

Enhancing EMDR clinical supervision through the utilisation of an EMDR process model of supervision and an EMDR personal development action plan

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Abstract

EMDR Clinical Supervision offers the opportunity for the EMDR Supervisee to engage in a number of important aspects in relation to exploring their EMDR practice and professional development. This paper will outline models of clinical supervision and how they relate to EMDR. It will propose an EMDR Clinical Supervision Process Model that captures both the micro and macro elements of EMDR as an eight-phase psychological treatment intervention for psychological trauma. An EMDR Personal Development Action Plan (EMDR PDAP) will also outline how this could be incorporated within EMDR clinical supervision in the promotion of theory and practice integration in EMDR. Although the paper will focus upon the EMDR Europe Practitioner Competency Framework the implications for enhancing EMDR clinical supervision apply to EMDR clinicians internationally.

Introduction

Eye Movement Desensitisation & Reprocessing (EMDR) is empirically supported, evidence based psychotherapy method for Post-Traumatic Stress Disorder (PTSD) (ICD-10:F43.1; WHO, 1992) and other mental health conditions (Shapiro, 2012). The recent endorsement by the World Health Organisation [WHO] (2013) supports its use with children, adolescents and adults with PTSD. Further endorsement for EMDR comes from many other sources: American Psychiatric Association (2004); National Institute of Health & Clinical Excellence (2005); Bisson and Andrew (2007); Pagani et al (2007); Van der Kolk et al (2007); International Society of Traumatic Stress Studies (2009); Department of Veterans Affairs and Department of Defence (2010); California Evidence-Based Clearinghouse for Child Welfare (2010); The Substance Abuse & Mental Health Services Administration (2011); Korn (2009); Maxfield (2009); Rothbaum, Astin, & Marsteller (2005).

According to Carrere (2013), since its inception in 1989, some 150,000 clinicians have been trained in EMDR worldwide. From these early days, EMDR has progressed from a relatively

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simple technique through to a complex psychotherapeutic method that is distinct from other psychotherapeutic paradigms (Shapiro & Forrest, 1997; Maxfield, 2009). Shapiro (1989) considered EMDR to be a convergent paradigm consistent with other psychotherapeutic modalities. Increasingly, EMDR is considered a distinct modality that is divergent and has its own unique characteristics and theoretical underpinning (Farrell & Keenan, 2013).

The basic structure of EMDR trainings (www.emdr.com) was established in the early 1990s and centred on a two level format, each spread over two 2.5-day training periods. The general structure of EMDR training has remained relatively unaltered over the last 20 years. Currently, the length of EMDR training ranges from 6 to 12 days depending on the training format and context despite its movement from convergence to divergence (Farrell & Keenan, 2013). Training in EMDR primarily utilises an entrepreneurial model of largely independent training institutes: a model that despite criticism (Russell, 2008; Sykes & Sykes, 2003) has been extremely successful in developing EMDR clinicians worldwide.

From its early outset, Shapiro (1989, 1995) recognized that to obtain academic credibility for EMDR, it was essential to standardize the training for appropriately qualified mental health workers in order to ensure treatment fidelity, reliability, and validity. More recently, academic training and university-based research in EMDR have emerged as a means of promoting stronger research and development potential in this psychotherapeutic approach.

The current format of training is relatively short and provides training participants with a certificate of attendance rather than a certificate of competence or knowledge check. Instead the integration between theory and practice in EMDR is primarily driven by EMDR clinical supervision and consultation. Therefore clinical supervision in EMDR is arguably one of the most important activities in relation to developing and maintaining therapeutic competence in EMDR.

“EMDR education is only the beginning of the learning process. Once formal training is complete, it becomes the responsibility of all therapists and researchers using EMDR to continue to upgrade their skills through on going practice, supervision and consultation with more experienced practitioners” (Shapiro, 1995; pg. 385)

Although EMDR attributes significance to the therapeutic relationship there are multiple agents of change involved within EMDR that are important for generating a positive, overall treatment effect. These include EMDR as an eight-phase protocol intervention, client preparedness and motivation, EMDR clinician’s expertise, skill and competence, activation and discharge of traumatic material, Adaptive Information Processing, emotional integration and the utilisation of bilateral and dual attention stimulation (Farrell, 2013). But what is adaptive information processing (AIP)? EMDR uses AIP as a theoretical model underpin the psychotherapeutic approach (Shapiro, 1995). This AIP framework is a relatively straightforward triadic model that explores the relationship between past, present and future experiences and memories. It posits three important assumptions:

1. As humans, we possess an intrinsic information processing system that has evolved to enable us to reorganise our responses to disturbing events from an initial dysfunctional state of disequilibrium to a state of adaptive resolution.
2. Trauma causes an imbalance in the nervous system thus creating blocked or incomplete information processing. This dysfunctional information is then stored in its unprocessed state.

