clinical Implications: The AIP model guides case conceptualisation, treatment planning, intervention, and predicts treatment outcome**			
5.3.1	Clinical complaints that are not organically based or are caused by insufficient information are viewed as stemming from maladaptively stored and unprocessed information which has been unable to link with more adaptive information.		Select	
5.3.2	Earlier memories which are maladaptively stored increase vulnerability to pathology including anxiety, depression, PTSD, and physical symptoms of stress and may interfere with healthy development of an individual's sense of self-worth, safety, ability to assume appropriate responsibility		Select	

	for self or other, or limits one's sense of control or choices.			
5.3.3	The information processing system and stored associative memories are a primary focus of treatment.		Select	
5.3.4	Procedures are geared to access and process dysfunctional memories and incorporate adaptive information.		Select	
5.3.5	The intrinsic information processing system and the client's own associative memory networks are the most effective and efficient means to achieve optimal clinical effects.		Select	
5.3.6	Targeted memories must be accessed as currently stored so the appropriate associative connections are made throughout the relevant networks.		Select	
5.3.7	Unimpeded processing allows the full range of associations to be made throughout the targeted memory and the larger integrated networks. **i.** Interventions to assist blocked processing should be minimal and support the brain to initiate its intrinsic processing capacity. **ii.** All interventions change the natural course of processing and potentially close some associated pathways.		Select	

5.4	**Differentiate from other models:** Highlight how pathology and treatment are viewed differently from other orientations (see Appendix B).		Select	
5.5	**Applications:** It is well documented that trauma can contribute to a wide range of presenting problems, not just PTSD. The curriculum provides an understanding of the wide range of applications for EMDR therapy, when the overall clinical picture (i.e., presenting problems, symptoms, and character structure and life stressors) is framed within the AIP model. This section also provides another opportunity for teaching how the AIP model guides case conceptualisation, treatment planning and overall clinical practice.			
5.5.1	Scientifically-validated applications		Select	
5.5.2	Non-validated applications still needing research		Select	
5.5.3	Current research and conceptualisation (e.g. See Laliotis, 2021; Hase, 2021; Matthijssen, et al., 2020)		Select	
	Applicant Response:			

6. Methodology

The curriculum explains and teaches the method of EMDR therapy. Although the standard EMDR therapy protocol is taught, other such issues surrounding the practice and professionalism of EMDR therapy are to be included in the curriculum.

8-Phases: EMDRAA requires that the latest edition of the Shapiro text guides the teaching for all 8 Phases of EMDR therapy. EMDRAA also requires that participants must have exposure to all 8 phases through a combination of lecture, demonstration, and practice. It is imperative that trainees understand how case formulation and treatment planning are incorporated into each of the 8 phases.

6.1. Phase 1: History Taking, Case Conceptualisation & Treatment Planning

	Requirement	Document/ Page and line number	(EMDRAA review) Met/ Not Met	(EMDRAA review) Comments/ Revision needs
6.1.1	The curriculum provides instruction on what information is gathered from the client and how this information is used. That information with the evaluation of current level of functioning, character structure, and treatment goals are used to assess appropriate client selection, client readiness, target selection based on the three-pronged protocol and treatment planning.		Select	
6.1.2	Focus on areas of history taking unique to EMDR therapy.		Select	
6.1.3	Offer a variety of ways to take a history of adverse events or thematic negative		Select	

	cognitions.			
6.1.4	Offer an understanding of the impact of adverse events on healthy development and assessment of potential developmental deficits or maladaptively stored information that underlies current problems or symptoms.		Select	
6.1.5	Introduce the three-pronged approach and methods to identify appropriate targets as treatment planning methodology.		Select	
6.1.6	Explain treatment planning, specifically strategies to select and sequence appropriate memory targets. This includes introducing appropriate techniques used to identify the earliest associated memories.		Select	
6.1.7	Introduce case conceptualisation issues, such as degree of stabilisation, affect intolerance, assessment of the adequacy of skills and resources, duration of issues/ dysfunction.		Select	
6.1.8	Client selection criteria and indications of client readiness.		Select	
6.1.9	Client's ability to sustain Dual Attention		Select	
6.1.10 a) b)	Explore issues that might impede or interfere with processing and readiness, such as: Secondary gain issues Present-day stressors (personal, work-		 Select Select	

