APPLICATION

EMDRAA
EMDR Association of Australia

EMDRAA Practitioner Accreditation Application

Please ensure this form is completed in printed format and **NOT** handwritten.

APPLICANT:

ADDRESS & POSTCODE:

EMAIL ADDRESS:

PROFESSIONAL DISCIPLINE:

SUPPORTING EMDRAA CONSULTANT:

SUPPORTING CONSULTANT EMAIL:

Please ensure you have completed each component of this process:

Part A: Practitioner Competency Based Framework Checklist
Part B: Consultation hours
Part C: Client log - download available at www.emdraa.org/training-log/
Part D: EMDRAA Accredited Consultant recommendation
Part E: Second reference to support application
Part F: Fidelity checklist

Completed applications should be emailed to: accred@emdraa.org

Please note that there are issues with the form when non-Adobe software is used to fill in the form. The most common culprits are Apple Preview and the various PDF plugins in browsers such as Chrome, Firefox, Safari, etc., which no longer support the Adobe plugin. Please **save the file**, do not open it in a browser window, and then open it using Adobe Acrobat or Reader.

Application Checklist

		YES/NO
1	I am a full member of the EMDR Association of Australia	Yes
2	I have **provided my EMDRAA Consultant** with evidence of completion of all parts of EMDR Therapy Basic Training including 10hrs of consultation. ***Date of completion of Basic Training:***	Yes
3	I have **provided evidence** of current registration/professional membership to my consultant **as per the EMDRAA Eligibility Criteria.**	Yes
4	I have attached a copy of my current CV	Yes
5	I have **provided my EMDRAA Consultant** with a log of our completed consultation hours.	Yes
6	I have had at least one (1) year of experience in conducting EMDR therapy following completion of basic training.	Yes
7	I have used EMDR Therapy for at least **50** sessions and seen at least **25** clients using EMDR after commencing EMDRAA Accredited Basic Training. I have **presented my EMDRAA Consultant with a completed log** summarizing my work with these cases. My consultant has confirmed this log complies with the requirements outlined in the Consultant Handbook.	Yes Yes
8	I have retained a copy of my completed client log and I am aware this could be requested at any time in the five years of my accreditation period.	Yes

9	I have completed a minimum of **10** hours consultation with an EMDRAA Accredited Consultant after completing basic training. (As Part B of this application)	Yes
10	I have provided my consultant video(s) or live demonstration(s) of my application of Phases 3-8 of the EMDR therapy standard protocol as assessed by the Cooper et al. (2019) Modified Fidelity Checklist.	Yes
11	I have a completed recommendation from my EMDRAA Consultant regarding my competency in using EMDR therapy in practice, participation in the consultancy process, professional ethics and character. (As per Part D of this application).	Yes
12	I have obtained a second reference in support of this application from a person who is in a position to comment upon professional practice and standing. (As per Part E of this application)	Yes
13	I have paid the application fee of **$150.00AUD + GST** and provided a copy of the receipt with my application.	Yes
14	I am aware that EMDRAA Accreditation is for 5 years duration after which I will need to apply for re-accreditation. I have reviewed and am aware of the requirements for re-accreditation, particularly maintaining full EMDRAA membership.	Yes

Part A: Practitioner Competency Based Framework Checklist - Applicant to complete self-assessment, consultant to verify competency.

INSTRUCTIONS FOR COMPLETION:

Applicant: Complete self-assessment as part of consultation until you feel you achieve each competency.

Consultant: Review client self-assessment and verify at the end of the form.

	YES	NO
The applicant demonstrates a grounded understanding of the theoretical basis of EMDR and the Adaptive Information Processing (AIP) Model and can explain this effectively to clients, as it applies to overall treatment.	○	○
THE BASIC EIGHT- PHASE PROTOCOL **Applicant Self-assessment on YES/NO responses**		
1. History Taking	**YES**	**NO**
Obtain a history of presenting problems informed by the AIP model, i.e. with consideration for target memory identification.	○	○
Determine if EMDR therapy is appropriate for the client's presentation, with appropriate identification of possible barriers to memory processing that need to be addressed in preparation	○	○
Collaboratively determines realistic therapeutic goals for the episode of care, with consideration for client and treatment setting factors.	○	○
Is able to identify safety factors, including screening with standardised assessment tool.	○	○
Conceptualises the case utilising the AIP model.	○	○