3. Identifying these dysfunctional information hotspots of unprocessed events is central to EMDR treatment.

The hallmark of EMDR is that it assumes that physiologically stored memories are the primary foundation of pathology and that the primary agent of change in EMDR is specifically targeted information processing. The AIP theoretical framework therefore guides the clinical application of EMDR in a manner that is both explanatory and predictive of positive treatment effects (Shapiro & Laliotis, 2011). What links the diverse clinical populations stated earlier is that of 'trauma' and blocked information processing. It is the ubiquitous interpretation of the EMDR AIP theoretical framework that enables EMDR therapists to use this paradigm with wider applications over and above that of PTSD. A paradox regarding the practice of EMDR is that with some clients it can be a remarkably simple intervention, for example with some clients with a circumscribed trauma experience, and yet with others, an intricate, complex, multi-faceted and abundantly technical psychotherapeutic endeavour, for example with complex trauma survivors.

Currently, the core aspects for EMDR basic training are: a training manual, theory/practice-driven active teaching and learning experience, behavioural role plays, and the inclusion of clinical supervision as part of the training experience (Farrell & Keenan, 2013). The diversity of teaching and learning approaches has the potential to optimise the integration and adoption of EMDR into the trainees' clinical practice.

The journey towards seeking accreditation in Europe in EMDR involves a competency based framework containing four parts (<http://www.emdr-europe.org/>)

Part A: *Supervisee demonstrates a grounded understanding of the theoretical basis of EMDR and the Adaptive Information Processing (AIP) Model and is able to convey this effectively to clients in providing a treatment overview.*

Part B: *Supervisee demonstrates competency in each of the eight phases of EMDR*

Part C: *Supervisee demonstrates an understanding of PTSD and traumatology, and of using EMDR either as part of a comprehensive therapy intervention or as a means of symptom reduction.*

Part D: *Has engaged with a minimum of 20 hours EMDR Clinical Supervision with an EMDR Europe Accredited Consultant.*

Further criteria for seeking EMDR Europe Accreditation as an EMDR Europe Practitioner are outlined in table 1:

- Completed EMDR Europe Basic training by a recognised EMDR Europe Accredited Trainer
- Applicants are required to be members of their National EMDR Organisation
- Applicants seeking EMDR Europe Accreditation as a Practitioner must have a minimum of two years professional experience before they can become accredited by EMDR Europe
- There should be a minimum period of time after completion of EMDR training before seeking EMDR Europe Accreditation as a Practitioner (1 year)

- Number of hours EMDR Clinical Supervision/Consultation - Until the applicant has demonstrated competency in all areas of Parts A, B & C of the Competency Framework. It is estimated that this would require a minimum of **20 hours clinical supervision** from an EMDR Europe Accredited Clinical Supervisor/ Consultant
- The EMDR Clinical Supervisor/ Consultant supervising the applicant needs to have directly witnessed the applicants EMDR work either through the use of video/DVD or In Vivo
- Number of EMDR Sessions to be completed by applicant - Minimum 50
- Number of clients to be treated with EMDR by the applicant - Minimum 25
- Number of references to support Application - Two references are required, one from an EMDR Europe Accredited Clinical Supervisor/ Consultant and the second from a person who can comment upon the applicants professional practice and standing.

Table 1: Guidelines for Accreditation as an EMDR Europe Accredited Practitioner (EMDR Europe Practice Committee - November 2013)

What however are the advantages in seeking EMDR accreditation? In broad terms there are five aspects to consider surrounding the rationale for being accredited in EMDR. These include:

1. Effective demonstration of the integration between the theory and practice of EMDR as a psychotherapeutic approach
2. Enhancing and maintaining patient/client protection and adherence to clinical governance procedures
3. Ensures the utilisation of empirically supported, effective psychological treatment interventions in enhancing quality assurance in practice
4. Maintains research treatment fidelity in the practice of EMDR
5. Defines a minimum standard of practice across all Europe

The EMDR Europe Competency Frameworks for both Practitioners and Consultants utilise the Dreyfus (2004) Model of Skill Acquisition. This model has illuminated on-going research on skill acquisition and articulation of knowledge embedded in expert practice in both medicine and nursing. At the core of the model is that it is developmentally based, targeted upon performance and involves experiential learning (Benner, 2004). The reason for this model being extremely apposite for EMDR is that EMDR exemplifies, as Aristotle would describe, both '*Techne*' and '*Phronesis*'. '*Techne*' can best be described as procedural and scientific knowledge, that can often be formal, explicit, and predictable and yet tailored specifically to an individual's needs, that captures the art, science and craft of EMDR. The activity centres upon producing outcomes, governed by means-ends rationality, that are embedded in gaining mastery. 'Where as '*Phronesis*', in contrast to '*Techne*', refers to practical reasoning engaged by experts in the field, an EMDR Clinician who, through experiential learning, continually lives out and is constantly striving in improving themselves as a clinician (Benner et al, 1999; Shulman, 1993). '*Phronesis*' is not governed by the same rational but instead uses the relationship itself to guide action.

