EMDR Consultants Resources Book

(2nd Edition)

Trauma Aid UK

2021

www.traumaaiduk.org

INTRODUCTION

Welcome to this Second Edition of the EMDR Clinical Supervision & Consultation Resource Pack, now renamed as the EMDR Consultants Resources Book.

Firstly, it is important to acknowledge and pay tribute to Liz Doggart who instigated and edited the first edition of this publication in 2014.

Much has happened in the EMDR world in the intervening seven years. Some of the papers and documents in the first edition have since been revised and plenty of new and useful material has been produced in the interim period. It was therefore decided by Trauma Aid UK (TAUK) that the time was ripe for a new revised edition of this publication.

As before, this publication has two purposes, firstly to provide a resource for EMDR Consultants and Consultants-in-training and, secondly to raise funds for TAUK.

This publication incorporates the work of many colleagues to whom we are extremely grateful for allowing us to include their work. These include:
- Derek Farrell
- Paul Keenan
- Lorraine Knibbs
- Tim Jones
- Ines Santos
- Jessica Woolliscroft
- Marian Tobin
- Sian Morgan
- Jo Scott
- Carolyn Stone

Changes to the second edition

Some of the content of the first edition is included in this edition although some papers are revised versions. I have removed sections of the first edition which were not specifically relevant to supervision. But, for those who already possess the first edition, this second edition includes a wealth of new information. In particular, there is a paper by Ines Santos on case formulation, Jessica Woolliscroft's presentation from the 2020 Consultant's Day about completing supervisees' accreditation forms and a paper by myself on applying supervision theory to the process of EMDR supervision. There are also new checklists from Marian Tobin and Sian Morgan and a sample supervision contract by Jo Scott. Also included is the introduction to the recently published NHS Competency Framework for EMDR with the link to whole document.

We hope you find this useful and, for everyone who picks up this publication, there is a least one nugget of new information that can make a difference to your work as an EMDR Consultant.

All your comments and suggestions for additions to the next edition would be welcome. Please contact me at info@robinlogie.com

Robin Logie
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Treasurer of Trauma Aid UK
2021

Further copies can be obtained from Trauma Aid UK: www.traumaaiduk.org

CONTENTS

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, & Marstellar (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 toEMDR 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 guidesthe 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 EuropeAccredited Trainer
- Applicants are required to be members of their National EMDR Organisation Applicants
- seeking EMDR Europe Accreditation as a Practitioner must have aminimum of two years professional experience before they can becomeaccredited by EMDR Europe
- There should be a minimum period of time after completion of EMDR trainingbefore 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 thesecond from a person who can comment upon the applicants professionalpractice 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 asa psychotherapeutic approach
2. Enhancing and maintaining patient/client protection and adherence to clinicalgovernance procedures
3. Ensures the utilisation of empirically supported, effective psychological treatmentinterventions 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 utilisethe 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 bothmedicine 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 P*hronesis*'. '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 criticalaspects in an individual's level of development in EMDR in integrating theory and practice.
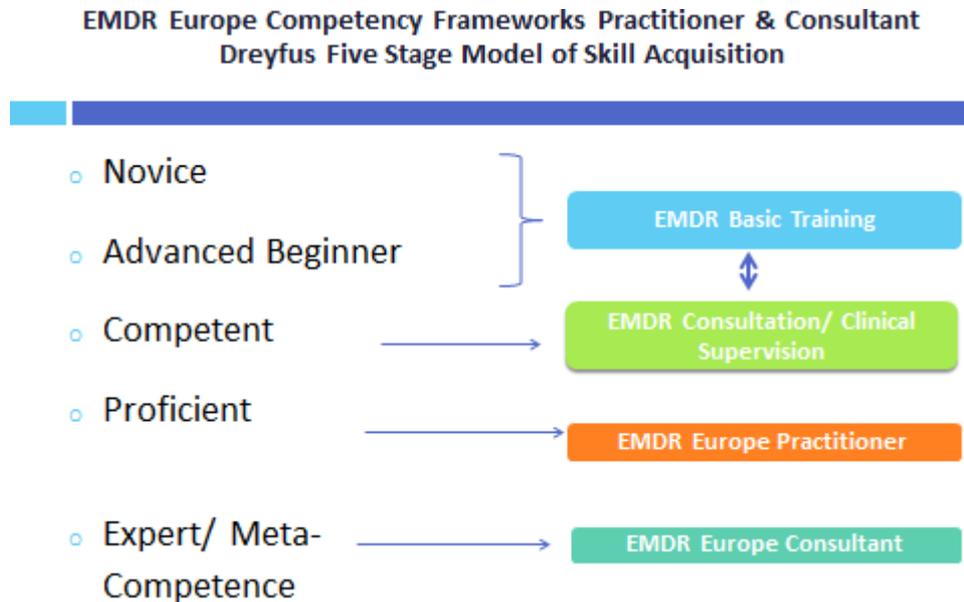

Figure 1: EMDR Europe Competency Frameworks

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 supportedpsychotherapeutic 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 healthand 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) whoconsider 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 etal 1994: pg4).

Wagner & Smith outline a slightly different emphasis incorporating the integration betweentheory 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 superviseemaintains 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 bestpossible 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.

- **Educative – (Formative)**
    - 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)**
    - Exploring the emotional reaction to pain, conflict and other feelings experienced during patient care, can reduce burn out.
- **Managerial – (Normative)**
    - 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 spacefor 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.
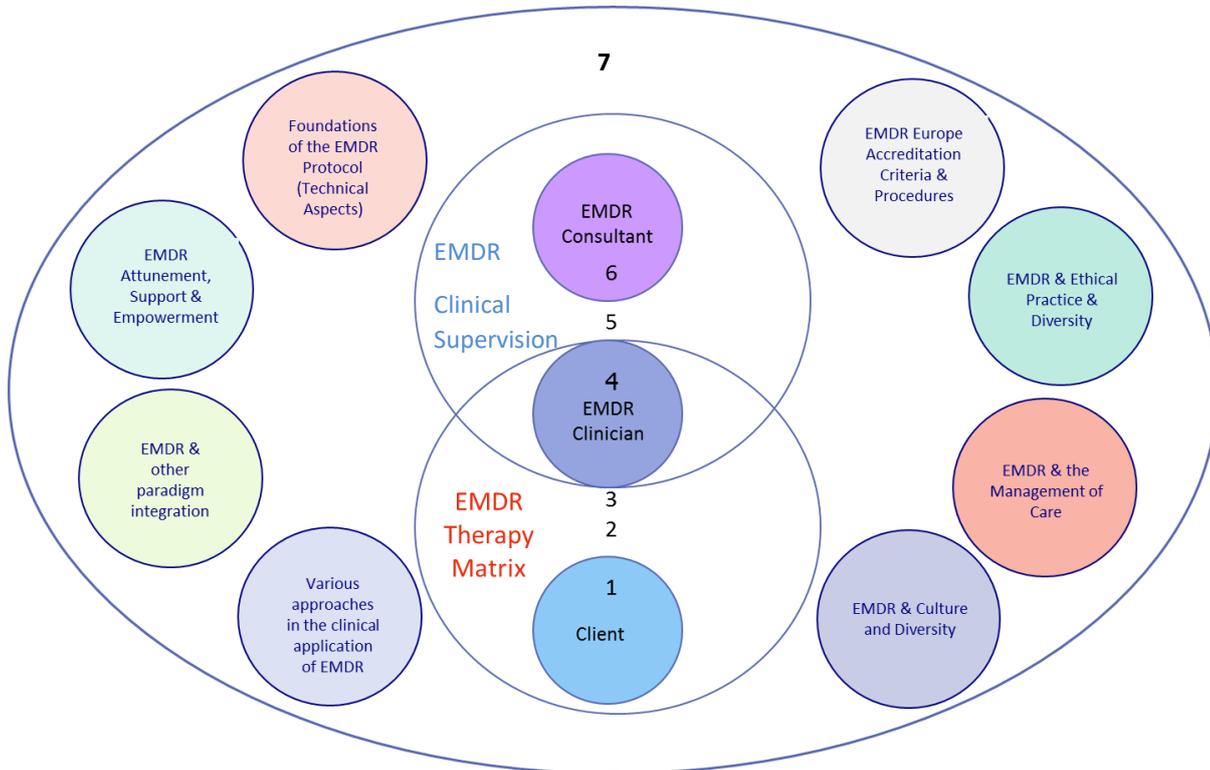
Figure 2: EMDR Clinical Supervision Process Model (Farrell, 2013; adapted from Hawkins & Shohet, 1989/ 2012)

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 elementsof 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 EuropeAccreditation 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 DevelopmentAction 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 wherethey 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 monitoringprogression 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.

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EMDR Therapy Personal Development Plan II

(Farrell, Knibbs, Mackinney & Miller, 2020)

The purpose of this EMDR Therapy Personal Development Plan II (EMDR Therapy PDP II) is to enable you to reflect upon your current knowledge, understanding, and clinical application of EMDR therapy. Secondly, in providing an insight into areas of your EMDR therapy practice that may require further development and skills enhancement. This tool can be used both as a structured means of subjective/ self-assessment, or in conjunction with your EMDR Therapy Clinical Supervisor/ Consultant as part of Clinical Supervision, or as part of an EMDR Europe Accredited Training Programme.

This EMDR Therapy PDP II is in five sections:

- o Section 1: The Adaptive Information Processing (AIP) Theoretical Framework, Neurobiology of Trauma & Psycho-traumatology

- o Section 2: EMDR therapy as an Eight Phase Treatment Approach

- o Section 3: Further Skills in EMDR therapy & Wider Applications

- o Section 4: EMDR therapy Clinical Supervision & Consultation Skills

- o Section 5: EMDR therapy Personal Development Plan – Strategic Action

For Sections 1 and 2 the following 6-point proficiency scale has been adopted to assess knowledge and competency

0 = None;   1 = Limited,   2 = Basic,   3 = Proficient,   4 = Advanced,   5 = Expert

Section 1: The Adaptive Information Processing Theoretical Framework, Neurobiology of Trauma and Psycho-traumatology

1.1 Understanding of the Adaptive Information Processing Paradigm as a Theoretical Model					
0	1	2	3	4	5

1.2 Adaptive Information Processing Case Conceptualisation					
0	1	2	3	4	5

1.3 Neurobiological Mechanisms of Psychological Trauma					
0	1	2	3	4	5

1.4 Neurobiological understanding of EMDR Therapy and potential mechanisms for action					
0	1	2	3	4	5

1.5 Understanding of Adverse Childhood Experiences (ACE's)					
0	1	2	3	4	5

1.6 Understanding of Attachment Theory					
0	1	2	3	4	5

1.7 Understanding of the Theory of Structural Dissociation					
0	1	2	3	4	5

1.8 Current empirical status of EMDR therapy, International Treatment Guideline and up-to-date knowledge of existing academic literature, research and development					
0	1	2	3	4	5

1.9 Knowledge and understanding of Post-Traumatic Stress Disorder (PTSD)					
0	1	2	3	4	5

1.10 Knowledge and understanding of Complex Post-Traumatic Stress Disorder (C-PTSD)					
0	1	2	3	4	5

Section 2: EMDR Therapy Eight-Phase Protocol

Phase 2.1: History Taking

2.1.1 Capacity to complete a comprehensive History Taking: Past, Present & Future					
0	1	2	3	4	5

2.1.2 Assessing client appropriateness for EMDR therapy					
0	1	2	3	4	5

2.1.3 Undertaking a thorough Risk Assessment, and assess the availability of support structures with each client					
0	1	2	3	4	5

2.1.4 EMDR therapy Treatment Planning and Target Memory Sequencing					
0	1	2	3	4	5

2.1.5 Ability to provide a rationale and cogent strategy when working with multiple distressing memories					
0	1	2	3	4	5

2.1.6 Able to clarify the client's desired state following EMDR therapy Treatment					
0	1	2	3	4	5

Phase 2: Preparation

2.2.1 Teaching clients self-regulation strategies					
0	1	2	3	4	5

2.2.2 Testing out the Bilateral Physical Stimulation					
0	1	2	3	4	5

2.2.3 Providing a 'client-centred' explanation of EMDR therapy					
0	1	2	3	4	5

2.2.4 Demonstrates an ability address client's fears, concerns, queries, anxieties or trepidations					
0	1	2	3	4	5

2.2.5 Ensuring the client is able to engage in effective 'Dual Attention' (Past & Present)					
0	1	2	3	4	5

Phase 3: Assessment

2.3.1 Identifying an appropriate distressing memory for EMDR Therapy trauma processing					
0	1	2	3	4	5

2.3.2 Understanding of the characteristics of cognitions, both negative and positive					
0	1	2	3	4	5

2.3.3 An appreciation in applying the Validity of Cognition (VOC) and the Subjective Unit of Disturbance (SUD) Scales					
0	1	2	3	4	5

2.3.4 Identifying associated, and presently held, emotions and body sensations in connected with the target memory

0	1	2	3	4	5

Phase 4: Desensitisation

2.4.1 Activation of the distressing memory and engaging in bi-lateral physical stimulation					
0	1	2	3	4	5

2.4.2 Timing each set to the client's needs (approximately 25-30 seconds)					
0	1	2	3	4	5

2.4.3 Understanding of what 'trauma processing' looks like					
0	1	2	3	4	5

2.4.4 Obtaining feedback from the client after each set					
0	1	2	3	4	5

2.4.5 Recognising when processing is blocked and able to intervene accordingly					
0	1	2	3	4	5

2.4.6 Knowledge of Cognitive Interweaves and when to apply them					
0	1	2	3	4	5

2.4.7 Familiarity in returning to the target memory at the end of a channel					
0	1	2	3	4	5

2.4.8 Able to recognise when clients experience heightened levels of affect and be able to manage these therapeutically					
0	1	2	3	4	5

2.4.9 Have a clinically effective understanding as to when Phase 4 might be completed					
0	1	2	3	4	5

2.4.10 Recognising when to use an 'incomplete session' closure and carry out accordingly					
0	1	2	3	4	5

Phase 5: Installation

2.5.1 Checking the appropriateness of the Positive Cognition in relation to the original target memory					
0	1	2	3	4	5

2.5.2 Installation of the positive cognition to a VOC level of either 6 or 7					
0	1	2	3	4	5

Phase 6: Body Scan

2.6.1 Enables the client to bring the original target memory to mind, holding the associated Positive Cognition, and then mentally scan the body for any undue disturbance or discomfort					
0	1	2	3	4	5