	related, medical)			
c)	Timing issues (e.g. unavailability of clinician)		Select	
d)	Medical concerns		Select	
e)	Legal issues, (e.g. impending testimony)		Select	
f)	Contraindications		Select	
	Applicant response:			

6.2 Client Preparation (Phase 2)

The goal of this section of the curriculum is to assure that the client is informed about EMDR therapy, prepared for EMDR therapy, and to help the client establish the necessary ability to maintain dual awareness during processing and the ability to manage affective reactions between sessions.

These activities include but are not limited to:

	Requirement	**Document/ Page and line number**	**(EMDRAA review) Met/ Not Met**	**(EMDRAA review) Comments/ Revision needs**
6.2.1	Education about EMDR and its effects		Select	
6.2.2	Assess/develop therapeutic rapport		Select	
6.2.3	Address client's concerns		Select	
6.2.4 a)	Explain the details of the EMDR therapy procedure Seating arrangement		Select	

b)	Dual attention stimulus in the form of bilateral eye movements, taps, or tones (e.g., different types, testing speed & distance)		Select	
c)	Accurate observation and reporting		Select	
d)	Setting expectations and utilisation of the "Stop" signal		Select	
6.2.5 a)	Client Safety and Stability: Assess/develop client's stabilisation skills		Select	
b)	Knowledge of commonly used procedures to enhance safety and self- control for issues related to safety and stability.		Select	
c)	Appropriate use of Safe Place, containment skills and resource development		Select	
6.2.6	Review client selection criteria and precautions		Select	
	Applicant response:			

6.3 Assessment (Phase 3):

All aspects of the assessment of targets are taught. The curriculum explains and teaches the function and importance of each component of the assessment, and how to obtain them, (e.g., distinguish between appropriate and inappropriate cognitions), and the rationale for the order of the assessment.

	Requirement	**Document/ Page and line number**	**(EMDRAA review) Met/ Not Met**	**(EMDRAA review) Comments/ Revision needs**

6.3.1 a) b) c) d) e) f) g)	Adequate teaching of: Image Negative Cognition (NC) Positive Cognition (PC) Validity of Cognition (VOC) Emotions Subjective Units of Disturbance Scale (SUDS) Sensations		Select	
	Applicat Response			

6.4 Desensitisation (Phase 4):
In this section, the curriculum provides instruction on all aspects and expectations of what and how rocessing occurs and evolves.

	Requirement	**Document/ Page and line number**	**(EMDRAA review) Met/ Not Met**	**(EMDRAA review) Comments/ Revision needs**
6.4.1	Explain channels of processing		Select	
6.4.2	Explain the application of all forms of Dual Attention Stimulus (DAS), provided in the form of bilateral eye movements, taps, or tones offered in discrete intervals, and circumstances when alternatives to eye movement may be necessary		Select	
6.4.3	Note types of processing to expect (e.g., visual, emotional, sensations)		Select	
6.4.4	Emphasise the importance of the therapist maintaining empathic connectedness while allowing the client to process without unnecessary therapist intrusion		Select	