The Dreyfus model of skill acquisition is ostensibly phenomenological and contains five levels: novice, advanced beginner, competent, proficient and expertise (*Phronesis*). So how

do these five levels relate to EMDR? Figure 1 outlines how the model parallels critical aspects in an individual's level of development in EMDR in integrating theory and practice.

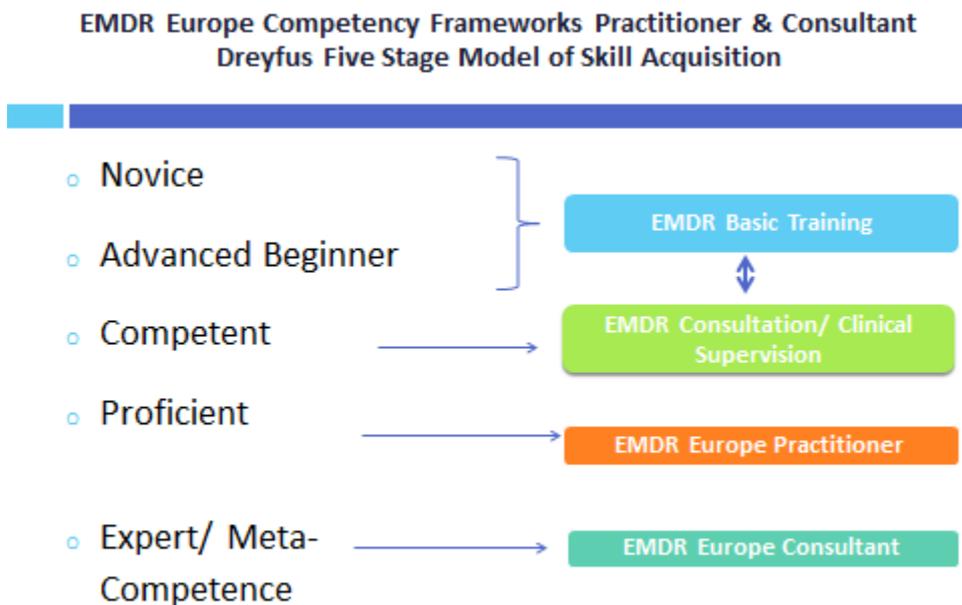


Figure 1: EMDR Europe Competency Frameworks

What Figure 1 also highlights is that in developing EMDR competency to a point of proficiency and meta-competence, then clinical supervision/ consultation is integral to reaching the point of 'Phronesis'/ Expertise.

Ladany and Inman (2012) consider that over the last decade empirical literature has argued that clinical supervision, albeit with benevolent intentions, has proven to be problematic, counter-productive, harmful and at times unethical. Though undoubtedly there may-be some elements of truth in this, it could be argued that clinical supervision requires an atmosphere of integrity and openness with the intent of supporting, evaluating and developing an individual clinician's professional practice.

A recent example of the positive impact of clinical supervision was highlighted in a study by Farrell and Keenan (2013) who conducted a comparison between EMDR Clinicians who were accredited in EMDR as opposed to those that were not accredited. An ANOVA was conducted to determine if there was a relationship between the reported outcome and the type of supervision received, whether it was provided by an EMDR-Accredited Consultant or not. Results suggested that supervision by an EMDR Accredited Consultant/Clinical Supervisor was related to outcomes for the accredited therapists ($p = .015$) but not for the non-accredited therapists ($p = .093$).

The determining of both competency and proficiency in EMDR Clinical Supervision requires six areas of consideration:

1. Foundations of EMDR as an eight-phase protocol, empirically supported psychotherapeutic approach
2. EMDR Research and Development (including evidence based practice and practice

- based evidence)
3. Various approaches in the clinical application of EMDR with diverse mental health and well-being populations
 4. EMDR Clinical Supervision and Consultation
 5. EMDR and Cultural Diversity
 6. EMDR Ethics and Practice

EMDR is increasingly recognised as a vital part of modern, effective health care systems in the treatment of PTSD (WHO, 2013). In maintaining this, EMDR Clinical Supervision is an important means of using reflective practice and shared experiences, as part of on-going, continuous professional development (CPD) in relation to both enhancing and maximising the efficacy of EMDR practice and development.