2.6.2 Addressing any residual disturbance that may arise during the Phase 6 Body Scan					
0	1	2	3	4	5

Phase 7: Closure

2.7.1 Allows sufficient time for closure and ensures that the client is 'grounded' and 'in the present'					
0	1	2	3	4	5

2.7.2 Utilise an effective debrief					
0	1	2	3	4	5

2.7.3 Encourages the client to engage in in-between session activity and monitoring					
0	1	2	3	4	5

Phase 8: Re-evaluation

2.8.1 Returning to the previous target memory activated in the last EMDR Therapy session					
0	1	2	3	4	5

2.8.2 Identifying any evidence of progress or re-adjustment since the last session					
0	1	2	3	4	5

2.8.3 Determine if any additional material has been activated since the last session					
0	1	2	3	4	5

2.8.4 Ensures that all necessary target memories have been processed – past, present, and future					
0	1	2	3	4	5

2.8.5 Is effectively able to conclude therapy					
0	1	2	3	4	5

Section 3: Further Skills in EMDR Therapy & Wider Applications

Part 1: Knowledge AND clinical application of the following:

3.1.1 EMD Restricted Processing (EMDr)					
0	1	2	3	4	5

3.1.2 Eye Movement Desensitisation (EMD)					
0	1	2	3	4	5

3.1.3 Future Template					
0	1	2	3	4	5

3.1.4 Future Anticipatory Anxiety					
0	1	2	3	4	5

3.1.5 Flash-Forward (FF)					
0	1	2	3	4	5

3.1.6 Blind -2-Therapist (B2T)					
0	1	2	3	4	5

3.1.7 Recent Traumatic Experience Protocol (RTEP)					
0	1	2	3	4	5

3.1.8 Group Traumatic Events Protocol (GTEP)					
0	1	2	3	4	5

3.1.9 Integrative Group Treatment (IGTP)					
0	1	2	3	4	5

3.1.10 Feeling State Addictions Protocol (FSAP)					
0	1	2	3	4	5

3.1.11 Urge Reduction Protocol (DeTUR)					
0	1	2	3	4	5

Part 2: Clinical Populations

3.2.1 Phobias and Aversions					
0	1	2	3	4	5

3.2.2 Major Depressive Disorders (MDD)					
0	1	2	3	4	5

3.2.3 Traumatic Grief, Bereavement and Loss					
0	1	2	3	4	5

3.2.4 Children and Adolescents					
0	1	2	3	4	5

3.2.5 Addictions					
0	1	2	3	4	5

3.2.5 Pain					
0	1	2	3	4	5

3.2.6 Perinatal PTSD					
0	1	2	3	4	5

3.2.7 Eating Disorders					
0	1	2	3	4	5

3.2.8 Schizophrenias and Psychosis

0	1	2	3	4	5

3.2.9 Obsessive Compulsive Disorder (OCD)					
0	1	2	3	4	5

3.2.10 Performance Enhancement					
0	1	2	3	4	5

3.2.11 Bodily and Medically-Based Conditions					
0	1	2	3	4	5

3.2.12 EMDR Therapy and the Older Person					
0	1	2	3	4	5

3.2.13 EMDR Therapy with Forensic Populations					
0	1	2	3	4	5

3.2.14 EMDR Therapy with Couples					
0	1	2	3	4	5

3.2.15 Application of EMDR Therapy as part of Trauma Capacity Building/ Humanitarian Activity					
0	1	2	3	4	5

Section 4: EMDR Therapy Clinical Supervision & Consultation Skills (EMDR Europe Consultants in Training or existing EMDR Europe Consultants Only)

This next section considers some of the factors involved within your existing clinical supervision style and skill set

4.1 Empathy					
0	1	2	3	4	5

4.2 Non-judgmental					
0	1	2	3	4	5

4.3 Validation					
0	1	2	3	4	5

4.4 Affirmation					

0	1	2	3	4	5

4.5 An ability to manage the supervision/ supervisee

0	1	2	3	4	5

4.6 Exploratory

0	1	2	3	4	5

4.7 Experimental

0	1	2	3	4	5

4.8 Assertiveness

0	1	2	3	4	5

4.9 Authenticity

0	1	2	3	4	5

4.10 Flexibility

0	1	2	3	4	5

4.11 Involvement

0	1	2	3	4	5

4.12 Mutuality

0	1	2	3	4	5

4.13 Empowerment

0	1	2	3	4	5

4.14 Support

0	1	2	3	4	5

4.16 Managerial

0	1	2	3	4	5

4.17 Governance & Ethics

0	1	2	3	4	5

4.18 Ability to maintain professional boundaries					
0	1	2	3	4	5

4.19 Provide structure during the clinical supervision sessions					
0	1	2	3	4	5

4.20 Maintain focus during the clinical supervision sessions					
0	1	2	3	4	5

4.21 Providing constructive feedback to supervisee's					
0	1	2	3	4	5

4.22 Receiving constructive feedback from supervisees					
0	1	2	3	4	5

4.23 Various theoretical models. Frameworks for clinical supervision					
0	1	2	3	4	5

4.24 A willingness to share own clinical experience/ expertise					
0	1	2	3	4	5

4.25 Knowledge and familiarity of the EMDR Europe Competency-Based Frameworks for Practitioner and Consultants					
0	1	2	3	4	5

Section 5: EMDR Therapy Personal Development Plan – Strategic Action

In relation to the above areas consider what action is needed to best develop your EMDR Therapy PDP plan both as an EMDR Therapy clinician and an EMDR Therapy Clinical Supervisor/Consultant?

Try and consider the following questions:

1. What do you need in order to achieve your EMDR Therapy PDP in the short, medium and long term both as an EMDR Therapy Clinician and an EMDR Therapy Clinical Supervisor/ Consultant?

2. What blocks or obstacles do you envisage you may encounter along the way?

3. Consider what strategies might be necessary to try and overcome these?

4. Is there a mentor (s) you could approach for guidance & support? And if so who might

this person be?

5. How will you know when you have met the targets within your EMDR PDP?

Possible areas to consider:

- More EMDR therapy Clinical Experience in general
- More Specific EMDR therapy clinical experience
- EMDR therapy Micro skills
- EMDR therapy Clinical Supervision & Consultation Skills
- Integrating EMDR therapy into your existing clinical practice
- EMDR therapy Research & Development
- EMDR Europe Accreditation
- EMDR Continuous Professional Development
- EMDR therapy Academic Writing & Publication
- Wider reading of EMDR therapy Literature
- Presenting at EMDR Conferences (Regional/ National/ International)

Please use the section below for matters to discuss with your EMDR Europe Consultant/ ClinicalSupervisor or EMDR Europe Accredited Trainer in connection with this EMDR therapy PDP II:
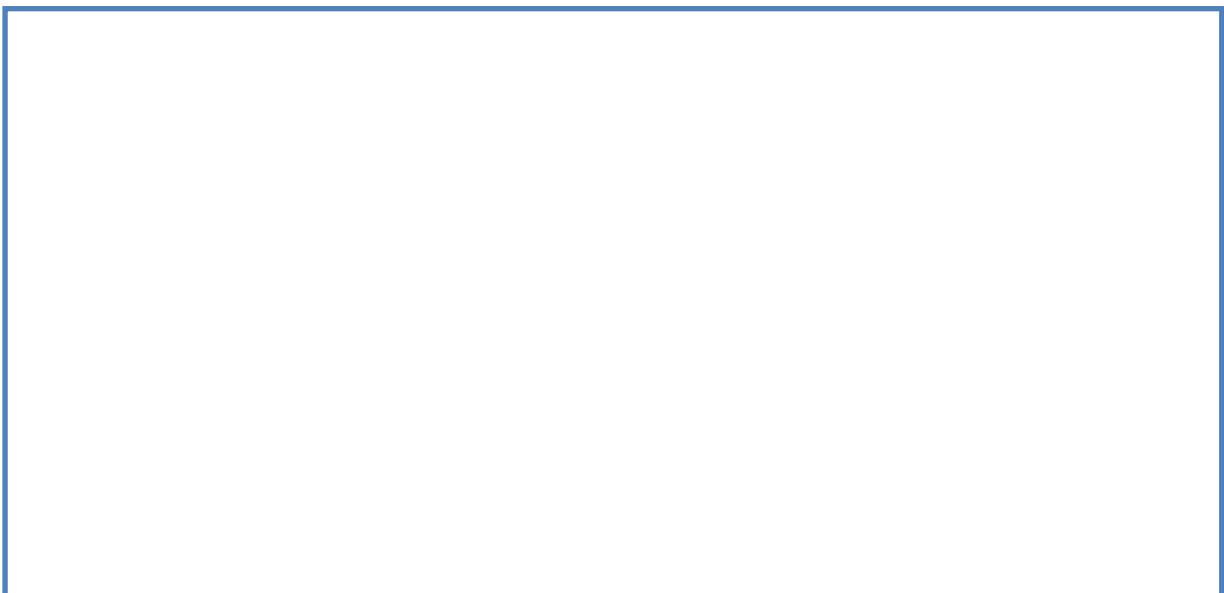
Using supervision theory to enhance effective EMDR supervision

Robin Logie, 2021

This section has been specially written for this Consultants' Workbook but will also form part of a book which I am writing in relation to EMDR supervision.

To make it easier to read I am using the term 'therapist' throughout this article to describe the supervisee. This is because the words 'supervisor' and 'supervisee' appear very similar and are hard to differentiate on the page.

Much of the theoretical content of this section is also summarised in the first paper in this Consultants' Workbook (Farrell, Keenan, Knibbs, & Jones, 2013) but, here, I am attempting to flesh this out and indicate how it can be applied, in a practical sense, to the process of EMDR supervision.

After reviewing the literature in relation to theories regarding clinical supervision, it appears to me that there are three main theoretical models of supervision which are particularly relevant and useful in understanding EMDR supervision. I describe these three models in terms of 'functions', 'modes' and 'levels':
- The three **functions** of supervision (usually known as 'formative', 'restorative' and 'normative')
- The seven **modes** of supervision (the 'seven-eyed' model)
- The four **levels** of supervision ('Developmental' models)

I will explain each of these in turn and explain how they are relevant to EMDR supervision.

Functions of supervision ('formative', 'restorative' and 'normative')

The terms 'formative', 'restorative' and 'normative', were first described by Proctor (1988). However, prior to that, Kadushin (1976) used the words 'educative', supportive' and 'managerial' for the same three functions and other authors such as Hawkins and Smith (2013) have used different terms for the these functions. 'Formative', 'restorative' and 'normative' are most often used to describe these three functions amongst therapists, but not necessarily because they are the best words to describe them. I believe that they have stuck, perhaps, merely because they rhyme with each other! I would suggest alternative terms which I believe might be more appropriate in relation to EMDR supervision, namely 'teaching', 'enabling' and 'evaluating'. To summarize this in a table:

Kadushin (1976)	Proctor (1988)	Hawkins and Smith (2013)	Logie (2021)
Educative	Formative	Developmental	Teaching
Supportive	Restorative	Resourcing	Enabling
Managerial	Normative	Qualitative	Evaluating

The formative function (teaching)
For much of the time, what is occurring during a supervision session is teaching. The supervisor may be teaching the therapist about the EMDR Standard Protocol or other EMDR protocols and how they may be relevant to the client under discussion. The supervisor may be helping the therapist to understand how their prior training in other modalities can be relevant to EMDR or how they need to case conceptualise. The supervisor may start by asking the therapist questions about the particular client and the therapist will be presenting information about the client and what work s/he has been doing with the client. The object of this will be for the supervisor to ascertain where the therapist may be going wrong or what gaps there may be in their knowledge, in order to assist the therapist to work more effectively

with the client. During this time, the therapist will be learning something new about EMDR or about how to work more effectively as a therapist.

*The restorative function (enabling)*
Most supervisors will have had therapists who have a clear formulation in relation to their client and clearly understand the protocol and how it should be applied. But they are just not going ahead with EMDR or are doubting their own ability or their client's readiness, for example, to commence processing. In such instances, what is required is not teaching, but enabling. Here, it is the job of the supervisor to address the therapist's concerns and fears in relation to the work they are doing. We may not be teaching, so much as boosting our therapist's confidence. "That's great! Yeah, just crack on!" Sometimes, when the therapist seems really stuck, I ask the Flashforward question: "what's the worst thing that could happen if you started processing now?" But sometimes the restorative/enabling function is more in relation to 'sharing the awfulness', for example, when the therapist says, "I'm not stuck with this client, but I have just had a really upsetting session with them and I feel that I need to share it."

The normative function (evaluating)
As an EMDR supervisor, our role is also to evaluate our therapist's practice, particularly in relation to the process of accreditation. In this situation, we are neither teaching nor enabling, but are evaluating. There may be times during supervision when this is occurring in quite a formal way such as when we are viewing the therapist's videos. But it is also likely to happen throughout the supervision process as we are gauging how well the therapist is managing case conceptualisation or how well they appear to understand the Standard Protocol.

Modes of supervision ('seven-eyed' model) (Hawkins & Shohet, 2012)

The easiest way to describe this model is in diagrammatic form as follows:
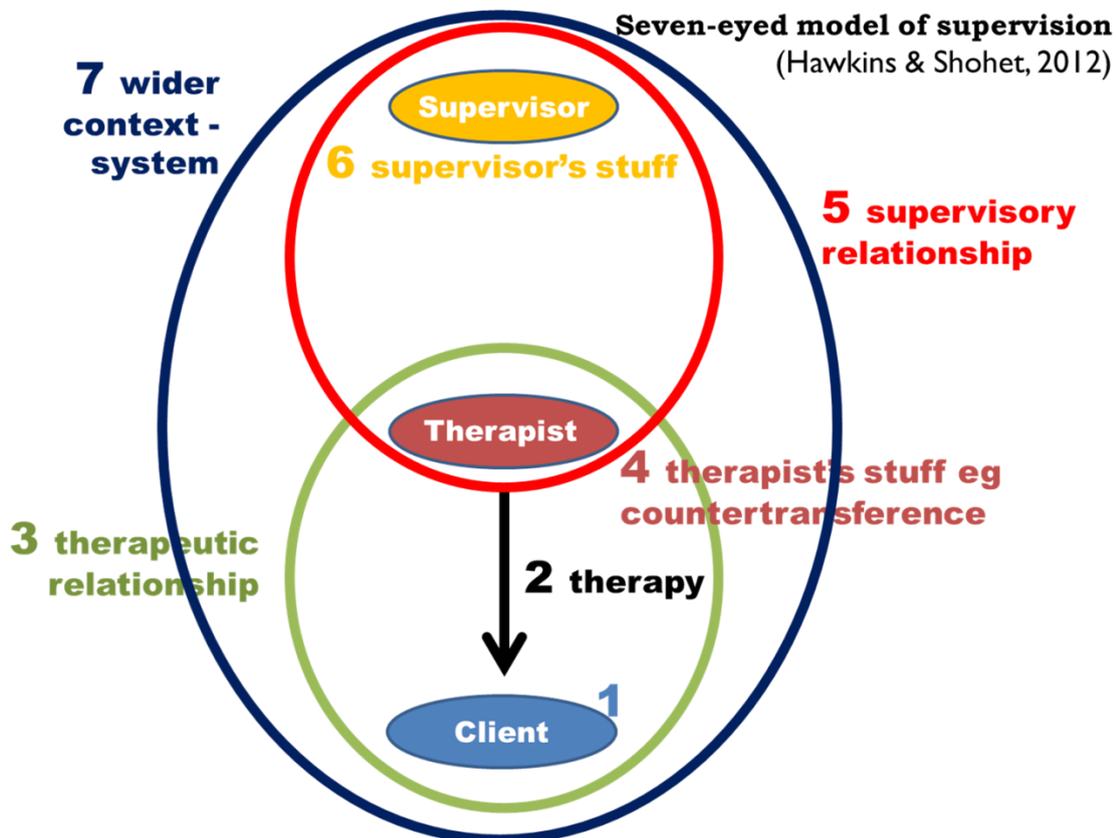
According to the 'seven-eyed' model of supervision, Hawkins and Shohet (2012) see the supervision process through the lens of seven different 'eyes', based upon the three people to whom supervision relates:

- Supervisor
- Therapist (supervisee)
- Client

I will describe each of the seven 'eyes' and how this may be relevant, in particular, to EMDR supervision:

Eye One: The client.
Often, what is occurring during a supervision session in that the therapist is describing the client, for example, the client's presenting problems, history, resources or demeanour during the session. At this time, we are in Eye One.