6.4.5	Emphasise the importance of following the client's processing in determining the length of DAS sets.		Select	
6.4.6	Reinforce the three-pronged approach		Select	
6.4.7	Note themes of plateaus or difficulties in processing such as self-worth, appropriate responsibility for self and other, safety, and choices		Select	
6.4.8	Explain working with abreactions		Select	
6.4.9	Note how to work with the emergence of new memories that spontaneously occur during processing which may need additional targeting		Select	
6.4.10	Identify the selection of appropriate clinical interventions for ineffective or blocked processing which include but are not limited to: change of DAS, return to target, maximise or minimise assessment components.		Select	
6.4.11	Explain cognitive interweaves.		Select	
6.4.12	Identify methods to identify early memories which were not previously linked, such as the use of the affect bridge, float back or touchstone events.		Select	
6.4.13	Explain timing of re-accessing and reassessing the target.		Select	
6.4.14	Explain therapist characteristics or responses that may interfere with adequate processing.		Select	
6.4.15	Explain client perceptions of therapist characteristics or responses that may interfere with adequate processing.		Select	

	Applicant Response:			
6.5	**Installation (Phase 5)**: The curriculum outlines all steps and components of Phase 5 as per the standard protocol.		Select	
6.6	**Body Scan (Phase 6)**: The curriculum outlines all steps and components of Phase 6 as per the standard protocol, including the importance of the information gained during the body scan.		Select	
6.7	**Closure (Phase 7):** The curriculum instructs the purpose of closure for both a single therapy session as well as closure to the processing of a given EMDR therapy target. Rationale and methods to ensure client stability in the event of incomplete processing of a specific target must be emphasised.		Select	
6.8	**Re-evaluation (Phase 8)**: The curriculum instructs on the rationale of "checking your work" of the previous session. It provides information on the status of a fully processed memory. A fully processed memory needs to have processed the past memory, present triggers, and future template. If the memory is not fully processed phase 8 instructs on how to reengage the target for continuing processing. A re-evaluation of all targets occurs at the conclusion of therapy.		Select	
	Applicant Response:			
6.9	Three-pronged model: – The curriculum includes instruction on the three-pronged model, including information on		Select	

	the sequencing of the three prongs and relevant targets within each prong.			
	Applicant Response:			
6.10	Advanced methodology: Procedural modifications are shown to produce better outcomes in specific situations. The curriculum must include the rationale for any modifications of the EMDR therapy basic protocol. This also provides another opportunity to discuss case conceptualisation and treatment planning from the framework of the AIP. Core inclusions are listed below; however, this is not an exhaustive list.		Select	
6.10.1	Protocols and procedures for special situations and populations Recent events		Select	
6.10.2	Common presentations such as anxiety and mood disorders (e.g., phobias, OCD, depression).		Select	
6.10.3	Chronic pain and physical health related conditions		Select	
6.10.4	Grief		Select	
6.10.5	Children and adolescents		Select	
6.10.6	Substance-use disorders and behavioural addictions		Select	

6.10.7	Applications for complex trauma presentations		Select	
6.10.8	Delivering EMDR therapy online		Select	
6.10.9	Collective trauma including racial or cultural marginalisation.		Select	
6.10.10	Military and first responders		Select	
	Applicant Response:			
6.11	Professional, legal, ethical issues in the Australian context: This curriculum provides an opportunity to remind trainees of the general principles and issues necessary for excellence in practice. It can also provide information about EMDRAA, the need for ongoing continuing education and other professional or practical issues.		Select	
6.12 6.12.1 6.12.2	Medico-legal issues Issues of informed consent. Witness statements and impending legal matters.		Select Select Select	
6.13 6.13.1 6.13.2	Scope of practice. Trainees are reminded to: practice within their competency level (i.e., education, training, and professional experience). to maintain the standards of practice of their professional discipline.		Select Select Select	

	Applicant Response:			
6.14	Hypothesised mechanisms of action and neurobiological aspects of EMDR therapy (see Appendix C). The curriculum must provide the most current information in these or any emerging explanatory models.		Select	
6.15	**Common EMDR derived techniques**: Techniques which may be implemented in addition to or combination with the standard protocol may be introduced. This can include RDI, container, and memory mapping. If mentioning, ensure you outline the importance of having clear the rationale for their use.		Select	
	Applicant Response:			

7. SUPERVISED PRACTICUM

The goal of Supervised Practicum is to facilitate the demonstration and practice of the EMDR therapy methodology as per the standard protocol.