But what is clinical supervision? Falender and Shafranske (2004) consider clinical supervision as a:

"...distinct professional activity in which education and training, aimed at developing science-informed practice are facilitated through a collaborative inter-personal relationship. It involves observation, evaluation, feed-back, the facilitation of supervisee self-assessment and the acquisition of knowledge and skills by instruction, modelling and mutual exploration. In addition, by building on the recognition of strengths and talents of the supervisee, supervision encourages self-efficacy. Supervision ensures that clinical consultation is conducted in a competent manner in which ethical standards, legal prescription, and professional practices are used to promote and protect the welfare of the client, the profession and society at large (Falender & Shafranske, 2004)

A working definition of clinical supervision is provided by Goldhammer et al (1993) who consider that clinical supervision is important for improving performance stating that:

"Clinical supervision is that aspect of instructional supervision which draws upon data from direct first-hand observation of actual teaching, or other professional events and involves face to face and other associated interactions between observer(s) and the person(s) observed in the course of analysing the observed professional behaviours and activities and seeking to define and/or develop next steps toward improved performance" (Goldhammer et al 1994: pg4).

Wagner & Smith outline a slightly different emphasis incorporating the integration between theory and practice to also include self-examination. They state that clinical supervision is:

"..... a required experience, designed to help students integrate academic training with practical experience and self-examination of their individual styles and strengths" (Wagner & Smith, 1979)

Bernard and Goodyear (1992) place important emphasis upon the distinction between clinical supervision and consultation proposing that if psychotherapists have the right to either accept or reject the suggestions of other then this is rather a process of consultation rather than clinical supervision. This perspective underlines why clinical supervision and consultation are two distinct entities. Consultation is a collaborative relationship between two mental health professionals which values the integrity and independence of the individual who is consulting them. It is the Supervisee's client to which the supervisee maintains primary responsibility for the decisions for the decisions involving treatment

Another helpful consideration is that of Inskipp and Proctor (1993) who highlights the necessity of ethics more so than other clinical supervision models. They regard the purpose of the relationship between supervisor and clinician is to enable the clinician to:

“... gain ethical competence, confidence, compassion and creativity, so as to give the best possible service to clients” (Inskipp & Proctor 1993).

Clinical supervision is therefore an exchange between practising health professionals recognised by numerous professional bodies as a supportive way to facilitate learning from experience (DoH, 1993); the process involves three key aspects referred to as triadic models of clinical supervision which include: education, support and management. These are outlined in Table 2.

<ul style="list-style-type: none">• Educative – (Formative)<ul style="list-style-type: none">• Developing an understanding of skills and ability• Understanding the client better• Developing awareness of reaction and reflection on interventions• Exploring other ways of working.• Supportive – (Restorative)<ul style="list-style-type: none">• Exploring the emotional reaction to pain, conflict and other feelings experienced during patient care, can reduce burn out.• Managerial – (Normative)<ul style="list-style-type: none">• How to address quality control issues• How to ensure health professional’s work reaches appropriate standards.

Table 2: Triadic Models of Clinical Supervision (Kaduschin, 1985; Procter, 1987)

Within the existing literature there is no existing model of clinical supervision specific to EMDR. This raises a question as to how do the principals of clinical supervision therefore then relate to EMDR as a psychotherapeutic treatment? EMDR Clinical Supervision is a space for the EMDR Supervisee to: explore their own EMDR clinical practice, to build theory from an EMDR/ AIP perspective, attend to feelings and values as a consequence of their clinical activity, and to examine their performance and competency as an EMDR Clinician. It provides a structured approach to deeper reflection on clinical practice which can lead to improvements in practice and client care, and contribute to clinical risk management. The central focus of EMDR Clinical Supervision is the quality of practice offered by the EMDR Supervisee to their clients in accordance with EMDR Europe Competency Frameworks and the EMDR Supervisee's professional body / organisation. The EMDR Europe Consultant/ Clinical Supervisor’s task includes imparting expert knowledge and making judgment regarding an EMDR Supervisee’s competence either through the EMDR Europe Competency Based Frameworks (CBFs) for Practitioner or Consultant (<http://www.emdr-europe.org/>). Consequently the EMDR Europe Consultant acts as a gatekeeper to EMDR Europe Accreditation.

Although there are many models of clinical supervision: Supervision Alliance Model (Inskipp & Proctor, 1993, 1995); Cyclical Model (Page & Wosket, 1994); General Supervision Framework (Scaife & Scaife, 1996); A Developmental Approach (Stoltenburg et al, 1998); Systems Approach to Supervision (Holloway, 1995); Process Model (Hawkins & Shohet, 2000); the EMDR Clinical Supervision Process Model (Farrell, 2013; adapted from Hawkins & Shohet, 1989/2012) specifically relates to all the core attributes involved in EMDR as a psychotherapeutic intervention. This is outlined further in figure 2.