Eye Two: The therapy.
Here, the therapist is describing to their supervisor or discussing with their supervisor what therapy they are providing, or they are contemplating what intervention they might take. The focus is on 'what to do'.

Eye Three: The therapeutic relationship
With this eye, the focus is not on the client or the therapy, but on the relationship between client and therapist. At times, there may be problems in the therapy, not because the therapist does not understand the client (Eye One) and not because they do not know an effective way of helping them (Eye Two) but because the therapeutic relationship is not conducive to therapeutic change. This may be due to lack of trust. It may be due to transference. The client may not want to 'get better' because they might risk losing the relationship they have with their therapist.

Eye Four: The therapist's 'stuff'
It may be that there are problems in the therapy progressing because the therapist's own issues or unprocessed adverse life events are getting in the way. For example, the client reminds the therapist of their own mother or their client's experience of bereavement awakens unprocessed grief in the therapist. At times, the supervision may need to address the therapist's difficulties that are triggered by what is happening in the therapy session. In EMDR therapy, we talk about the 'blocking beliefs' held by the client which may impede processing in a therapy session. Similarly, the therapist may hold a blocking belief of their own which may prevent them from responding or acting in a way that is therapeutic to their client.

Eye Five: The supervisory relationship
This is about how the supervisor and therapist relate to each other. There may exist tension between the supervisor and therapist which bears no relation to the client in question. For example, the supervisee may be eager to be approved for accreditation by the supervisor and therefore fail to disclose their own doubts and mistakes in order to create a good impression. However, the particular client under discussion might also affect what is happening in supervision. A parallel process (McNeill & Worthen, 1989) may be occurring in which the supervisory relationship is manifesting similar relationship dynamics to those in the therapeutic relationship. For example, a particular client may be very dependent on the therapist which may be reflected in the therapist appearing to be dependent on the supervisor when discussing this particular client. Or a client whose NC is "I'm not good enough" may manifest in parallel process as the therapist feeling 'I'm not a good enough therapist'.

Eye Six: The supervisor's 'stuff'
It may be that the supervisor's own unprocessed past experiences are getting in the way of them being able to effectively assist the therapist. This may be in the form of countertransference where the therapist reminds the supervisor of someone from the past with whom they had a difficult relationship which was never resolved.

Eye Seven: The system
Therapy always occurs in a context. For example, who is funding the therapy and what influence do they have about how it proceeds? If the therapy is on the NHS, is there a limit to the number of sessions or a limit on what events can be targeted during processing? If it is funded by a compensation claim, must the processing only be in relation to the accident in question? And if a relative is paying for the therapy, what is their attitude to the therapy and how it should be conducted? In this situation the supervision is not relating to three people (client, therapist and supervisor) but to four or more.

Levels of supervision ('Developmental' models)

A number of theories of supervision can be grouped into what are described as 'developmental' models. These describe the level the trainee is at in terms of their development as a therapist and how this is relevant to how they are supervised.

The Integrated Developmental Model (IDM) of Stoltenberg and colleagues (Stoltenberg & McNeill, 2011; Stoltenberg, McNeill, & Delworth, 1988) is the best known and most widely used developmental model of supervision.

Stoltenberg describe four stages (levels) of supervisee development within three overriding structures: The first of these structures is 'self and other awareness', reflecting the level of the therapists' self-pre-occupation, self-awareness and awareness of the client's world. Secondly 'motivation' describes the therapist's interest, investment and effort expended in clinical training and practice. The third structure is 'autonomy' which describes the extent to which the therapist becomes independent. The four levels are as follows:

Level 1. Dependency stage
The supervisee experiences anxiety and insecurity whilst being highly motivated in the work. Awareness is self-focussed and performance anxiety is likely to be dominant. The therapist may be preoccupied by surviving the session with the client. Because they are preoccupied by the rules, skills, theories and didactic material being learned, the therapist may find it hard to tune in to the process information provided by the client in the session. At this stage the supervisor's job may be to provide safety and containment. Dependency and insecurity can manifest itself in different ways in the supervisory relationship. Some supervisees may cope with this situation by presenting as helpless which forces the supervisor into the role of rescuer. Other may conversely present themselves as super-confident, saying that they understand everything, making it equally hard for the supervisor to assist them in supervision.

Level 2. Dependency-autonomy
At this stage the supervisee fluctuates between feeling over-confident and feeling overwhelmed. (On some days I think I am still stuck at this stage myself!) The focus will move away from the supervisee themselves to the client. Therapists at this stage are still unlikely to be aware of counter-transference issues that arise during therapy. At this stage the supervisor needs to continue providing a 'secure base.'

Level 3. Conditional dependency
Therapists are developing increased self-confidence, greater insight and more consistency in their therapy sessions. They are more able to focus on the process. Supervision should be undertaken in a framework of enquiry in order to facilitate the development of self-supervision and reflective practice.

Level 4. Master professional
The therapist has personal autonomy, insightful awareness and is able to confront personal and professional issues themselves. The supervisory process becomes increasingly collegial and the structure and process of the supervision session is more often determined by the therapist. Often the therapist will now be supervising others and supervision may involve discussion of issues with supervisees rather than clie

It should be accepted that these stages refer to a therapist's general development, not just in relation to a particular therapeutic modality such as EMDR. So, some of the issues, especially in relation to the earlier levels, may not apply to very experienced and accomplished therapists who are new to EMDR. But even for such therapists, thinking about their level of development as an EMDR therapist can be useful when providing supervision.

In any event, the level that the therapist is at may be particularly relevant to EMDR supervision. This is because the form that the supervision will take will depend to a large extent on what level of EMDR training and development the supervisee is at. At one end of the spectrum the therapist has just completed their Part 1 training. At the other end of the spectrum the therapist is an experienced EMDR Consultant or Trainer.

So how do these correspond to the stages of development of an EMDR therapist? In their paper, Farrell et al (2013) describe a different developmental model (Dreyfus, 2004) and how it corresponds with the development of an EMDR therapist. I will do the same in relation to Stoltenberg's four stages in the IDM model:

Level 1. Dependency stage for EMDR therapists
This will apply to the stage at which therapists are still in the process of receiving their basic 7/8 day training in EMDR. Supervision is provided as part of the training and should also be provided on a regular basis after Part 1 of the training. Prior to completing the training, therapists have not yet even been taught the full EMDR protocol and, even after training has been completed, their grasp of the Standard Protocol may be tenuous. So much of what the supervisor will be doing is providing reassurance and often quite basic didactic teaching in relation to the Standard Protocol.

Level 2. Dependency-autonomy for EMDR therapists
This level will be reached at some point after the basic EMDR training has been completed and will occur during the early stages prior to the therapist being ready to apply for Practitioner accreditation. The therapist will still be learning the Standard Protocol but will be able to work more autonomously and reflect to a greater extent on their work.

Level 3. Conditional dependency for EMDR therapists
This stage will be reached after the therapist has been accredited as a Practitioner and is working toward becoming an accredited Consultant. They should now have the Standard Protocol firmly in their grasp and be only consulting their supervisor about particularly complex clients and learning some advanced protocols.

Level 4. Master professional for EMDR therapists
This stage would be reached after the therapist becomes an accredited Consultant. The therapist will still be bring clients to supervision with whom they are having particular problems. But at this stage, 'supervision of supervision' will occur as the therapist discusses difficulties that they are having with particular supervisees.

The 'Supervision Question'

We all learned, at our Consultant's Training, the importance of asking the 'Supervision Question'. I have been surprised, on reading the literature regarding clinical supervision, that the "Supervision Question" is very rarely referred to. It appears that the concept was, perhaps, first referred to by Christine Padesky, a well know cognitive therapist (Padesky, 2014). She quotes George Bernard Shaw who once famously wrote: "Sorry for the letter, I didn't have time to write a postcard," the point being that if the therapist can take time to prepare for supervision by framing a succinct Supervision Question, it can help them to clarify what they hope to achieve in the session with their supervisor.

Often, the therapist finds it hard to formulate the Supervision Question and just wants to get on with telling their supervisor lots of information about their client and how much they are struggling with them. As an EMDR therapist we can liken this to the frustration our clients sometimes experience when we ask them for their Negative Cognition (NC) ("you want me to tell you what I believe about myself <u>now</u> about what happened <u>then</u>? Derr!") But we know as therapists how important this question is and how transforming and therapeutic it can be to just formulate the NC even before processing has commenced. Similarly, with the Supervision Question, it can be hard work for the therapist, but formulating this question in itself can be transformative and put the therapist already on the road to understanding where they may be going wrong even before they have said any more about their client. An example comes from my own experience in supervision when I said to my supervisor that my Supervision Question was, "How can I overcome my client's resistance?" As soon as I had uttered these words I knew where I was going wrong and did not require any further help with this particular client.

How frustrating can politicians be, when they are being interviewed and they say, in order to avoid the line of enquiry, "that's not the question you should be asking". However, as supervisors, I believe that is sometimes the most helpful thing we can say in response to the Supervision Question once we have an idea of the relevant issues are in relation to a particular client. One of the reasons why the therapist might be stuck with a particular client is because they are asking the <u>wrong</u> Supervision Question. This is where awareness of the functions, modes and levels described above can be helpful. For example, the Supervision Question might be, "have I chosen the right target for my client?" a question that lies in the mode of *Eye Two: the therapy*. However, after receiving further information from the therapist, the supervisor may realise that they have not really taken a thorough history, do not have a coherent formulation and have rushed into doing the processing. The real question needs to be in *Eye One: the client*. Until we really understand what is happening in terms of formulation, we cannot decide on an appropriate target for processing and, indeed such a target is likely to be obvious once we have a clear formulation.

Integrating the three theoretical models: functions, modes and levels

The process of clinical supervision is a very complex one and I can imagine some readers exclaiming, "I have enough to think about during supervision without also trying to work out which function, mode or level we are in!" Once again let us look at how this corresponds to what occurs in therapy. During a session of therapy, the therapist cannot possibly be fully aware of all that is going on, holding in mind the content of what their client is saying, their formulation, plans as to what to do next, their own feelings about the client, the therapeutic relationship and so on. Often it is not until we reflect on what has happened after the session, alone or with a colleague or supervisor, that we realise what has been happening. Similarly, in supervision, there is so much going on that one cannot possibly be aware of everything that is relevant. However, understanding and knowing the theories behind supervision will enable the supervisor to work more effectively and also to sometimes instinctively respond in a way

which the supervisor may only fully understand until after the session or during their own supervision of supervision.

What follows are a couple of examples of how an understanding of the functions, modes and levels of supervision can be helpful to the supervisor.

The novice EMDR therapist
Let us start with a supervisee who has just completed their basic 7-day training. Their Supervision Question is as follows: "Is my client ready to start EMDR processing?"

Obviously, the supervisor will need to know more about the client, the formulation and what has been done in terms of preparation. But immediately we hear this question there are some things to think about: The therapist is clearly at *Level 1 (Dependency stage for EMDR therapists)* in terms of their development as an EMDR therapist although they may be very experienced in other modes of therapy. The question relates to what they should do with their client so, in terms of the mode, we are working within *Eye Two (The therapy).* And finally, which function are we in? At face value it looks like the *formative/teaching* function because the therapist is asking a question about what they should do. However, the subtext may be that it is really around the therapist's trepidation about starting EMDR processing, in which case this is really about the *restorative/enabling* function. And it may be that we have never supervised this therapist before so there are still issues of trust and, in fact, the more relevant mode may be *Eye Five (The supervisory relationship).*

As a supervisor in this situation, I may tell the therapist a story about when I started out as an EMDR therapist, how scary it was when I began the Desensitization phase with my first client, but how well it actually went and how delighted I was with the result. I would then advise the therapist that they had a good formulation, their client is adequately prepared and would exclaim, "crack on!". So, I would be presenting myself as a coping model in order to address the therapist's fears before giving them the encouragement to start processing.

The aspiring EMDR Consultant
The second example is a therapist who trained in EMDR seven years ago and has been an accredited Practitioner for four years. They do not wish to discuss a particular client but, instead, to ask you why you have not yet agreed to recommend them for accreditation as an EMDR Consultant.

The therapist presents as having a high opinion of themself and their therapeutic skills. When they do bring a client to supervision, it is usually in order to demonstrate how skilled they are as a therapist rather than to ask for help with a particular point of stuckness. They have attended the Consultant's Training and the report from this training outlined a number of issues that they needed to work on, particularly an inadequate grasp of the Standard Protocol and a tendency, in supervision, to patronise the supervisee and give advice which does not bear any relation to the Supervision Question. The therapist denies that these are issues that need to be addressed and says that the tutor on the Consultants Training "had it in for me."

In terms of their level of development one would expect this therapist to be at *Level 3 (Conditional dependency)* but they may, in fact, still be at the previous stage of *Level 2 (Dependency-autonomy).* At this level, the supervisee fluctuates between feeling over-confident and feeling overwhelmed. In this particular example, it appears that the therapist has developed narcissistic overconfidence as a coping strategy to deal with occasions when, in fact, they feel overwhelmed. In terms of the function, we are clearly looking at the *normative/evaluating* realm as the issue is whether the supervisor will agree to sign their accreditation form. In terms of the mode, we appear to be in *Eye Five (The supervisory relationship).* The quality of the supervisory relationship, like the quality of the therapeutic relationship, is highly dependent on trust and respect. We may also be dealing with the therapist's own issues which relates to previous unresolved events in terms

of their education or earlier family relationships, in other words, *Eye Four (The therapist's 'stuff')*. But the supervisor's own issues may also be affecting what is happening here (*Eye Six. The supervisor's 'stuff'*).