All practicum exercises must be supervised by an EMDRAA Accredited Consultant. The ratio of practicum supervisors to trainees should not exceed 1:12 to allow for direct behavioural observation of each trainee.

It is imperative that trainees receive direct behavioural observation and feedback. Whenever appropriate, trainees practice with real life experiences.

Ample practice is recommended before introducing/teaching the cognitive interweave.

	Requirement	Document/ Page and line number	(EMDRAA review) Met/ Not Met	(EMDRAA review) Comments/ Revision needs
7.1	Time requirement: 20 Hours		Select	
7.2	Practicum exercises To achieve the goals of the supervised practicum, the practice may be done in dyads or triads.		Select	
7.2.1	The role of the therapist is required.		Select	
7.2.2	The role of the client is required.		Select	
7.2.3	The role of observer is preferred but not mandatory. EMDRAA recognises that it is not always possible to fill the role of observer during the supervised practicum.		Select	
7.3	Practice should be included for each phase of the procedure as outlined in the instructional section.		Select	

7.4	Phase one Practice using different history taking strategies		Select	
7.5 7.5.1 7.5.2	Phase two Explaining a rationale for EMDR and the AIP model Establishing seating and practising DAS (including testing appropriate distance, speed, etc of eye movements). Implementation of self-regulation, containment, or other preparation skills.		Select Select Select	
7.6 7.6.1 7.6.2 7.6.3 7.6.4	Phase three Appropriately moving through all components of Phase 3 in the standard sequence Obtaining valid negative and positive cognitions Obtaining valid *Validity of Cognition* and *Subjective Units of Distress* ratings		Select Select Select Select	
7.5 7.5.1 7.5.2	Phase four: Desensitisation Application of all aspects of Phase 4, including effective implementation of DAS, navigation of blocks or issues in processing, and appropriate progression through the standard protocol. It is understood that trainers will have different ways of implementing this practice, but it is recommended that every		Select Select Select	

	effort be made to include each aspect of the three-pronged protocol – Past, Present and Future. In addition, it is recommended that trainees work on their own issues to the extent consistent with participant safety.			
7.5.3	Additional areas that may be explored when they arise:		Select	
7.5.4	Therapist characteristics or responses that may interfere with adequate processing.		Select	
7.5.5	Client perceptions of therapist characteristics or responses that may interfere with adequate processing		Select	
7.6	Phase five. Application of all aspects of Phase 5 including when to progress to Phase 5, checking the positive cognition, and when to conclude Phase 5.		Select	
7.7	Phase six. Application of the body scan including appropriate decision making based on client responses.		Select	
7.8	Phase seven. Application of appropriate closure activities including decision to move to closure, initiating a positive closure, and providing appropriate advice and information for after processing.		Select	
7.9	Phase eight. Application of an appropriate re-evaluation including changes in symptoms, target memory (as per Phase 3 components).		Select	

	Applicant responses:

Appendix A: Antecedent, historical models of emotional information processing:

1. Peter J. Lang (1977, 1979, 2000)
2. Stanley Rachman (1980)
3. Gordon Bower (1981)
4. Edna Foa and Michael J. Kozak (1986)

Appendix B Differentiate from other models:

Highlight how pathology and treatment are viewed differently from other orientations. The trainer should be prepared to highlight and/or to answer questions regarding how EMDR therapy and the Adaptive Information Processing Model contrast and compare with other psychotherapeutic approaches. This might include the view of pathology and health, case conceptualisation, and how change occurs. Examples would include:

Cognitive

- Irrational thoughts are the basis of pathology
- Cognitions are changed through reframing, self-monitoring, and homework exercises

Behavioural

- Cannot see within the “black box” (the brain)
- Learned behaviour is changed through conditioning, exposure, modelling, etc. (learning processes)