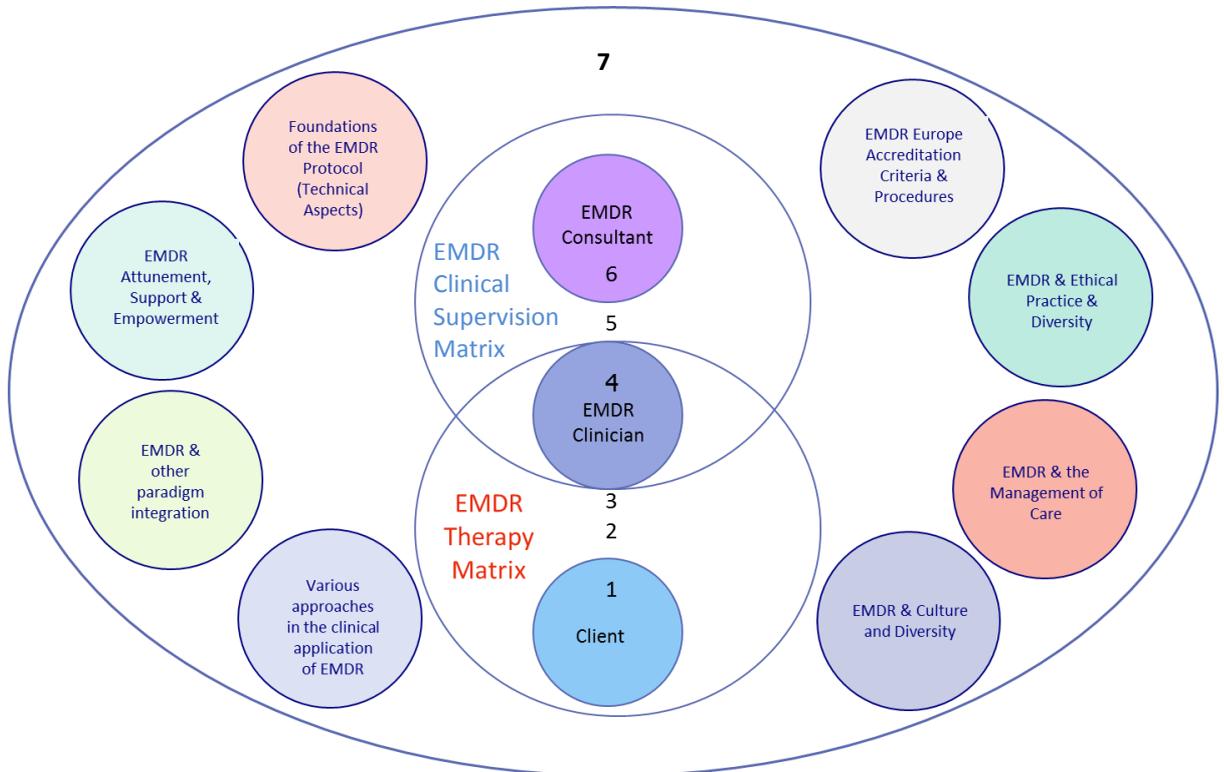


Figure 2: EMDR Clinical Supervision Process Model (Farrell, 2013; adapted from Hawkins & Shohet, 1989/ 2012)

Mode 1 – EMDR Clinical Supervision Session Content – The primary focus on this aspect centres upon effective history taking (EMDR Phase 1) from the client considering diagnosis and case conceptualisation (ICD-10/ DSM 5), co-morbidity, impact of levels of functioning, etc; and re-formulation using the AIP framework. This would also include target sequence planning, symptom reduction, comprehensive treatment planning and also the key elements of Phase 3 assessment.

Mode 2 – Involves a review of the EMDR Clinician’s strategies & interventions used during Phase 2 (Preparation), phase 4 (Desensitisation), Phase 5 (Installation), Phase 6 (Body Scan), Phase 7 (Closure & Incomplete) and Phase 8 (Re-evaluation). However this mode also needs to address the issue of EMDR Paradigm Integration (Dunne & Farrell, 2011).

Mode 3 – Focuses upon the therapeutic process and relationship between client & the EMDR Clinician. This addresses issues around psychotherapeutic attunement and dyadic regulation within EMDR.

Mode 4 – Addresses the internal experience of the EMDR Clinician, addressing aspects such as transference, vicarious trauma, competency, and professional and personal development.

Mode 5 – Explores the ‘Here & Now’ between both the EMDR Consultant & EMDR Clinician considering aspects such as parallel processing, the quality and effectiveness of the clinical supervision relationship, its effectiveness as a resource for the supervisee, and considering the level of attunement that exists between both parties.

Mode 6 – Considers the internal experiences of the EMDR Consultant/ Clinical Supervisor again considering important aspects such as counter-transference, vicariousness, competency, and the EMDR Consultant/ Clinical Supervisor’s professional & personal development. This may also need to address issues such as potential fractures within the clinical supervision relationship and considering on certain occasion when there may be a need to ‘refer on’.

Mode 7 – Addresses the broader context of EMDR clinical supervision within the following areas: socio-economic, cultural, political, organisational, contextual variables, ethical practice and governance related context. Importantly this includes the current EMDR Europe Accreditation Competency Based Frameworks.