In such a situation the supervisor's first task is, perhaps, to do some work on themselves in order that they do not become too emotionally involved in what is going on. They need to accept, perhaps, that they cannot be held in high regard by all their supervisees. Discussing it with their own supervisor may assist with this. Secondly the supervisor may need to give the therapist some very concrete and specific feedback about what they still need to work on and how this might be achieved. This needs to be done with acceptance of the strong possibility that this feedback may be rejected and the therapist may flounce off and seek another supervisor. The specific feedback may consist of a written list of bullet points, for example, regarding how to brush up on the Standard Protocol and critically reflect on their own videos of supervision sessions regarding the supervisory relationship. Again, telling a story about a time when the supervisor, themselves, had to deal with negative feedback and respond to it in an appropriate way might also help to ensure that the therapist actually hears what the supervisor is saying.

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<u>CONSENT FORM</u>

Video Recording of Treatment Sessions for Teaching Purposes

Video recordings of treatment sessions with patients can facilitate the session, especially in the case of EMDR treatment. Such a video can provide helpful information to the therapist on an individual's difficulties and their treatment, and assist the therapist's own clinical supervision. It can also be useful for teaching purposes in order for the therapist to demonstrate their work to other therapists.

This video will be seen only by qualified mental health professionals who are trained or undergoing training in the use of EMDR. The data will be kept secure.

Videos of treatment sessions do not form part of a patient's health record, and the individual would not be identified by name.

If you do not agree to your therapy being recorded it will not affect your treatment in any way.

If you subsequently wish the recording to be erased directly after the session has been completed, this will be carried out.

I hereby agree to the treatment sessions being video recorded for the purposes stated.

Name …………………………………………….

Signature ……………………………………….

Date ………………………………………………

CONSENT FORM

Video Recording of Treatment Sessions

Video recordings of treatment sessions with patients can facilitate the session, especially in the case of EMDR treatment. Such a video can provide helpful information to the therapist on an individual's difficulties and their treatment, and assist the therapist's own clinical supervision.

This video will be seen only by the therapist and the therapist's supervisor who is an experienced EMDR Consultant. The data will be kept secure.

Videos of treatment sessions do not form part of a patient's health record, and the individual would not be identified by name.

If you do not agree to your therapy being recorded it will not affect your treatment in any way.

If you subsequently wish the recording to be erased directly after the session has been completed, this will be carried out.

I hereby agree to the treatment sessions being video recorded for the purposes stated.

Name ....

Signature ....

Date ....

Accreditation Applications - Good Practice Examples
Jessica Woolliscroft

Presentation at Consultants Training Day
Saturday 14th November 2020

This presentation will cover:
- Accreditation – Why bother?
- Start as one means to continue
- Learning from my mistakes
- S**t happens!
- Preparing the application form
- An example draft
- The accreditation panel's point of view
- An example of an edited draft application form
- An example of a covering letter
- An example of a Consultants application form
- The order of things
- Gratitudes – my supervisees, my supervisors

Just because *you* think you are great, does not mean everybody else would agree.
- Who do we want working with clients? Representing us in the therapeutic and wider community?
- Training other practitioners? There are many stakeholders in the accreditation process; the supervisee and the supervisor are the most obvious, but we also need to hold in mind all the future clients/supervisees of the applicant, the standing of our profession and the interests of the wider community.
- Accreditation provides a set of agreed standards and triangulation to ensure they are met.
- This is why the accreditation process, in order to work, has to be conducted in good faith.
- Each of us acts as a mentor, guiding our supervisees through this process.
- Mentors have a responsibility to ensure this work is taken seriously and carried out ethically.

Start as one means to continue.
- Check they are a member of EMDR UK and Ireland and that their training was accredited.
- Contracting – frequency, fees, the accreditation journey, who will do what, when, how and why.
- Encourage videos as early in the process as possible – viewing in session cf. outside session
- Encourage supervisee to acquaint themselves with the forms early on. Explain it will take weeks not days to complete and no guarantee timelines will be met due to the workload of the panel.
- Explain the importance of bringing every client that will be referred to on the log.

Learning from my mistakes

Things I wish I had done differently:
- I wish I had told an applicant how much to write.
- I wish I had realised sooner how many applicants struggle with dyslexia and IT.
- I wish I had told all my supervisees how the application process proceeds from the outset of supervision, that is, warned them how long it takes.
- I wish I had been firmer with guidance around the best time to attend the Consultants' Training Event.

S**t happens!
- There have been situations that could not possibly have been predicted, where a supervisee has had to deal with a bizarre, surreal or extreme situation, not of their making e.g. supervisees crossing boundaries; workplace difficulties affecting the process.
- In these circumstances it is so important to remember that the supervisee needs our 100% unconditional support.
- By standing by our supervisee through the rough times we are also modelling ethics, that we do not throw someone under the bus when the going gets tough. This is particularly relevant to trauma therapy, where our clients may have been subjected to injustice.

Preparing the application form
- Draft in third person
- Log book analogy
- How much to write - succinct
    - Section IV Part A - no more than one side A4
    - Part B - three or four paragraphs per phase
    - Part C - one side of A4 plus a list of relevant CPD/reading
    - Part D - the reference need be no longer than one side of A4
- Get organised – mapping the text to the questions in order – make it easy for the panel
- Subheadings
- Bullet points
- Key words in bold
- Real world examples of anomalies
- Good to look at, clearly written, spaces between paragraphs, decent sized font.
- Spelling and grammar – it makes a difference
- Covering letter – contents and introduction – pages numbered
- Does it make sense and answer the questions?! I always check that the whole form answers the questions, that the log is understandable, the signatures are in the right place, nothing is missing, it is all in one Word doc.

This is a strong actual anonymised draft from a historical supervisee, as I received it, showing his description of Part B Phase 1. History Taking before being worked on for the forms
- In the first session with a new client, I take a comprehensive history. This includes asking about what has brought them to therapy now and exploring their reply to this enquiry with questions around how long that has been happening, what was happening in their life around the time that started, whether that kind of thing has happened before – further back in their life, and whether they can remember a time before that started happening. I enquire about their childhood, parents, siblings, other significant relationships in childhood and adulthood, partners, children and so on. If it does not come out of these enquiries, I ask about experiences of abuse and/or neglect, both in childhood and adulthood. I ask about work and social relationships as well as family and personal relationships. Sometimes their experiences at school or university are significant. Losses of significant people, places or possessions can also be relevant. I ask about any physical or mental health diagnoses they have been given

and, sometimes, whether they agree with them, also about medications, risk, and their social support system. I always ask for the contact details of the client's GP and, if they have one, their psychiatrist or psychologist and explain why I am asking for that information. During this kind of general history taking, the client almost always directs me to what they consider is the relevant information about why they are seeking therapy and from their point of view what the background to that is. I am also listening out for indications of things that are relevant from an AIP perspective that the client may not be aware of. Either I enquire about these things in the first session or note them to follow up later, asking about how the difficulties affect them in terms of behaviour and other symptoms. From this general history, I gain an impression of the client with respect to their level of trauma symptoms, anxiety, stability, dissociation, ego strength or fragility, and of course I am seeking to build a good working relationship with the client from the beginning. In addition, I enquire whether the client has had therapy before, what they want from the current therapy, and how they would like to be when the therapy is completed.

- If there are obvious red flags in this first session, I have some time to think about how to proceed, to do some research and consult my supervisor if necessary. Red flags may include current or recent self-harming behaviour or suicidality, significant fragmentation and dissociation, a history of psychosis, recent or active addiction, and medical conditions such as epilepsy, asthma, heart conditions, or neurological conditions. Someone with poor emotional regulation, who is psychologically unstable, or is significantly isolated with no support network would be a concern. Sometimes it is possible to do EMDR therapy with such clients, but sufficient stabilisation, appropriate planning and possible use of special protocols is called for. If it is appropriate to let a psychiatrist or GP know of the intention to use EMDR therapy with their patient, with the client's permission, their medical team is contacted.

- In order to pick up any client who might have a dissociative disorder, the Dissociative Experiences Scale II (DES II) is done with every client, and anything significant is followed up and carefully considered. Working with clients who have dissociative disorders is a specialist area and referral to a clinician with appropriate expertise may be necessary. Other concerns which may need addressing before EMDR can be contemplated include when a client is living in a currently abusive situation, uses social drugs or medications which may interfere with the efficacy of EMDR, or is involved in a legal case. An important function in the stabilisation phase is ego strengthening. To the extent it may be necessary with an individual client so they can engage with EMDR safely and successfully, resource installation and development (Leeds & Korn, 2002) should be undertaken. The stabilisation phase is also the time to develop the client's ability to tolerate the potential levels of upset anticipated when EMDR reprocessing begins. This might be done with guided meditations and relaxation techniques. The need for these stabilisation phase resources can be ascertained during the history taking. It is also useful to identify with the client what resources they have in their support network in terms of friends and family they can call on, plus any other resources they could use, e.g., regular exercise, yoga classes, support groups, and so on.

- By the end of the history taking process the therapist would usually have elicited from the client the main disturbing events and/or negative beliefs to be targeted with EMDR and a plan about how to sequence them. It is also useful to note at this stage any secondary gains or potential blocking beliefs that might interfere with processing. Where the touchstone event is not obvious or is unknown, a floatback or affect bridge can often uncover it or take you nearer to it. Unless a special protocol suggests otherwise, using the three-pronged approach means you start by processing past events, then target any triggers that are still occurring in the present and do any flash forward work necessary, then do future template work. Similar episodes can be grouped and targeted as a cluster. Where the trauma history is complex, it may be helpful to do a timeline with the client to facilitate this grouping. Sequencing of targets may be chronological, or you may start with the most disturbing event or perhaps with a less disturbing, peripheral event, depending on the client's ability to tolerate any distress arising.

- Some potential targets may not be included in the initial plan in the expectation that they will be processed through generalisation of processing of other targets. The initial plan is updated as necessary as the work proceeds.

The Accreditation Panel's point of view:
- I try to imagine what it would be like for the panel to read each draft as presented. My experience of being on employment panels, boards, and as a Trade Union rep reading scores of application forms and disciplinary reports is that after a period of time it is very easy to lose focus, glaze over ...in a word, dissociate. I can remember my own feelings of irritation when on any panel, trying to read forms that were badly spelt, poor grammar, not laid out clearly, with things put in a different order to that requested, or information not provided that was asked for.
- I go through the draft adding my feedback to draw attention to any of these issues. I then send this feedback to the supervisee or, if I know that the supervisee struggles with dyslexia etc. I may discuss in person first and sometimes I will edit the application myself and input the edited draft onto the application form. My approach varies with each supervisee's strengths.
- As will be seen from the examples, every application is unique and even though I give guidance and offer editorial changes, the application retains each supervisee's unique style and voice.
- I never submit an application form unless I believe it stands a good chance of being accepted.
- If the application form could speak to the panel it would say: *"Hello, this is who I am. I am well organised and professional. You do not need to worry about referring clients to me. I do understand how to deliver EMDR therapy and I am experienced enough to know what to do when it all goes off piste. I am also kind and compassionate to my clients, I know how to keep professional boundaries. I am committed to improving my skills and keeping up to date. I will not bring the Association into disrepute. You don't need to worry if you accredit me."*

This is a section of the same previous draft after it has been worked on for the accreditation form:

The Dissociative Experiences Scale II (DES II) is done with every client, and anything significant is followed up and carefully considered. X is aware that this is not a diagnostic measure, rather a descriptive measure, which helps him to get a flavour of the type of dissociative experiences the client may experience. In order to diagnose Dissociative Disorders the SCID-D psychological interview is used and only by someone who knows the client well and is able to diagnose, such as a Consultant Psychiatrist. X is aware that working with clients who have dissociative disorders is a specialist area and referral to a clinician with appropriate expertise may be necessary.

Other concerns which X knows may need addressing before EMDR can be contemplated include:
- when a client is living in a currently abusive situation,
- uses social drugs
- or medications which may interfere with the efficacy of EMDR,
- or is involved in a legal case.

This brings us to the need for stabilisation before processing trauma can proceed. An important function in the stabilisation phase is ego strengthening. To the extent it may be necessary with an individual client so they can engage with EMDR safely and successfully, resource installation and development (Leeds & Korn, 2002) will be undertaken by X. The stabilisation phase is also the time when X helps to develop the client's ability to tolerate the potential levels of upset anticipated when EMDR reprocessing begins. This might be done with guided meditations and relaxation techniques. The need for these stabilisation phase resources can is ascertained by X during the history taking. X also identifies with the client

what resources they have in their support network in terms of friends and family they can call on, plus any other resources they could use, e.g., regular exercise, yoga classes, support groups, and so on.

By the end of the history taking process X would usually have elicited from the client the main disturbing events and/or negative beliefs to be targeted with EMDR and a plan about how to sequence them. He will have noted at this stage any secondary gains or potential blocking beliefs that might interfere with processing. Where the touchstone event is not obvious or is unknown, a floatback or affect bridge may be used by X to uncover it or take one nearer to it.

Unless a special protocol suggests otherwise, using the three-pronged approach means X will start by processing past events, then targeting any triggers that are still occurring in the present and do any flash forward work necessary, then future template work

X may work efficiently by grouping similar events and targeting them as a cluster. Where the trauma history is complex, X may do a timeline with the client to facilitate this grouping. Sequencing of targets may be chronological, or start with the most disturbing event or perhaps with a less disturbing, peripheral event, depending on the client's ability to tolerate any distress arising.

An example of an edited draft application form – Part B Phase 1 History Taking
This is from a different historical application that succeeded in being accredited:
> X has attended additional training since his basic training parts 1,2,3 to explore this phase at a deeper level including 'Enhancing your EMDR practice' by Dr Michael Patterson OBE, and Healing Complex Trauma and Dissociation with Ego State Therapy and EMDR also by Dr Michael Patterson OBE.

> X understands that the history taking phase of treatment is fundamental to the client's journey and recovery. He considers risk, safeguarding and assesses the social support network available to the client. It also indicates the severity of trauma and adaptations to it, eg: levels of dissociation, hypervigilence, addicted behaviour, self harming etc.

> X also feels that if he spends time on the history taking, he gains a fuller understanding to formulate his sessions with his clients, essential for a treatment plan.

> X looks at history, adds a 3 Pronged Protocol approach considering past, present and future, starting with the present and what is the clients priority then moves to the past X asks about symptoms, when they started, what makes them worse, or better.