Establishes that the client has resources and supports to tolerate emotional distress within and outside of sessions.	◯	◯
Selects appropriate target, and memory processing sequencing in consideration to the past, present and future.	◯	◯
2. Preparation	**YES**	**NO**
Explains therapy and obtains informed consent. Establishes a therapeutic relationship.	◯	◯
Tests Bilateral Stimulation (BLS) with clients	◯	◯
Teaches and checks client's ability to self-regulate using the safe/calm place, resourcing with clients, and ensuring social support.	◯	◯
Demonstrates the 'Stop' signal.	◯	◯
Identifies, addresses client's concerns, fears, queries, or anxieties about engaging in trauma memory processing and recovery.	◯	◯
Utilises an effective metaphor for memory processing.	◯	◯
Instructs client to 'just notice' whatever comes up during processing and not discard or judge any information that may arise.	◯	◯
3. Assessment	**YES**	**NO**
Selects target image and/or worst aspect of the event.	◯	◯
Identifies the appropriate Negative and Positive Cognition in relation to the target image.	◯	◯
Uses the Validity of Cognition (VOC) scale pairing the Positive Cognition with the target image.	◯	◯

Identifies emotions generated from the target image and the Negative Cognition.	○	○
Uses SUDs Scale to identify the level of distress associated with the image, negative cognition, and emotions.	○	○
Identifies body sensations and location	○	○
4. Desensitisation	**YES**	**NO**
Demonstrates competency in the provision of Bilateral Stimulation emphasising the importance and effectiveness of eye movements	○	○
'Stays out of the way' as much as possible.	○	○
Uses post 'set' interventions where appropriate.	○	○
Engages in the use of verbal and non-verbal reassurance to clients during each set.	○	○
Identifies a plateau and rechecks the target memory appropriately.	○	○
When processing becomes blocked, uses appropriate interventions, including alteration in the Bilateral Simulation and/or other unblocking techniques. Holds and manages heightened affect and emotional and physiological distress.	○	○
Utilises grounding skills appropriately	○	○
Uses therapeutic cognitive interweaves to assist processing where necessary	○	○
5. Installation	**YES**	**NO**
The Positive Belief is checked for both applicability and current validity, i.e. that it is the most meaningful to the client in relation to the negative cognition.	○	○

The Positive Belief is linked with the target issue or event	○	○
Utilises the Validity of Cognition (VoC) scale to evaluate the Positive Belief integration.	○	○
Addresses any blocks during the 'Installation Phase'.	○	○
If new material emerges the applicant effectively returns to the most appropriate phase of the EMDR Protocol or the utilisation of an 'Incomplete Session'	○	○
Responds appropriately to the emergence of new material during the installation phase.	○	○
6. Body Scan	**YES**	**NO**
Guides client through a body scan, holding the target incident and the Positive Cognition in mind.	○	○
Prepares for further material to surface and to appropriately respond by either returning to the most appropriate phase of the EMDR Protocol or the utilisation of a 'Incomplete Session'.	○	○
7. Closure	**YES**	**NO**
Allows adequate time for closure.	○	○
Utilises the debrief, including that post-session processing may occur.	○	○
Effectively utilises the 'Incomplete Session'.	○	○
Incorporates containment exercises, grounding, and safety assessment.	○	○
Encourages clients to maintain a log between sessions.	○	○
Offers opportunity to access therapist support between sessions	○	○

8. Re-evaluation			
Reactivates previously processed target memory, emotions, body sensations, SUDs, and checks PC validity.			
Ensures that the individual target has been resolved.			
Ensures other activated material is appropriately addressed.			
All necessary targets have been processed in relation to the past, present and future.			
Assess for future fears (i.e. flashforwards and anticipatory anxiety) and utilises a 'Future/ Positive Template' to ensure effective behaviour change.			
Ensures that the client has readjusted appropriately with their social system, i.e. is setting healthy boundaries, has healthy attachments, working towards life goals.			
Effectively closes therapy.			
		YES	**NO**
1	The applicant demonstrates an understanding of PTSD, complex PTSD, and traumatology.		
2	The applicant demonstrates an understanding of using EMDR therapy either as part of a comprehensive therapy intervention or as a means of symptom reduction		
3	The applicant demonstrates experience in applying the standard EMDR protocol, and procedures to special situations and clinical problems, including recent events, phobias, excessive grief, somatic disorders, and self-use.		

4	Which protocols/procedures/special situations used appropriately?

Part B: Consultation Hours

1. Please list when EMDRAA Consultation took place and the number of hours

	Number of hours	Dates of consultation
Individual hours		
Group hours		
Asynchronous hours		

Part C: Client Log

To download the client log and provide to your consultant visit https://emdraa.org/forms/

Part D: Consultant Recommendation

Please specify your reasons for recommending your applicant's accreditation as an EMDRAA Practitioner.