- i. Foundations of the EMDR Protocol (Technical Aspects)
- ii. EMDR Attunement, Support and Empowerment
- iii. EMDR & other Paradigm Integration
- iv. Various approaches in the clinical application of EMDR
- v. EMDR Europe Accreditation Criteria & Procedures
- vi. EMDR & Ethical Practice & Diversity
- vii. EMDR & the Management of Care
- viii. EMDR & Culture and Diversity

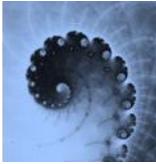
EMDR Clinical Supervision offers the opportunity for the EMDR Supervisee to engage in a number of important aspects in relation to exploring their EMDR practice and professional development. These include building a theory about their particular client from an EMDR/AIP perspective. It also provides an opportunity for the supervisee to attend to feelings and values that may arise as a consequence of their clinical activity. From an accreditation perspective it also allows for an examination of their performance and competency as an EMDR Clinician. From the view of the EMDR Consultant/ Clinical Supervisor a questions arises as to what is the level of training, knowledge, clinical ability, and understanding your EMDR Supervisee has? As a consequence, a useful strategy to use with new EMDR Supervisee’s is to consider the following EMDR Personal Development Action Plan (EMDR PDAP). The purpose of this EMDR PDAP is for the supervisee to go through each of the micro-aspects involved in EMDR and to then subjectively consider how ‘strong’ or ‘not strong’ they are regarding each aspect. The advantage of this is that it provides a context for the EMDR Clinical Supervision of areas that supervisee’s consider themselves to be very strong, areas they would like to enhance further, and areas where they presently consider that developing their skills, knowledge and EMDR clinical application

maybe warranted. An advantage of the EMDR PDP is that it could be included in work-based portfolios as part of continuous professional development. This gives supervisee's a sense of ownership and empowerment of their clinical supervision in guiding the process rather than it being imposed upon. A further advantage is that it could be used as a means of monitoring progression and as an evaluation that supervisee's can refer back to reinforce progress in their clinical competence. A full version of the EMDR PDAP is available in appendix 1.

Conclusion

This paper has highlighted how in the effective integration of the theory and practice of EMDR, clinical supervision is a vital facet in developing competency and proficiency. It has explored how a model of supervision can be adapted to capture the multiple dimensions that are involved in EMDR as a complex, multi-faceted psychotherapy. The utilisation of the EMDR Personal Development Action Plan is a structured means in determining levels of competency and understanding of EMDR supervisee's knowledge, practice and theoretical understanding. EMDR Consultants/ Clinical Supervisors can use it not only for their supervisee's but also in providing a potential structure to the EMDR clinical supervision process. The EMDR PDAP could equally apply to EMDR consultation were the relationship is much more collaborative within which values the integrity and independence of the individual who is consulting them. Furthermore the EMDR PDAP could be used as part of research and development in promoting fidelity in EMDR as a psychotherapy approach.

Appendix 1



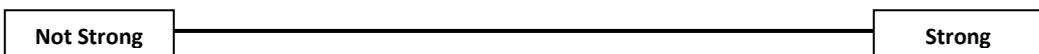
EMDR Personal Development Action Plan (Farrell, Keenan, Knibbs & Jones 2013)

Instructions: The purpose of this EMDR Personal Development Action Plan (EMDR PDAP) is purely to enable you to critically reflect upon your current knowledge, understanding and application of EMDR so as to then determine the areas you consider you may wish to develop further as an EMDR Clinician.

This EMDR PDAP has three aspects:

- **Section 1: EMDR Protocol & Practice**
- **Section 2: Possible areas of consideration for your own EMDR Personal Development**
- **Section 3: EMDR Personal Development Plan – Strategic Action**

For **Section 1** the use of the rating Scale is to purely indicate how strong, or not, you currently consider yourself as an EMDR Clinician in relation to the EMDR Protocol and EMDR Clinical Practice.



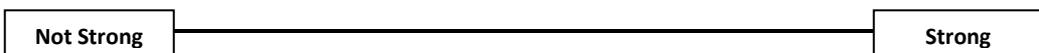
Section 2 lists a number of areas you may be interested in developing further. The intention of both sections 1 and 2 is hopefully to enable you to consider your own EMDR PDAP and to formulate this into an overall strategic action plan.

Material from **Section 3** will then form the basis of group discussion later.