> X considers any indication to a touch stone memory being the earliest recalled experience that may have laid the foundations for the clients presenting problem.

> X also considers triggers and the clients view of the future.

> History taking in EMDR - Checklist
> X uses a template with a checklist considering:
- Background information
- Place of birth
- Parents still alive
- Siblings

- Mother's pregnancy
- Developmental milestones
- Area bought up
- Relationships in family
- Substance misuse
- Domestic violence
- Bullying
- Separations
- Parents and emotional support
- Schooling
- Work
- Sexuality
- Trauma's considered by client
- Abuse
- Medical history
- Family psychiatric history
- Personal psychiatric history
- Diagnosis and medication

  X states that the tick form is used as a check list from his training to guide his safe practice and formulation.

  Outcome measures
- X is familiar with using screening tools including DES-II and ACE (Adverse Childhood Experience) questionnaire, psychometric screening such as PHQ9 and GAD7, Core forms, and checks his clients regarding readiness, medical conditions and risk. He has a fuller understanding of the clinical signs of Dissociative Disorders from additional training.
- Supervision time is used to explore case conceptualisation and X has always been open and honest in his reflections of case material. X will spend time in the history taking phase to 'get to know' his client with emphasis on risk and safety management and finds that past clinical work experience within the IAPT NHS service, has assisted his understanding in this area.
- X demonstrates during our sessions examples of how he clarifies the client's desired state following a therapeutic intervention, if the client has never had a safe place, X is able to help. X is able to ensure the client is able to deal with high levels of disturbance assisting this in phase 2 of treatment. X discussed self-soothing and other resources covered in his additional training 'Enhance your EMDR Practice' by Dr Michael Patterson OBE where extended safe place and development of other resources were explored eg: breathing, superheroes.
- X is able to prioritise multiple targets once determining the client's integrative capacity. X worked with a client who had been involved in a road traffic collision and was able to work with clusters, the related memories that had similar components or themes of the accident such as injury and treatment.
- The video's X has bought to supervision evidence his ability to identify a touchstone event. He demonstrates his knowledge and helps the client to recall the earliest experience that laid down the foundation.

An example of a covering letter

31st October 2019
Alison Russell
Chair of the Reaccreditation Committee
EMDR Association UK and Ireland
P. O. Box 3356
Swindon
SN2 9EE

Dear Alison and Committee

Application for 5 year reaccreditation of EMDR Europe Consultant status
(Accredited 11th December 2014)

Please find in this document supporting evidence for my reaccreditation as an EMDR Europe
Consultant as follows:
   • A letter of introduction outlining contents of the document and describing my EMDR
      practice.
   • A record of all my CPD since my Consultant accreditation in Dec 2014. I meet both the old
      and the revised criteria. I have *59 EMDR Association validated CPD points and 339 other
      CPD hours* relevant to my growth and practice as an EMDR Consultant, supervisor and
      trauma psychotherapist. I also document any published articles and training that I have
      delivered. P:4
   • A representative record of my reading, podcasts, and relevant DVDs (not exhaustive) p:15
   • Proof of attendance and CPD certificates p:21
   • A reference from my clinical supervisor Sandi Richman (May 2019 to date) p: 46
   • A reference from my previous clinical supervisor Matt Wesson (May 2013 to May 2019) p: 47
   • Scan of reaccreditation fee sent as a cheque to P.O.Box 3356, Swindon.p:48
   •

 Followed by one side of A4 bringing panel up to date with my EMDR practice and plans for the
future

Example of a Consultants Application Form showing colour coded CPD log and a reading list

4

CONTINUING PROFESSIONAL DEVELOPMENT LOG Dec 2014-2019

JESSICA WOOLLISCROFT

	EMDR Association validated training Total CPD points = 59
	CPD Training courses and book clubs attended = 339 Hours CPD
	Qualifications Awarded (Certificates, Diplomas, and Commendations)
	CPD Delivered
	Published articles
	Other training with significant CPD benefit to psychotherapy practice.

DATE	TITLE OF ACTIVITY	DURATION or CPD Points	LEARNING OUTCOMES as defined by the course presenters.
2019			
16th Nov 2019	EMDR Consultants Training Day Organised by Trauma Aid UK	6 CPD points	Dilemmas for EMDR consultants
April to November 2019	Containment in theory and practice **Marilyn Miller** Psychoanalytic Psychotherapist from Tavistock Clinic/WMIP	30 CPD hours	To examine the container-contained relationship in theory and practice.
22nd March and 23rd March 2019	EMDR Association UK and Ireland CONFERENCE	12 CPD points	UK EMDR Conference, workshops and AGM

5

16th March 2019	Psychiatric Diagnosis and Medication **Dr Ian Rogerson Consultant Psychiatrist**	6 CPD points	To understand the varieties of medication and processes involved in psychiatric diagnosis And their impact on psychotherapy and recovery.
2018			
Nov 2018	Evidence Base Psychoanalytic Psychotherapy NOW 2018 Johnathan Shedler Stephen Grosz Hewitson	6 CPD	A series of lectures on the evidence base and research on psychoanalytic psychotherapy.
June to Dec 2018	Understanding Symbol Formation **Marilyn Miller** **Psychoanalytic psychotherapist from Tavistock Clinic/WMIP**	30 CPD hours	To explore and discuss some classic and other selected readings on the development of symbol formation in connection with ongoing clinical work.
21st 22nd July 2018	R-Tep and G- Tep training delivered by **Elan Shapiro**	12 CPD points	To learn the EMDR protocols of R-Tep and G –Tep under supervision
24th June 20018	CTC/ISSTD Developmental trauma. Delivered a presentation on a case study…The Girl in the Mirror about Emdr for a client with Psychosis	2 days	To illustrate how diagnostic confusion can affect case conceptualisation and how EMDR can still alleviate suffering in these circumstances
23rd March and 24th March	EMDR Association UK and Ireland CONFERENCE	12 CPD points	UK EMDR Conference, workshops and AGM

<u>READING LIST, Podcasts, Audio and DVD</u>

<u>CONTINUING PROFESSIONAL DEVELOPMENT LOG 2012-2019</u>

<u>JESSICA WOOLLISCROFT</u>

Those of significance and influential for me are marked with an asterisk *

(This list is not exhaustive and it does not include the references that are listed in the bibliography for my published article *"Compassionate Design of Therapeutic Space"*).

<u>2019</u>

Bridges, H. Reframe your thinking around autism: How the polyvagal theory and brain plasticity help us make sense of autism (2015)

*Miller, P.W. EMDR for Schizophrenia and other psychoses (2015)

Hinshelwood, R.D. A Dictionary of Kleinian thought (1989)

Flett, M, Mastering the DSM-5: Integrating new and essential measures into your practice (2014)##

<u>2018</u>

Walker, P. Complex PTSD : from surviving to thriving (2013)

Eisenstein, C. Climate: A new story (2018)

Moskowitz, A, et al Psychosis, trauma and dissociation: emerging perspectives on severe psychopathology (2008)

Brach,T. Radical Acceptance; Awakening the love that heals fear and shame (2003)

Gonzalez,A. and Mosquera, D. EMDR and Dissociation : The Progressive Approach (2012)

Davies,D. Terminating Therapy : A Professional Guide to Ending on a Positive Note (2008)

2017

Schore, A,   The Science of the Art of Psychotherapy (2012)

Rachman, Arnold (2000) *Ferenczi's "Confusion of Tongues "Theory and the Analysis of the Incest Trauma,* Psychoanalytic Social Work, 7:1, 27-53,

Birksted- Breen (1993) The Gender Conundrum: Contemporary Psychoanalytic Perspectives on Femininity and Masculinity (The New Library of Psychoanalysis).

Chasseguet-Smirgel (1985) Creativity and Perversion Free Association Books

Downing and Nobus (EDS) (2006) Perversion: Psychoanalytic Perspectives/Perspectives on Psychoanalysis Karnac

Holliday Willey (2014) Pretending to be Normal: Living with Asperger's Syndrome Jessica Kingsley

Steward (2013) The Independent Woman's Handbook for Super Safe Living on the Autistic Spectrum

- Attwood (1998) Asperger's Syndrome: A Guide for Parents and Professionals Jessica Kingsley

Moore , Grandin (2016) The Loving Push: How Parents and Professionals Can Help Spectrum Kids Become Successful Adults . Future Horizons

Simone (2010) Aspergirls: Empowering Females with Asperger Syndrome Jessica Kingsely

Featherstone (1999) Love & Eroticism (Published in association with Theory, Culture & Society) SAGE

The Order of things

We quite often are working in the dark, especially when it comes to the fraught area of IT and getting everything signed and organised in the right order. This is the checklist I give to supervisees:

1. Read the forms and be sure to understand what is being requested
2. Keep a log and record each client brought to supervision
3. Submit videos for feedback
4. Secure a second reference from a suitable professional
5. Complete a draft application form
6. Submit the draft for feedback from supervisor
7. Rewrite the application and input onto the required form
8. Write a covering letter to add to the beginning of the application form
9. Add scanned documents of qualifications and CPD attendance in an Appendix at the back of the form
10. Make sure all of these sections are put into one Word doc
11. Add own signature to each section
12. Get second reference to add signature to final application form on Word doc
13. Submit completed application form in a Word doc to supervisor to add their reference and their signatures to each section
14. Supervisor returns signed application form to supervisee
15. Supervisee pays fee and submits application form to the panel
16. Wait for response from the panel

Gratitudes

To my supervisors/mentors, Fokkina, Matt and Sandi who have taught me so much and stood by me through thick and thin.
To my supervisees for their
- Patience with my very slow response time on video feedback reports
- Working with me and teaching me so much about their client groups, often working in areas or with situations that I would find extremely challenging, and yet having the willingness to accept me as their supervisor.

EMDR Case Formulation Tool

Ines Santos

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This article describes a diagrammatic clinical tool to be used when formulating cases in eye movementdesensitization and reprocessing (EMDR) therapy. Based on the Adaptive Information Processing (AIP) model, the EMDR Case Formulation Tool is a way of illustrating psychological difficulties, mapping out the relationships between six key elements: unprocessed traumatic experiences, triggers, intrusions, negative beliefs, and symptoms, as well as resilience. From the diagrammatic formulation, a narrative formulationcan be developed. The case formulation tool can be shared with the client, used to guide treatment planning, in supervision, and in case consultations. The use of the tool is explained and its clinical applications demonstrated with case examples.

Keywords: eye movement desensitization and reprocessing (EMDR) therapy; case formulation; case con- ceptualization; Adaptive Information Processing (AIP); clinical tool

I t is widely accepted that case formulation or case conceptualization (the two terms are generally used interchangeably) is the cornerstone of psychological therapies. It is the process through which the therapist and the client collaboratively make sense of the client's difficulties (Johnstone, 2011) and this is then used to inform clinical practice. Simply, a shared formulation gives the therapist and the client a *map* of where the client is at now, where they have been and how they got here, and where they are going and how to get there.

Case formulation aims to describe a person's presenting problems and uses theory to make explanatory inferences about causes and maintaining factors that can inform interventions. Different therapeutic approaches (e.g., psychodynamic, cognitive behavioral, or systemic) have their own take on the purpose and the process of formulation (Johnstone & Dallos, 2006) as does the Adaptive Information Processing (AIP) model, which underpins eye movement desensitization and reprocessing (EMDR) therapy (Shapiro, 2018; Shapiro & Laliotis, 2011; Shapiro & Maxfield, 2002; Solomon & Shapiro, 2008).

AIP Case Formulation

Case conceptualization is as important in EMDR therapy as it is in any other therapy modality. At some level, as EMDR therapists, we all formulate our clients' difficulties; however, we do not always make this formulation an explicit process that is shared with clients, as it is in other therapies such as cognitive behavioral therapy (CBT). The AIP model provides a solid basis from which to formulate cases (e.g., Shapiro, 2007; Solomon & Shapiro, 2008).

So, what might case formulation according to the AIP model look like? The AIP model (Shapiro, 2007, 2018) posits that when there is a failure in adaptive information processing (perhaps due to excessive distress, physiological arousal, or dissociation), life events are not processed and are thus stored in their original form (with associated cognitions, affect, and sensory perceptions) in maladaptive memory networks. A whole range of experiences are hypothesized to form these maladaptive networks, such as disturbing life events (small "t" traumas), for example, as a child getting lost in a supermarket, being teased by peers, or wetting oneself in school; as well what are more commonly recognized as traumatic experiences (large

"T" traumas), such as sexual abuse, road traffic accidents, or the death of a parent (e.g., Shapiro, 2001). These unprocessed memories are understood to be disconnected to other memory networks, therefore disconnected from adaptive information. These memories are stored in a raw form, alongside the original emotions, physical sensations, and beliefs. This conceptualization has parallels with implicit and explicit memories in Brewin's dual representation theory of posttraumatic stress disorder (PTSD; Brewin, Dalgleish, & Joseph, 1996).

The unprocessed nature of these memories means that they are easily activated by current triggers that match an aspect of the original experience. Triggering stimuli can be external (e.g., the color red, the smell of body odor, hearing a loud voice) or internal (e.g., the sense of fear, a certain bodily position, a specific pain). These matching stimuli trigger the identical emotions, cognitions, physical sensations, and behaviors that were present at the time of the original event (Shapiro, 2018). These are experienced by traumatized clients as distressing symptoms, such as intrusive memories, flashbacks, nightmares, fear, shame, and physical manifestations of anxiety. Thus, "the continued influence of these earlier experiences is due in a large part to the present-day stimuli eliciting the negative affects and beliefs embodied in these memories. [. . .] the lack of adequate assimilation means the client is still reacting emotionally and behaviorally in ways consistent with the early disturbing incident" (Shapiro, 2018, p. 16).

"In this way, when the past becomes present and patients react in a dysfunctional manner, it is because their perceptions of current situations are coloured by their unprocessed memories" (Shapiro, 2014, p. 73). Thus, a history of earlier unresolved trauma creates dysfunctional memory networks that compromise one's ability to cope with current crises.

These unprocessed memories are also activated in the absence of stimuli, for example, in nightmares and in spontaneous intrusive memories. This can be seen as a natural attempt at processing this information that gets disrupted because the memories are so disturbing. The intrusions of these unprocessed traumatic memories can range from an overwhelming experience such as a flashback to a barely noticeable memory that nevertheless affects current experience and behavior (Hase, Balmadeda, Ostacoli, Libermann, & Hofmann).

Hase et al. (2017) suggest that these memories can be usefully understood as pathogenic memories; that is, memories that are experienced as intrusions when the memory is activated, which is accompanied by physiological arousal and disturbance. They argue that pathogenic memories have a central role in a range of difficulties, not just PTSD, which is in line with the AIP model. As unprocessed traumatic memories are activated, the associated negative beliefs or cognitions that are still *currently held* are also activated in the *here and now*. These negative cognitions can be organized into four main domains around safety, control, responsibility, and self-defectiveness (e.g., Shapiro, 2007). For example, someone who is constantly re-experiencing a sexual assault has the currently held belief "I'm not safe"; someone who was sexually abused may believe "It's my fault; I deserve bad things."