“Third wave” of CBT

- Suffering is inevitable
- Change is through acceptance, commitment, and Mindfulness exercises

Psychodynamic

- Explores the impact of Family of Origin, Object relations
- Change is created by insight or “working through”
- Goal is to make the subconscious conscious

Family Therapy

- Problems and solutions are interactional
- Exploration and evaluation of family dynamics
- Change through education and role realignment

Experiential

- Facilitates client self-healing

- Affect and body are central
- Uses relationship, “two-chair,” “meaning bridge”

Appendix C: Hypothesised Mechanisms of Action:

Amano, T., & Toichi, M. (2016a). Possible neural mechanisms of psychotherapy for trauma-related symptoms: Cerebral responses to the neuropsychological treatment of post-traumatic stress disorder model individuals. SciRep, 6, 34610. doi:10.1038/srep34610

Amano, T., & Toichi, M. (2016b). The role of alternating bilateral stimulation in establishing positive cognition in EMDR therapy: A multi-channel near-infrared spectroscopy study. PLoS ONE, 11(10), e0162735. doi:10.1371/journal.pone.0162735

Andrade, J., Kavanagh, D. & Baddeley, A. (1997). Eye-movements and visual imagery: a working memory approach to the treatment of post-traumatic stress disorder. British Journal of Clinical Psychology, 36 (Pt 2):, 209-223.

Bossini, L., Tavanti, M., Calossi, S., Polizzotto, N. R., Vatti, G., Marino, D., & Castrogiovanni, P. (2011). EMDR treatment for posttraumatic stress disorder, with focus on hippocampal volumes: A pilot study. The Journal of Neuropsychiatry and Clinical Neurosciences, 23(2), E1-2. doi:10.1176/appi.neuropsych.23.2.E1

Boukezzi, S., El Khoury-Malhame, M., Auzias, G., Reynaud, E., Rousseau, P.-F., Richard, E. et al. (2017). Grey matter density changes of structures involved in Posttraumatic Stress Disorder (PTSD) after recovery following Eye Movement Desensitization and Reprocessing (EMDR) therapy. Psychiatry Res, 266, 146-152.

Bower, G. (1981). Mood and Memory. American Psychologist, 36(2), 129-148.

Calancie, O. G., Khalid-Khan, S., Booij, L., & Munoz, D. P. (2018). Eye movement desensitization and reprocessing as a treatment for PTSD: current neurobiological theories and a new hypothesis. Ann N Y Acad Sci.

de Voogd, L. D., Kanen, J. W., Neville, D. A., Roelofs, K., Fernández, G., & Hermans, E. J. (2018). Eye movement intervention enhances extinction via amygdala deactivation. The Journal of Neuroscience, 0703-0718.

El Khoury-Malhame, M., Reynaud, E., Beetz, E. M., & Khalfa, S. (2017). Restoration of emotional control ability in PTSD following symptom amelioration by EMDR therapy. European Journal of Trauma & Dissociation, 1(1), 73-79.

Foa, E. B., & Kozak, M. J. (1986). Emotional Processing of Fear: Exposure to Corrective Information. Psychological Bulletin, 99(1), 20-35.

Landin-Romero, R., Moreno-Alcazar, A., Pagani, M., & Amann, B. L. (2018). How Does Eye Movement Desensitization and Reprocessing Therapy Work? A Systematic Review on Suggested Mechanisms of Action. Frontiers in Psychology, 9.

Lang, P. J. (1977). Imagery in therapy: An information processing analysis of fear. Behavior Therapy, 8, 862-886.

Lang, P. J. (1979). A bioinformational theory of emotional imagery. Psychophysiology, 16, 495-512.

Lang, P. J., Davis, M., & Ohman, A. (2000). Fear and anxiety: animal models and human cognitive psychophysiology. Journal of Affective Disorders, 61(3), 137-159.