Section 1: EMDR Protocol & Practice

Consider how you would rate your current position in relation to the following areas:

1. Understanding of the Adaptive Information Processing (AIP) Model



2. Neurobiological Mechanisms of Action in EMDR



3. Ability to integrate EMDR into your existing clinical practice



4. EMDR/ AIP History Taking and Treatment planning

Not Strong	_____	Strong
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5. Assessing client's suitability for EMDR

Not Strong	_____	Strong
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6. EMDR/AIP Case Conceptualisation

Not Strong	_____	Strong
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7. Identifying appropriate safety factors including the utilisation (where appropriate) of the Dissociative Experience Scale II (DES)

Not Strong	_____	Strong
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8. Undertaking a thorough risk assessment with each client

Not Strong	_____	Strong
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9. Considering client's life constraints, ego strength, and their availability of effective support structures

Not Strong	_____	Strong
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10. Clarifying the client's desired state following EMDR treatment

Not Strong	_____	Strong
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11. Determining that the client is able to effectively deal with high levels of physical and emotional levels of disturbance

Not Strong	_____	Strong
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12. In cases of multiple targets, effectively utilises either prioritising or clustering techniques

Not Strong	_____	Strong
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13. Identifying a 'Touchstone Memory' event that relates to the client's issue(s)

Not Strong	_____	Strong
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14. Preparing the client for EMDR

Not Strong	_____	Strong
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15. Carrying out the 'Safe/ Secure/ Calm Place' Exercise with clients

Not Strong	_____	Strong
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16. EMDR Resource Installation/ Resource Development Installation

Not Strong	_____	Strong
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17. Psycho-education of Trauma/ Psycho-traumatology

Not Strong	_____	Strong
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18. Psycho-education of disturbing memories

Not Strong	_____	Strong
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19. Ability to explain EMDR to various client groups of various ages, culture, and emotional intellect

Not Strong	_____	Strong
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20. Identifying appropriate targets for selection for processing

Not Strong	_____	Strong
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21. Considering the three prong 'Past, Present & Future' in relation to targets

Not Strong	_____	Strong
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22. Identifying an appropriate stationary image as an appropriate target

Not Strong	_____	Strong
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23. Identifying appropriate Negative Cognitions

Not Strong	_____	Strong
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24. Identifying appropriate Positive Cognitions

Not Strong	_____	Strong
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25. Ensuring that Cognitions are in the same domain

Not Strong	_____	Strong
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26. Rating the Validity of Cognition (VOC) correctly

Not Strong	_____	Strong
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27. Ascertaining Subjective Levels of Distress/ Disturbance (SUD's) correctly

Not Strong	_____	Strong
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28. Location of body sensations

Not Strong	_____	Strong
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29. Beginning Desensitisation by requesting the client to just notice the image, Negative Cognition, emotion and physical reaction

Not Strong	_____	Strong
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30. Performing Bilateral Stimulation (BLS)/ Dual Attention Stimulus (DAS) at a good tempo

Not Strong	_____	Strong
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31. Applying the duration of the BLS for approximately 25-35 seconds

Not Strong	_____	Strong
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32. Offering reassurance during a set

Not Strong	_____	Strong
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33. Able to effectively manage abreactions

Not Strong	_____	Strong
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34. Consider the importance of therapeutic attunement and dyadic regulation

Not Strong	_____	Strong
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35. Obtaining short feedback from clients after each set of BLS

Not Strong	_____	Strong
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36. Returning to target and the end of a channel

Not Strong	_____	Strong
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37. Managing blocks that occur during processing

Not Strong	_____	Strong
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38. Float-Back & Float-Forward techniques

Not Strong	_____	Strong
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39. Knowing when to accelerate during processing

Not Strong	_____	Strong
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40. Knowing when to decelerate during processing

Not Strong	_____	Strong
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41. Recognising, managing and integrating Therapeutic Interweaves in EMDR

Process	Not Strong	Strong
Cognitive	Not Strong	Strong
Relational	Not Strong	Strong

42. Working with Primary Dissociation

Not Strong	Strong
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43. Working with Secondary Dissociation

Not Strong	Strong
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44. Working with Tertiary Dissociation

Not Strong	Strong
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45. Managing incomplete sessions in EMDR

Not Strong	Strong
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46. Knowing when to proceed to Phase 5 - Installation

Not Strong	Strong
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47. Checking out the Positive Cognition for 'best fit' at the start of Phase 5 - Installation

Not Strong	Strong
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48. Installation of the Positive Cognition using BLS

Not Strong	Strong
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49. Maintaining momentum of BLS/DAS in Installation phase

Not Strong	Strong
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50. Know when to proceed to Phase 6 - Body Scan

Not Strong	Strong
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51. Carrying out the body scan in an appropriate manner

Not Strong	Strong
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52. Allowing sufficient time for closure (Phase 7)

Not Strong	Strong
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53. Carrying out an effective debrief as part of Phase 7

Not Strong	Strong
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54. Utilisation of containment exercises as grounding techniques

Not Strong		Strong
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55. Encouraging clients to maintain a log between sessions

Not Strong		Strong
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56. At the next session carrying out Phase 8 - Re-evaluation

Not Strong		Strong
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57. Addressing issues that may arise since last session

Not Strong		Strong
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58. If necessary returning to previous target (following incomplete session)

Not Strong		Strong
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59. Ensuring all past, present and future targets have been addressed