According to Hase et al. (2017), these currently held negative beliefs and the intrusive memories cause a whole range of other difficulties, which will vary across presentations and conditions. For example, in some cases there is a PTSD presentation, including avoidance of any stimuli associated with the traumas, symptoms of hypervigilance due to the present sense of danger, and dissociation as a survival response to overwhelming experiences. In cases of obsessive com-pulsive disorder (OCD), there may be obsessive ruminations or compulsive rituals. In body dysmorphia, for example, symptoms might include a distorted sense of the body or a body part. Or people may present with a combination of these. In addition, the unprocessed memories may manifest themselves in other difficulties, which may be understood as secondary, such as depressive mood and anxiety, and maintained by behaviors such as not going out, substance mis- use, or self-harm. Some of these can be understood as attempts at coping; for example, substance misuse as an attempt at self-medication to dampen the distressing flashbacks and to help with sleep. The negative cognitions can be seen as underpinning some of these difficulties. For example, "I am a bad person" under-pins depressive feelings and "I am in danger" under- pins anxiety.

According to the AIP model (e.g., Shapiro, 2018), the current symptoms result in present fears, situations which are currently feared and avoided and future fears, situations which are anticipated as fearful in the future. For example, let us say that the unprocessed memory of a rape is triggered by someone hearing footsteps close behind while walking home at dusk. This causes a flashback of being held down, which is experienced with the sensation of pressure in the chest, the smell of alcohol and body odor, the emotion of fear, and the beliefs "I'm in danger" and "It's my fault, I should have stopped it." As a result, a whole range of difficulties may be manifested and maintained in the present including avoidance of going out,

especially in the dark, mistrust in people, high levels of hypervigilance, and high levels of generalized anxiety. These may feed into low mood and low self-esteem including feelings of failure and shame. In this case, a current feared situation might be going out at night and a feared future situation might be going on a date or on a vacation.

As illustrated here, the AIP model provides a comprehensive understanding of how current difficulties are the result of unprocessed past traumas. Shapiro (e.g., Shapiro, 2006; Shapiro 2007) has given many examples of how the AIP model can be used in case conceptualization; for example, the case of Tara who presented with excessive anxiety, panic attacks, and pronounced school phobia, whose difficulties, within an AIP model, are understood to stem from unprocessed memories of earlier childhood where she'd felt vulnerable, experiences compounded by her mother's overprotectiveness (Shapiro, 2007).

The EMDR Case Formulation Tool: The Six Elements

In supervision and in case consultation, I am frequently asked, especially by therapists trained in CBT, how to formulate within an AIP model and how to capture an AIP formulation in a visual way that could easily be shared with a client and in supervision. Shapiro's AIP model, as thorough as it is in case conceptualization, is not that easy to use for a quick and practical case formulation. For lack of a better alternative, therapists often used Ehlers and Clark's (2000) cognitive model of posttraumatic stress behavior. However, the model, as useful as it is for CBT, does not have a particularly good fit with the AIP model and EMDR therapy. There lacked an appropriate tool in my clinical practice, as well as in supervision.

The EMDR Case Formulation Tool was developed as a way of capturing and simplifying the AIP approach to case formulation using a visual diagram and a narrative formulation. Drawing a visual representation of the case conceptualization is a useful way of capturing the carious elements and how they relate to each other. A diagrammatic case formulation is also useful for sharing the therapist's understanding of the client. The EMDR Case Formulation Tool is based on 6 key elements within the AIP model and the relation-
ship between them:

- Trauma (s) (unprocessed traumatic memories)
- Triggers

- Intrusions (intrusive memories, flashbacks/nightmares, sensory memories including pain)
- Negative beliefs (four domains)
- Symptoms/behaviors/difficulties
  - Resilience factors (positive experiences, positive attachment figures [past and present], strengths, achievements, current positives in life [strong marriage, parenting, career, hobbies])

At its simplest, one could see an AIP formulation as the process of trying to establish the relationships between each of these elements as it applies to each clinical presentation. By drawing possible causative arrows between these elements, one can have a formulation suggesting how unprocessed traumatic memories underpin the psychological symptoms and current difficulties.

Based on this simple premise, the EMDR Case Formulation Tool provides a diagrammatic description of the AIP model and how it informs EMDR therapy, as shown in Figure 1, which can be used as the basis of the case formulation. Before the clinical application of the EMDR Case Formulation Tool is discussed and illustrated with examples, other diagrammatic tools for case conceptualization within the AIP model are briefly discussed.

Diagrammatic EMDR Case Formulations

In a thought-provoking article, De Jongh, Ten Broeke, and Meijer (2010) discussed the process of case conceptualization in EMDR and proposed a two-method approach in which two forms of questioning lead to two types of case conceptualization. They developed a visual diagram to illustrate their method. Broadly speaking, the First Method deals usually with Axis I disorders, including simple PTSD, where memories of the etiological (and aggravating) events can be meaningfully formulated on a timeline. The Second Method is generally used with complex PTSD and/or personality disorders, and identifies memories that in some way form the groundwork under the client's so-called dysfunctional (core) beliefs underpinning the condition. The De Jongh et al. (2010) approach is a useful tool in identifying target memories and making treatment decisions.

Jarecki (2014) developed the "seed to weed technique," a strategy that is based on the AIP model and is used with clients to explain how trauma happens, how past experiences have ongoing impacts, and to monitor progress throughout treatment. This technique
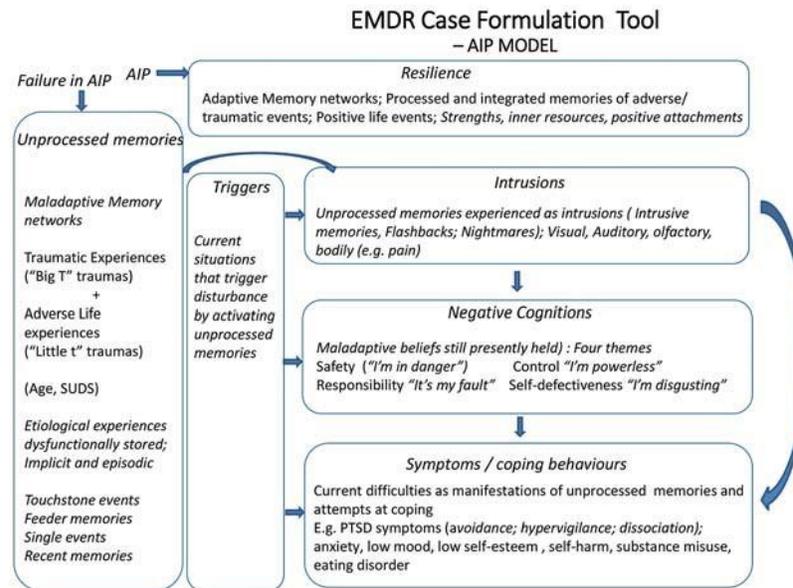
FIGURE 1. EMDR case formulation tool explanatory diagram.

Note. EMDR = eye movement desensitization and reprocessing.

is based on an illustrative metaphor, including visual diagrams, where positive experiences and resilience factors are represented by flowers, fruits, or vegetables, and traumas are represented by weeds (the roots and seeds earlier underpinning memories and the visible parts the more recent disturbing memory). As EMDR processing happens, weeds get destroyed and are replaced by flowers, fruits, or vegetables, reflecting adaptive material. The seed to weed technique can be used to develop personalized case formulations that are developed and added to as the therapy progresses. Another diagrammatic approach to case conceptualization was developed by Leeds (2017). Leeds describes how, based on the AIP model, a patient's symptoms and pathology are understood as arising as the result of etiological and contributory experiences that contribute to the formation of maladaptive (unprocessed) memory networks. The case conceptualization makes hypothetical links between contributory and etiological experiences, current triggers, and current symptoms and uses this as the basis for target sequencing and treatment planning. The case conceptualization includes identifying the maladaptive memory networks, the current symptoms and defenses, the adaptive memory networks, and the evolution of symptoms over time. Leeds' (2017) approach to case conceptualization is useful for treatment planning and target sequencing.

Each of these visual ways of conceptualizing a case within an AIP model has their strengths and their limitations. All three are useful ways of collaboratively developing and sharing with a client the ther-

apist's understanding of the origins of the difficulties and maintenance of the current difficulties, as well as informing clinical decisions about how to proceed with EMDR therapy. The EMDR Case Formulation Tool is an alternative diagrammatic formulation based on the AIP model. How this tool can be used clinically, with illustrations from clinical case examples, is described in detail next.

Using the EMDR Case Formulation Tool

The EMDR Case Formulation Tool is very flexible in how it can be used. The idea is that the six elements are identified for each case and the relationships between the elements explored. There is a visual diagram that be used to facilitate this process (see Figure 2) but the tool can be used without the diagram, with the therapist drawing freehand the six elements and the relationships between them.

The clinical application of this formulation tool is wide. Clinicians can fill the formulation diagram on their own once they have met with the client after the assessment session, or it can be used to increase a therapist's understanding of an ongoing case. The formulation can be shared with a client as a way of promoting an understanding of their difficulties and the rationale for treatment. The formulation can be used within a session, drawn collaboratively with the client, at any stage in therapy. It can also be used as part of the assessment, guiding the questioning so that all the necessary information is obtained or at a later stage in reformulation. Additionally, the tool can be used in
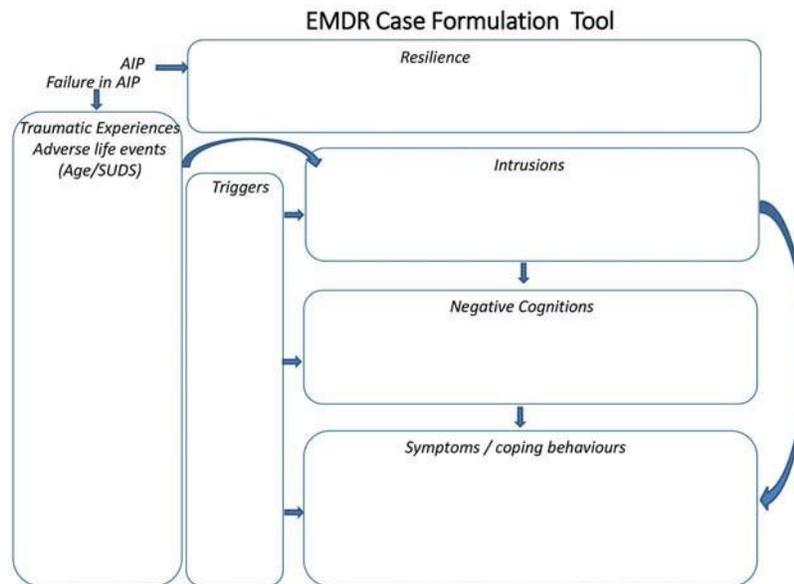
FIGURE 2. EMDR case formulation tool.

Note. EMDR = eye movement desensitization and reprocessing.

supervision or case consultation to quickly and easily share key aspects of a client's history and presentation, to inform case discussion and treatment planning.

The process of doing the actual formulating is also flexible. Therapists can start from left to right by identifying the traumatic memories, triggers, intrusions, negative cognitions, and how this leads to current difficulties; or start with the current difficulties and work the other way, moving from right to left. With com- plex clients where there are many traumas and disturbing life experiences, it can be helpful to pace the formulation process, using one formulation diagram to depict a cluster of memories; for example, a cluster of all the memories associated with the negative belief ("I'm in danger"), organized by perpetrator (sexual abuse by pedophile ring), or by a time period (tourof duty in Afghanistan). Later on, another diagram may be used to depict the next cluster, and so on.

This tool is broad and flexible enough that it can be used to formulate the whole range of difficulties where EMDR therapy can be used, from simpler presentations such as single event adult onset PTSD or a phobia, to more complex presentations such as com-plicated grief, complex PTSD, and even personality disorder presentations. It could be used with other presentations such as addictions, chronic pain, or obsessive compulsive disorders. In fact, because of the central role of unprocessed (pathogenic memories),it can be used to formulate any complaints that have these memories at their core.

One important aim of a case formulation is to help to make treatment decisions regarding identifying and sequencing targets, and this formulation tool

can help with that process. Several other approacheshave been developed to facilitate this process (seeLombardo, 2012) for a discussion of these various approaches. Lombardo (2012)'s EMDR Target Time Line is another approach to developing a timeline of target memories; however, it goes a step further in taking into account how targets can be clustered around negative cognitions, symptom/body sensations, and situation/person/ circumstance, which can inform the treatment plan. The EMDR Case formulation Tool can be used in this way, incorporating as it does a time-line of traumas, which may be organized in clusters.Additionally, though, it links the traumas to the negative cognitions and the current symptoms so that a comprehensive treatment plan can be developed andrevised as therapy progresses.

The Narrative Formulation

Alongside the formulation diagram, the clinician maythen write and share a narrative formulation of the client's difficulties. It is important to highlight that, in this case formulation, the links between these six elements are theoretical links, assumptions based onthe AIP model, and thus, as all formulations, it should be expressed tentatively (as a "best guess"; Johnstone, 2011). The formulation narrative can be done any wayit suits the therapist and client. The following is a suggested format:

One way of understanding your difficulties is that as a result of [trauma(s)] having happenedto you, when you are exposed to [triggers] you

experience [intrusive symptoms] which make you believe [NC] about yourself. This can be thought to cause you difficulties in terms of [symptoms/maladaptive coping]. It makes you fear [present fear] and dread [future fear] happening in the future. Although you have all these difficulties, you have strengths [positive experiences/resilience factors] which give you resilience.

In the above example of the rape, the therapist could develop a formulation narrative that could be shared with the client, in a way that the client could tolerate. The level of detail in the narrative needs to be titrated depending on the client. For quite a resilient client, such a narrative might be as follows:

One way of understanding your difficulties is that as a result of the rape, when you are exposed to certain situations such as hearing footsteps, being out at night, walking through empty parks, hearing loud male voices, you experience memories of the rape, including the sensations, the pain, the smell of alcohol and of body odour. This makes you believe "I'm unsafe" and you feel a strong feeling of fear. This causes you difficulties in terms of high levels of jumpiness, lots of anxiety, avoidance of going out, mistrust in people, especially men. You are also troubled by the memory of having frozen and not shouting out for help which makes you believe, "It's my fault, I should have stopped it," which makes you feel ashamed and weak and makes you feel depressed. You avoid going out and social situations and are dreading having to go to a family wedding that is coming up. Although you have all these difficulties, you have strengths such as being creative with a strong interest in painting which give you resilience.