Fidelity Average Rating (minimum 1.4 of 2.0): Average Score	
Re-evaluation phase:	
Assessment phase:	
Desensitisation phase:	
Installation phase:	
Body scan phase:	
Closure phase:	

Consultant Recommendation Summary

Consultant Declaration:

- I confirm that I **have sighted the applicant's training certificates** of an EMDRAA accredited training and that they received the necessary 10 hours of consultancy as a part of basic training.

- I confirm that the applicant has completed a minimum of 10 Hours Consultation following completion of basic training, with at least 5 of these 10 hours being individual consultation.

- I confirm that **I have observed the applicant's EMDR work** either through recordings or in vivo and have scored the fidelity checklist on this basis and provided a copy of the completed Fidelity Checklist to the applicant.

- I confirm that **I have reviewed the applicants Client Log** (a minimum of 25 Clients) and that it meets the requirements outlined in the EMDRAA Consultants Handbook (a minimum of 20/25 Clients achieving Phases 1-8). I confirm I have retained a copy of this should it be requested.

- I confirm that **I have reviewed the applicant's self-assessment checklist,** have mitigated any concerns, and deem them competent across all domains.

- I confirm that if more than two years has lapsed between training and accreditation, that the **applicant's client work and fidelity assessment is based on recent practice** (predominantly within the last 2 years).

CONSULTANT NAME:

CONSULTANT SIGNATURE: **DATE:**

Applicant's Declaration:

- I confirm that **I have fully reviewed and/or completed all aspects of this application**
- I confirm that all information provided is truthful and accurate
- I confirm that if accredited, I will ensure I practice within the appropriate standards and guidelines set out by EMDRAA and by my professional discipline
- I confirm that **I will maintain my eligibility for EMDRAA Full Membership for the duration of the accreditation period and will notify EMDRAA immediately should my eligibility status change in any way.**
- I confirm that should my practice as an EMDRAA Accredited Practitioner not adhere to the required standards EMDRAA may revoke my accreditation

APPLICANT NAME:

APPLICANT SIGNATURE: **DATE:**

Part E: Second Reference to Support an Application for EMDRAA Accreditation

This reference forms part of the application process for accreditation as an EMDRAA Practitioner.

I support this application for EMDRAA Accreditation as an EMDRAA Practitioner for:

NAME OF APPLICANT:

I know the applicant from the following context:

- ◯ **Clinical Manager**
- ◯ **Professional Colleague**
- ◯ **Academic Colleague**
- ◯ **Clinical Supervision Group member**

I can confirm the applicant's experience in the practice of EMDR therapy and that the applicant's professional practice is in accordance with the ethical guidelines of their respective professional organization.

It will be helpful if you could comment on the applicant's integration of EMDR therapy into their general work and if possible, provide details and examples of the following:

1. Benefits to the service and clinical outcomes regarding the applicant's use of EMDR therapy
2. Feedback from clients and or clinical colleague regarding the applicant's use of EMDR therapy
3. Examples of how the applicant has promoted/developed EMDR therapy through education and teaching.

Please provide this information in the form of a short report below or on a separate sheet if needed. Please include your name and job title.

Part F: The Modified EMDR Fidelity Checklist

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

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				
1	Did the clinician reevaluate the subject's experience since the last session with attention to feedback from the log, presenting complaints, responses to current stimuli, and additional memories or issues that might warrant modifications to the treatment plan? (This is crucial after history-taking sessions as well as after stabilization and reprocessing sessions.)	0 ○	1 ○	2 ○

	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.			
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 The clinician never explored this. 1 Clinician explored this in an incomplete or fundamentally flawed manner (e.g., asked "Have you been getting any flashbacks?") ***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. 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.			
	Desensitization Phase			
15	Before beginning bilateral eye movements or alternate bilateral stimulation, did the clinician instruct subject to focus on the picture, NC (in the first person), and the body location? No target was selected. 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, behavioral 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	1	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	1	2
		0	1	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.	0	1	2

	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.			
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.	0 ◯	1 ◯	2 ◯

	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.			

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 scored) proceed to score Installation Phase items. If the Desenitization 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 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 he 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 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 ○
44	Did the clinician request that the subject keep a written log of any continuing or new issues or other changes to share at the next session? 0 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.	0 ○	1 ○	2 ○
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.	0 ○	1 ○	2 ○

	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.			
	Closure Phase average score (items 39–45):			