Not Strong		Strong
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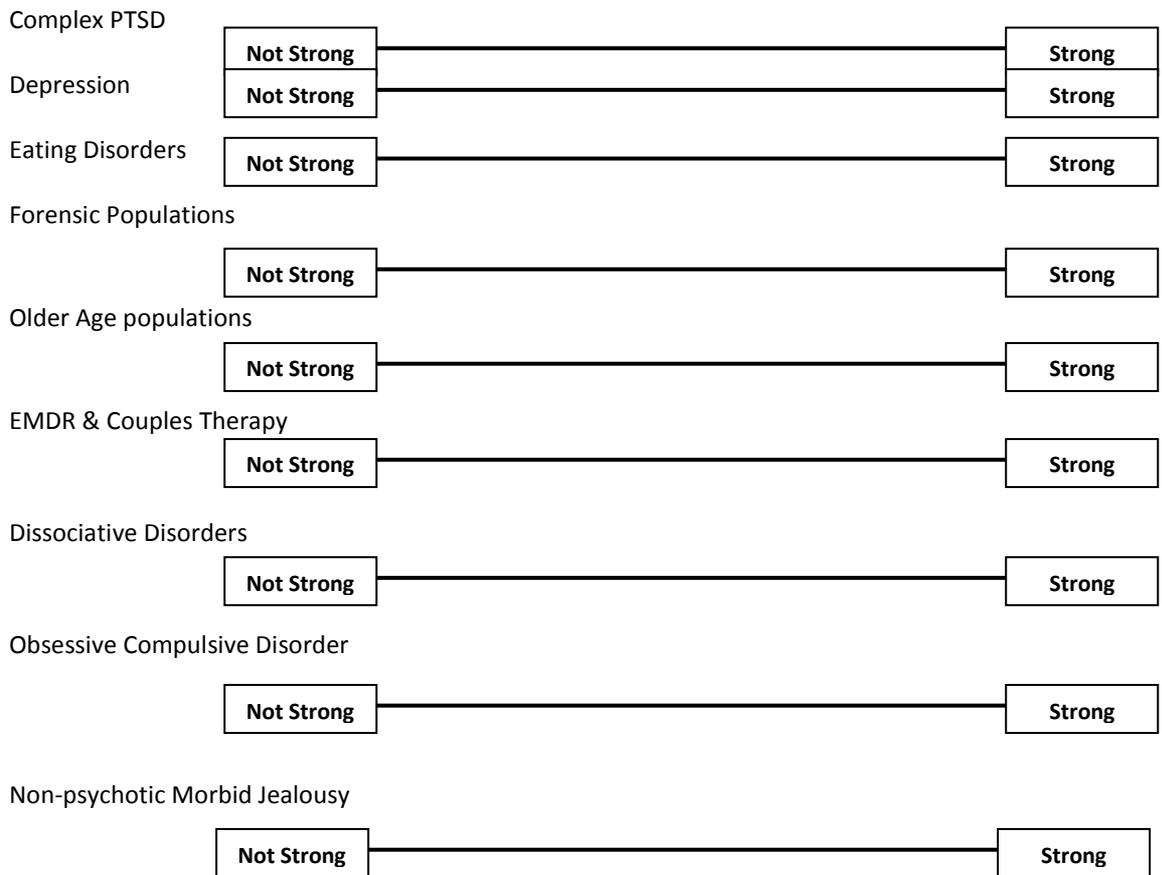
60. Addressing the Future Template

Not Strong		Strong
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61. EMDR Scripted Protocols

Phobia	Not Strong		Strong
Panic Disorder	Not Strong		Strong
Depression	Not Strong		Strong
Pain	Not Strong		Strong
Grief, Loss & Bereavement	Not Strong		Strong
Children & Adolescents	Not Strong		Strong
Addictions	Not Strong		Strong
Performance Enhancement	Not Strong		Strong

62. Specialist EMDR Populations



Section 2: Possible areas of consideration for your EMDR PDAP (Please Tick)

Main Themes	Yes	No	Maybe
More EMDR Clinical Experience in general			
More specific EMDR Clinical Experience			
EMDR & Dissociation			
EMDR & Ego States			
Medico-Legal aspects of EMDR			
EMDR Research & Development			
Teaching and Learning of EMDR			
EMDR Europe Accreditation Practitioner			
EMDR Europe Accreditation Consultant			
EMDR Europe Accreditation Trainer			
EMDR Europe Accreditation Child & Adolescent Trainer			
Involvement in EMDR Humanitarian Assistance Programmes			
EMDR Continuous Professional Development			
Related Areas of Continuous Professional Development			

EMDR Academic Writing & Publication			
Wider reading of EMDR Literature			
Presenting at EMDR Conferences			
Participating in EMDR Regional Groups			
Gaining more experience as a Supervisee in Clinical Supervision			
Gaining more experience as a Supervisor in Clinical Supervision			

Section 3: EMDR Personal Development Action Plan – Strategy Review

In relation to the above areas consider what action is needed to best develop your EMDR PDAP plan? Try and consider your individual plan period in the short, medium and long term.

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