Three actual clinical case examples are presented below where the tool was used to formulate a range of difficulties (the clients gave permission for their cases to be written about in this article). As the case examples demonstrate, the formulations can be brief or very thorough and detailed, and additional suggested causative arrows can show the hypothetical theoretical links between the various aspects of the model.

Case Examples

Motorbike Accident (Male, 30s)

The EMDR Case Formulation Tool was used to formulate this clinical case who presented following a motorbike accident. The diagrammatic formulation (see Figure 3) illustrates the case formulation, using arrows to show hypothesized links between the six elements.

Narrative Formulation.

A narrative formulation was developed on the basis of the diagram and shared with the client.

One way of understanding your difficulties is that as a result of the motorbike accident two years ago, when you hear loud noises, sirens or motorbikes and when you smell smoke, it takes you back to the moment of the accident and it makes you believe that you are going to die and you feel extreme fear. As we have discussed, this accident brought back memories of a previous accident where you also felt that you were going to die. Because of this currently held fear and belief that you're in danger, you avoid driving and are terrified of being in a car, you are jumpy, you are constantly in a state of alert and suffer from poor concentration and irritability, which makes you snap at your wife and kids, which in turn makes you feel bad about yourself. You are currently off work as a result.

There are earlier experiences in your life which may be compounding these difficulties. As a child, you were made to feel bad for cry- ing on your first day of school. These same feel-ings were replayed when you cried in hospital and make you believe that you are weak. You feel ashamed of this weakness. You see your cur- rent difficulties as proof of your weakness and feel depressed, guilty, and have low self-worth as a result.

Despite all these difficulties, you have lots of resilience. You enjoyed school and did well and were particularly good at sport. You've built up a successful career which gives you a strong sense of achievement and you have a supportive mar-riage and family. You particularly enjoy playing football with your kids. Therefore, you have lots of strengths that we can work with.

Complex PTSD (Female, Late 40s)

The EMDR Case Formulation Tool was used to for- mulate this clinical case of a female client who was referred to an National Health Service secondary care service because of longstanding "blackouts" where she lost consciousness and fainted, which were occurring several times per day, every day (see Figure 4). Organic causes for the blackouts had been ruled out prior to the referral. The client was baffled by the blackouts
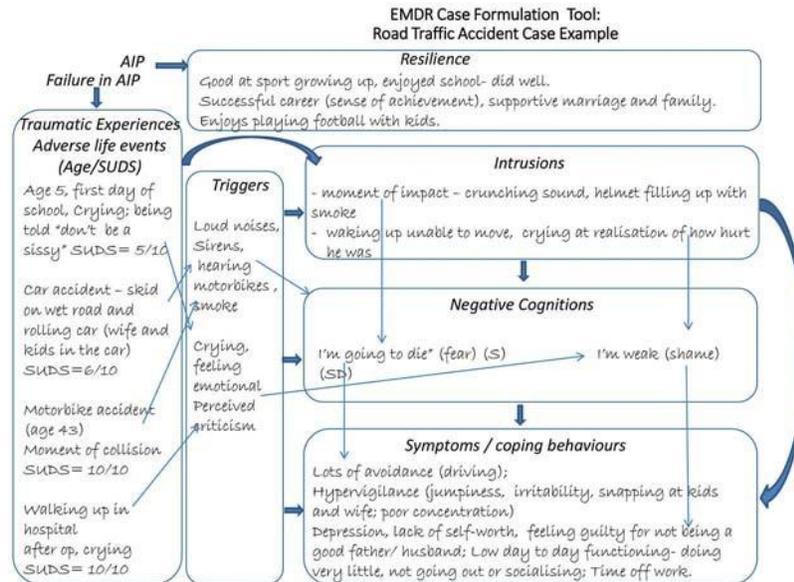
FIGURE 3. EMDR case formulation tool road traffic accident case example.

Note. EMDR = eye movement desensitization and reprocessing.

and her life was extremely limited as a result of the frequent loss of consciouness. The diagrammatic formulation shows some of the hypothesized causative links, but not all of them for the sake of legibility.

Narrative Formulation. A narrative formulation was developed on the basis of the diagram and both were shared with the client a few weeks into treatment.

As we have come to understand, your traumas started right from birth, with your mother reject-ing you because you were not a boy, and thus not a replacement for the son she'd just lost, some-thing that she told you from a young age; she openly preferred your older sister. Your father sexually abused you from age 5 to 11, and you remember your mother removing your sister from your shared bedroom while the abuse was taking place.

It might make sense that as a result of these traumas, when you are exposed to a range of situations, like, experiencing feelings, both negative and positive, weekly calls from your father, the constant and ongoing criticism by your mother even though you visit and care for her on a daily basis, intimacy and sexual contact, they bring back memories of these events and negative self-beliefs that you are worthless and your feelings don't matter, that it must be your fault and you deserve bad things, that you're dirty.

There were further difficult experiences. Your mum remarried but your new stepfather had a psychotic breakdown and was violent and threat-ening; your mother stayed with him until social

services made her leave him. In your teens you were sexually abused by your sister's boyfriend. In your 20s, your sister became terminally ill and your parents abdicated responsibility and made you make the decision to turn off the life support machine. Each of these events further compounded the previous traumas and negative beliefs that you're bad, that it's your fault.

It is perhaps as a result of all this that you experience a whole range of difficulties in your daily life. You experience "episodes" several times a day, which are dissociative seizures in which you lose consciousness. This can be seen as a survival strategy that you developed as a child to cope with overwhelming experiences and this happens now when you need to "numb out" for example, if you experience memories or flashbacks of abuse, if you experience any feelings, even positive ones ("I don't deserve good things"); after you speak to your father, after visits or calls from your mother. You struggle to express yourself and to set boundaries with your family and with people in general. You tend to avoid social situations and live quite a restricted life, including avoiding intimate relationships. You continue to be preoccupied with the death of your sister as the guilt ("I did the wrong thing") has blocked your ability to grieve, and the anniversary of her death and her birth-day lead to increased periods of dissociation.

Despite all these difficulties, you are an extremely resilient person. You have a great
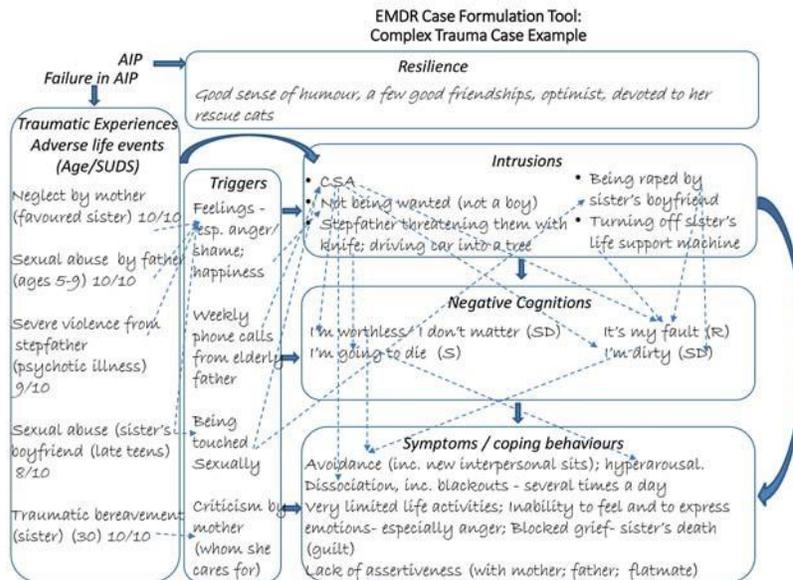
FIGURE 4. EMDR case formulation complex trauma case example.

Note. EMDR = eye movement desensitization and reprocessing.

sense of humor and we frequently laugh in sessions. You are an optimist and able to see the positive side of a situation and of people. You have some good friendships, and you are devoted to the maltreated cats that you have rescued.

PTSD, Emotional Instability, and Narcissistic Presentation (Male, 50s)

The EMDR Case Formulation Tool was used to formulate this clinical case who was referred to secondary care mental health services by his General Practitioner because he was presenting with high levels of distress and who had struggled to engage with mental health services in the past. The diagrammatic formulation (see Figure 5) was developed collaboratively with the client, a few months into the therapy, as a way of trying to disentangle the many facets of complexity in the presentation. (In the hand-drawn original diagram, the hypothetical arrows were present; however, there were too many to include in the digital diagram, as it would make it too confusing).

Narrative Formulation. A narrative formulation was developed on the basis of the diagram and shared with the client.

You had a difficult start in life characterized by rejection and loss, which continued throughout your childhood and then into your army career. One understanding is that as a result of these unprocessed traumas, when you are exposed to certain situations, such as being humiliated (e.g.,

in a work place situation), being rejected (e.g., by a girlfriend), any reminders about armed forces, or driving triggers or mention of the accident, you experience intrusive memories (flashbacks, nightmares) of these traumas—especially the humiliating punishments by your stepfather, the harsh treatment and abuse within the army, the car accident in which your friend was killed, and being discharged from the army. These bring up negative self-beliefs such as: I'm vulnerable/I must not show vulnerability; I'm power- less; I'm unsafe. It's my fault—I ruin everything; I'm unlovable/I'm bad/I don't belong.

As well as making you feel under constant threat (hypervigilant and hyperalert), this may cause you difficulties such as extreme feelings of self-hatred, alcohol and drug abuse, and dissociation to cope with overwhelming feelings and numb out; self-harm to numb and punish your- self, difficult interpersonal dynamics where you feel the need to rescue and then feel rejected and in order to protect yourself you feel the need to act tough and superior to others. You are afraid of current situations in which you might appear weak or might be rejected and you are terrified of aging as it might make you vulnerable and dependent on others.

Although you have all these difficulties, you have strengths and positive experiences: you have a sense of having been loved by your grand- parents, you recognize that you are a quick learner and can pick up things quickly in new
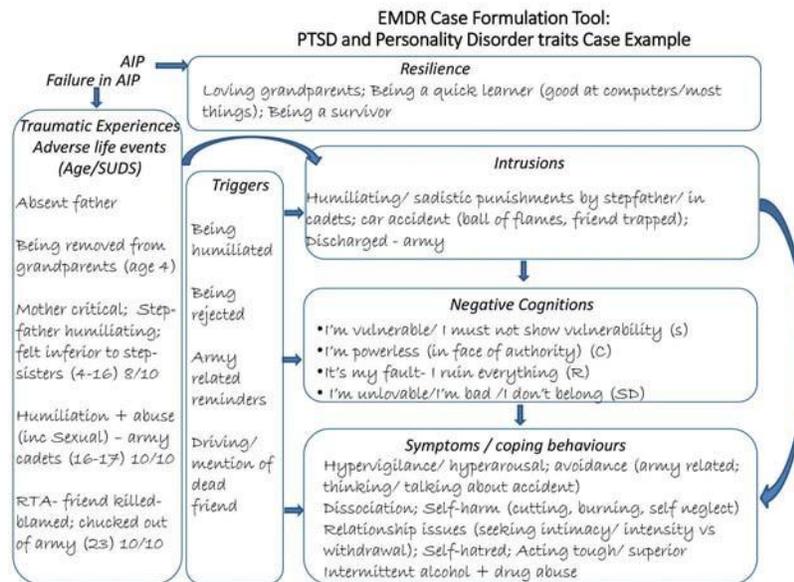
FIGURE 5. EMDR case formulation PTSD and PD traits case example.

Note. EMDR = eye movement desensitization and reprocessing; PD = personality disorder; PTSD = posttraumatic stress disorder.

work places and you see yourself as a survivor—"I've survived worse." All this gives you a lot of resilience.

Discussion

The EMDR Case Formulation Tool was developed over a period of about 2 years, with feedback from local EMDR therapists and clients. As a result of the feedback, the tool is considerably more comprehensive with the addition of a section for positive experiences and resilience as well as for triggers. Through its use in clinical practice and in supervision and case consultation, the tool has helped to share with clients an understanding of their current difficulties and how it relates to past experiences and can help in the creation of a coherent narrative.

One of the strengths of this tool is that it can be used to formulate any clinical presentation where EMDR therapy is being used. Case examples given above illustrate its use with some of these, including a simple PTSD case, a complex PTSD case, and a mixed PTSD and personality disorder presentation. The tool is helpful in each case helping to map the links between the current difficulties and their traumatic origins. For example, in the case example of the client with PTSD and some personality disorder traits (emotionally unstable and narcissistic traits), it seems that is clear the emotionally unstable personality traits to do with traumas of rejection and abandonment and negative beliefs around "I'm unlovable" and "I don't

belong." The narcissistic traits are more about humiliating experiences and beliefs such as "I mustn't show vulnerability." The PTSD, on the other hand, is more about lack of safety.

This tool can be used to aid treatment planning in a variety of ways. For example, it can be used to high-light resources that can be installed as well as perhaps a lack of resources, suggesting that more resources may need to be developed and installed. It can high-light issues in current functioning that may need to be addressed directly in the stabilization phase, for example, difficulties sleeping that might respond to some psycho-education, dissociation that may need to be addressed with grounding. The formulation allows for the identification of negative beliefs linked to each memory and underpinning specific current difficulties; as well as current triggers.

Through the linking of negative beliefs and specific symptoms, the function of the symptom can be more clearly understood. For example, the behavior of not going out could be underpinned by the negative belief "I'm in danger," therefore the function is to keep the person safe; or in another case by the belief "I'm out of control" and it being more about keeping others safe. Self-harm might be underpinned by the negative belief "I deserve bad things" or by a belief "I'm overwhelmed/I can't cope" and thus serve different functions. Understanding the function of the symptom/ behavior is extremely helpful in planning treatment. Importantly, the formulation can be used to identify target memories for processing by identifying

memories that are causing the current disturbances and intrusions.

Although the tool has its own diagrammatic formulation that has clinical usefulness, one of the its main strengths is its simple understanding of how to formulate within the AIP model by linking the six key components: unprocessed traumatic experiences, triggers, intrusions, negative cognitions, symptoms, and resilience as it applies to each clinical case. Once clinicians understand the tool, they can draw their own versions, maybe on a large piece of paper, perhaps in different colors, using suggested causative arrows to link the different elements.

It is argued, that the EMDR Case Formulation tool described here is a valuable addition to the existing tools. It is a visual, working tool which provides an easy-to-use approach to case formulation within the AIP model. Other visual ways of conceptualizing cases within EMDR do exist, namely Leeds' case conceptualization (2017), Jarecki's (2014) Seed and Weed Technique and the de Jongh et al. (2010) two method approach. Compared to these other published diagrammatic case conceptualizations, this tool seems both comprehensive and simple to use, therefore it seems to have clinical utility. The Case Formulation Tool includes elements of a timeline but its application is broader than other tools to that effect (e.g., Lombardo, 2012).