Lee, C. W., & Cuijpers, P. (2013). A meta-analysis of the contribution of eye movements in processing emotional memories. Journal of Behavior Therapy and Experimental Psychiatry, 44(2), 231-239. doi:10.1016/j.jbtep.2012.11.001

Rachman, S. (1980). Emotional processing. Behaviour Research and Therapy, 14, 125-132.

Rimini, D., Molinari, F., Liboni, W., Balbo, M., Darò, R., Viotti, E., & Fernandez, I. (2016). Effect of ocular movements during eye movement desensitization and reprocessing (EMDR) therapy: A near-infrared spectroscopy study. PLoS ONE, 11(10), e0164379. doi:10.1371/journal.pone.0164379

Schubert, S. J., Lee, C. W., & Drummond, P. D. (2010). The efficacy and psychophysiological correlates of dual attention tasks in eye movement desensitization and reprocessing (EMDR). J Anxiety Disord, [doi:10.1016/j.janxdis.2010.06.024].

Schubert, S. J., Lee, C. W., & Drummond, P. D. (2016). Eye Movements Matter, But Why? Psychophysiological Correlates of EMDR Therapy to Treat Trauma in Timor-Leste.

Journal of EMDR Practice and Research, 10(2), 70-81.

Shapiro, F. (1989). Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories. Journal of Traumatic Stress, 2, 199-223.

Shapiro, F., (2001). Eye movement desensitization and reprocessing: Basic Principles, Protocols and Procedures. (2nd Edition) New York: The Guilford Press.

Stickgold, R. (2002). EMDR: A putative neurobiological mechanism of action. Journal of Clinical Psychology, 58, 61-75.

Yaggie, M., Stevens, L., Miller, S., Abbott, A., Woodruff, C., Getchis, M. et al. (2015). Electroencephalography Coherence, Memory Vividness, and Emotional Valence Effects of Bilateral Eye Movements During Unpleasant Memory Recall and Subsequent Free Association: Implications for Eye Movement Desensitization and Reprocessing. Journal of EMDR Practice and Research, 9(2), 78-97

Appendix D: Publications regarding the conceptualisation of EMDR therapy

De Jongh, A., Amann, B. L., Hofmann, A., Farrell, D., & Lee, C. W. (2019). The status of EMDR therapy in the treatment of posttraumatic stress disorder 30 years after its introduction. Journal of EMDR Practice and Research, 13(4), 261–269. https://doi.org/10.1891/1933-3196.13.4.284

Laliotis, D., Luber, M., Oren, U., Shapiro, E., Ichii, M., Hase, M., . . . Tortes St. Jammes, J. (2021). What Is EMDR Therapy? Past, Present, and Future Directions. *J EMDR Prac Res*(4), 186-201. doi:10.1891/EMDR-D-21-00029

Matthijssen, S. J., Lee, C. W., de Roos, C., Barron, I. G., Jarero, I., Shapiro, E., et al. (2020). The current status of EMDR therapy, specific target areas, and goals for the future. Journal of EMDR Practice and Research, 14(4), 241– 256. http://doi.org/10.1891/EMDR-D-20-00039

Maxfield, L. (2019). A clinician's guide to the efficacy of EMDR therapy. Journal of EMDR Practice and Research, 13(4), 239–246. https://doi.org/10.1891/1933-3196.13.4.239

Shapiro, F. (1991). Eye movement desensitization & reprocessing procedure: From EMD to

EMD/R-a new treatment model for anxiety and related traumata. Behavior Therapist, 14, 133–135

Shapiro, F. (1995). Eye movement desensitization and reprocessing: Basic principles, protocols and procedures. Guilford Press.

Shapiro, F. (2001). Eye movement desensitization and reprocessing: Basic principles, protocols and procedures (2nd ed.). Guilford Press.

Shapiro, F. (2018). Eye movement desensitization and reprocessing: Basic principles, protocols and procedures (3rd ed.). Guilford Press.