It was a real challenge to attempt to come up with a formulation tool that captured the complexities of the AIP model in a way that was simple enough to be used clinically. Inevitably, elements had to be left out; for example, the distinction between causative and contributory factors (Leeds, 2016), which has clinical utility. These elements could nevertheless be incorporated into the formulation and discussed with clients. An inevitable but major limitation is lack of space on a single page to do justice to each of the elements; for example, to record all the current symptoms or all the unprocessed traumatic memories. This becomes more of an issue with increasing complexity. For clients with multiple traumas and very com- plex current presentations, a diagram on a single page may not be enough and multiple formulations (organized for example around clusters of traumas) might be helpful so that the formulation is detailed enough to be clinically helpful. In my experience, clients found this very helpful and we used the multiple formulations with ease, using in the moment the one that was most relevant. Connections can be made across the different diagrams and recurrent patterns identified across clusters, memories, or symptoms.

The next stage is for the EMDR Case Formulation Tool to be evaluated in a systematic way, across clinical settings, and populations, so that its clinical useful-ness can be ascertained and perhaps revisions made. In addition, the EMDR Case Formulation Tool, as it stands, is not ideal to use with children, young people, or people with learning disabilities, and adaptations would be needed. This is a piece of work that is being considered in collaboration with child and learning disabilities specialist EMDR therapists, to be published in the future.

Conclusions

In many ways, nothing in the EMDR Case Formulation tool is new, which is as it should be given that it is a way of formulating EMDR clients within the AIP model. But what is new is the diagrammatic representation of the AIP model and the way that the formulation of the client's difficulties are mapped onto the AIP model through the six key elements. This enables looking at the whole of the clients' difficulties, making suggested causal links and connections. The tool is also very simple at its core, which means that it is robust and easy to apply.

This tool is just the beginning, and hopefully other adaptations will arise that may capture even more aspects of the AIP model or the complexities of the presentations we see in clinical settings. It will be interesting in the future to see published worked formulations using this tool with clients with OCD, chronic pain, or a myriad of other presentations. The goal is that this tool will encourage the widespread use of formulation within EMDR therapy.
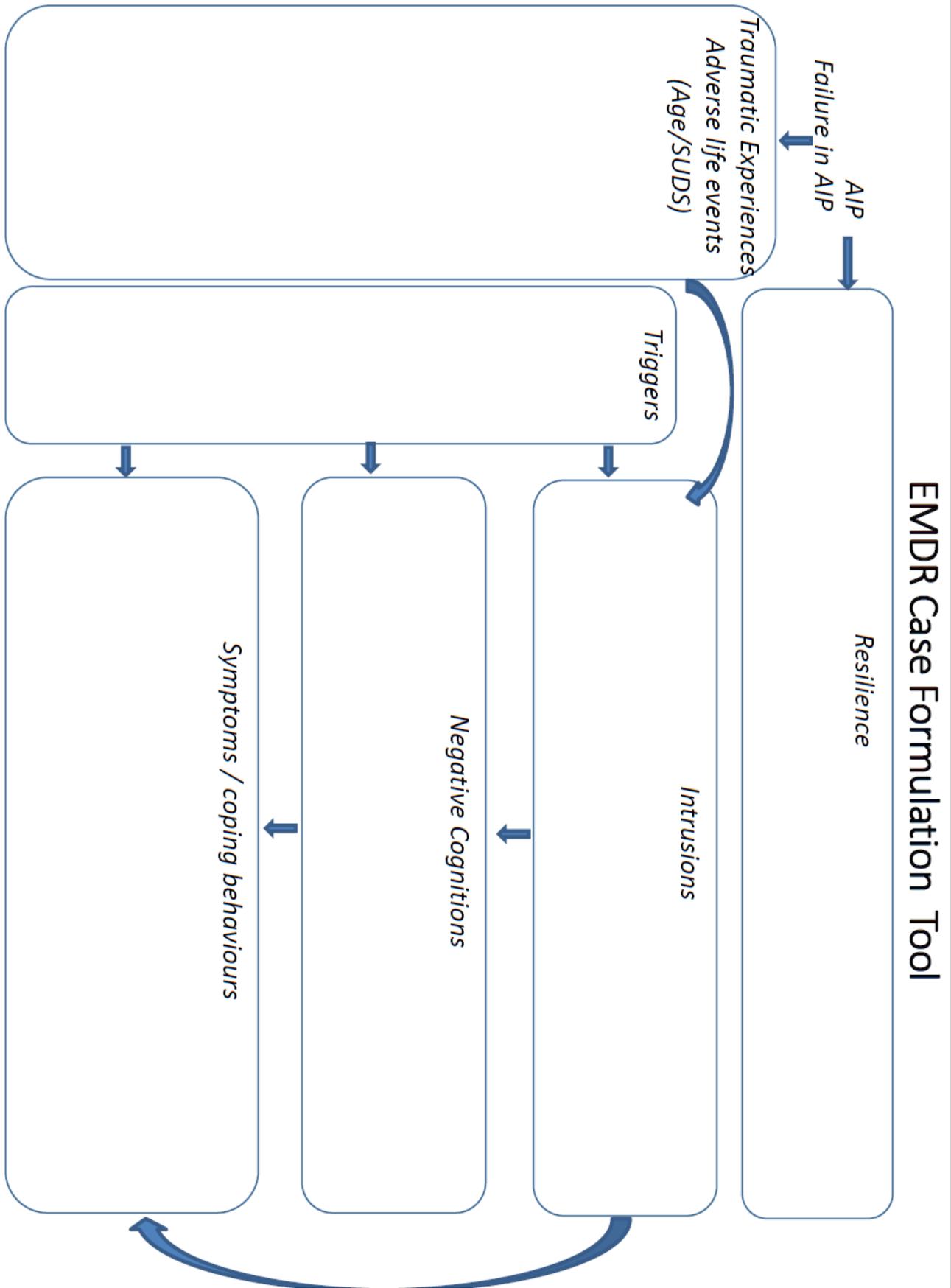
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Case Formulation Tool Template - Ines Santos
photocopyable sheet

EMDR Case Formulation Tool

AIP
Failure in AIP

Traumatic Experiences
Adverse life events
(Age/SUDS)

Triggers

Resilience

Intrusions

Negative Cognitions

Symptoms / coping behaviours

A competence framework for Eye Movement Desensitisation and Reprocessing (EMDR) therapy

Supporting document

Developed in partnership with Health Education England

Developing people
for health and
healthcare

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The competences described in this report are designed to be accessed online and should be downloaded from the [University College London (UCL) website](#).

www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks-18

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Expert reference group (ERG)

The work was overseen by an Expert Reference Group, whose invaluable advice, editorial comments and collegial approach contributed enormously to the development of the work. The ERG comprised:

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Contents

Executive summary

The report describes a method for identifying competences for practitioners deliveringeye movement desensitisation and reprocessing (EMDR) therapy. It organises the competences into six domains:

- The first domain identifies **core professional competences** – the knowledge andskills needed to operate in a professional context.
- The second domain (**generic therapeutic competences**) identifies the competences required to manage clinical sessions and engage clients in a psychological intervention. It also identifies the competences for assessing andmanaging risk.
- The third domain identifies the areas of **generic knowledge** that professionals willneed when working with people with post-traumatic stress disorder (PTSD), including knowledge of trauma and dissociation.
- The fourth domain is **EMDR-specific knowledge** of the Adaptive Information Processing (AIP) model
- The penultimate domain sets out **EMDR interventions**, and so details the eight phases of the standard EMDR protocol, as well adapting the EMDR protocol in thecontext of mental health presentations additional to PTSD, and the use of EMDR with complex PTSD.
- The final domain identifies **meta-competences** – overarching, higher-order competences that practitioners need to use to guide the implementation of any assessment or intervention.

The report then describes how the competences are organised into a 'map', which shows how the competences fit together and inter-relate. Finally, it addresses issuesthat are relevant to the implementation of this competence framework for EMDR therapy (referred to as 'the Framework), and considers some of the organisational issues around its application.

How to use this document

This report describes the model underpinning the Framework, and indicates the various areas of activity that, taken together, represent good clinical practice. It alsodescribes how the Framework was developed and how it may be used.

The report does not include the detailed descriptions of the competences associatedwith each of these activities. These are available to download as PDF files from the [website of the Centre for Outcomes Research and Effectiveness](#) (CORE) at UCL.

Scope of the Framework

The Framework is relevant to clinicians delivering EMDR therapy for individualspresenting with PTSD.

Supervision clearly plays a critical role in supporting the development of competences,and the ability to make use of supervision is included in the Framework. Competencesassociated with the delivery of supervision are detailed in a separate framework, available at the UCL website (www.ucl.ac.uk/core/competence-frameworks).

The development of the Framework

Oversight and peer-review

The work described in this project was overseen by an expert reference group (ERG)comprising experts in EMDR therapy, selected for their expertise in research, trainingand service delivery. As well as face-to-face meetings, the ERG advised on process,and debated and reviewed materials as they emerged.

Adopting an evidence-based approach to framework development[1]

A guiding principle for the development of previous frameworks (Roth and Pilling, 2008) has been a commitment to staying close to the evidence base for the efficacy of

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[1] An alternative strategy for identifying competences could be to examine what workers in routine practice do when they carry out a psychological intervention, complementing the observation with some form of commentary from theworkers to identify their intentions as well as their actions. However, the strength of this method – that it is based onwhat people do when putting their competences into action – is also its weakness. Most psychological interventionsare rooted in a theoretical framework that attempts to explain human distress, which usually links to a specific set ofactions aimed at alleviating the client's difficulties. It is these more 'rigorous' versions of an intervention that are examined in a research context, forming the basis of any observations about the efficacy of an approach or intervention. In routine practice, these 'pure' forms of an intervention are often modified as workers exercise their judgment in relation to their sense of the client's need. Sometimes this is for good, sometimes for ill, but presumablyalways in ways that do not reflect the model they claim to be practising. This is not to prejudge or devalue the potential benefits of eclectic practice, but it makes it risky to base conclusions about competence on the work done by practitioners, because this could pick up good, bad and idiosyncratic practice.

therapies, focusing on those competences for which there is either good researchevidence or strong expert professional consensus about their probable efficacy.

Extracting competence descriptions

The procedure for extracting competences started with the identification of representative trials of EMDR. The manuals associated with these trials were examined in order to extract and to collate therapist competences – a process detailedin Roth and Pilling (2008). As described above, draft competence lists were discussedand peer reviewed by members of the ERG.

EMDR therapy

EMDR therapy is an empirically validated therapy that can be used to treat people presenting with PTSD (as well as with trauma in the context of other presentations).

EMDR therapy is carried out in eight phases and follows a standard protocol and procedure. These phases include a comprehensive assessment, client preparationand processing of:

   a) past events that underpin current difficulties
   b) current disturbing situations
   c) future challenges.

A consistent (and recurrent) focus on the past, present and future is referred to as the'three prongs' of EMDR.

A central feature of the processing phases of EMDR is the use of dual attention stimuli(referred to as bilateral stimulation), usually in the form of bilateral eye movements, butalso as bilateral taps or bilateral auditory stimuli (such as tones, beats or buzzes).

EMDR therapy is guided by the AIP model, developed by Francine Shapiro (Shapiro, 2018). This posits that just as there is an innate process for healing physical injury, there is an innate process for healing psychological injury, and this can become blocked when a person is subjected to traumatic events that are too overwhelming to process in the normal adaptive way. Instead, the high level of arousal engendered by distressing life events causes them to be stored differently with the original emotions, physical sensations and beliefs, which remain unintegrated into the rest of the memorynetwork. As a result, they continue to be re-experienced in the form of flashbacks, nightmares and intrusive thoughts that are characteristic of PTSD.

Three dominant hypotheses have been proposed as mechanisms of action of EMDR –that the eye movements a) tax working memory, b) elicit an orienting response, and c)link into the same processes that occur during rapid eye movement sleep.

According to the AIP model, current experiences can trigger unprocessed emotions, physical sensations and beliefs linked to memories of adverse life experiences. When

the past becomes present and clients react with symptoms associated with PTSD, it isbecause their perceptions of current situations are driven by unprocessed memories.

Processing of targeted memories using the three-pronged EMDR therapy protocol is assumed to transfer them from implicit memory to explicit and semantic memory systems (in other words, moving from fragmented, decontextualised sensory experiences associated with the traumatic event to a meaningful narrative that can be stored in memory in the normal way). As the targeted memory is integrated with more adaptive information, the associated negative emotions, physical sensations and beliefs are altered, resulting in affects, somatic experiences and cognitions that are nolonger disturbing.

EMDR reprocessing sessions promote an associative process that reveals the connections of memories that are being triggered by current life experiences; the aim is to help the client to access an adaptive memory network. This contrasts with other therapies (particularly cognitive behavioural therapy [CBT]), which involve extended focused attention on the disturbing event and associated automatic negative thoughts,and which aims to restructure these cognitions by challenging the evidence used to support them.

The competence model for EMDR therapy

Organising the competence lists

Competence lists need to be of practical use. To achieve this, they need to be structured in a way that reflects the practice they describe, be set out in a way that isboth understandable and valid (that is, recognisable to practitioners as accurately representing the approach, both as a theoretical model and in terms of its clinical application).

Figure 1 shows the six domains into which the competences have been organised.

The first domain identifies **core professional competences** – the knowledge andskills needed to operate in a professional context.

The second domain (**generic therapeutic competences**) identifies the competencesrequired to manage clinical sessions and engage clients in any psychological intervention.

The third domain identifies the areas of **generic knowledge** that professionals will need when working with people with PTSD – specifically, knowledge of mental healthconditions, and knowledge of trauma.

The fourth domain is **EMDR-specific knowledge** of the AIP model.

The penultimate domain sets out **EMDR interventions**, and so details the eight phases of the standard EMDR protocol, as well as adapting the EMDR protocol in thecontext of mental health presentations additional to PTSD, and the use of EMDR withcomplex trauma.

The final domain in the model focuses on **meta-competences**, so-called because theypermeate all areas of practice, from 'underpinning' skills through to specific interventions. Meta-competences involve making procedural judgments – for example,judging if and when something needs to be done, or judging the ways in which an action needs to be taken or to be modified. They are important because these sorts of judgments are seen by most clinicians as critical to the fluent delivery of an intervention; effective implementation takes more than the rote application of a simple set of 'rules', and so meta-competences attempt to spell out some of the more important areas of judgment being made.

Core professional competences

Generic therapeutic competences

Generic knowledge of trauma

EMDR-specific knowledge

EMDR interventions

Phases 1-8 of the standard protocol

Adapting EMDR for managing trauma inthe context of different mental health presentations

Adapting EMDR for managing complex PTSD
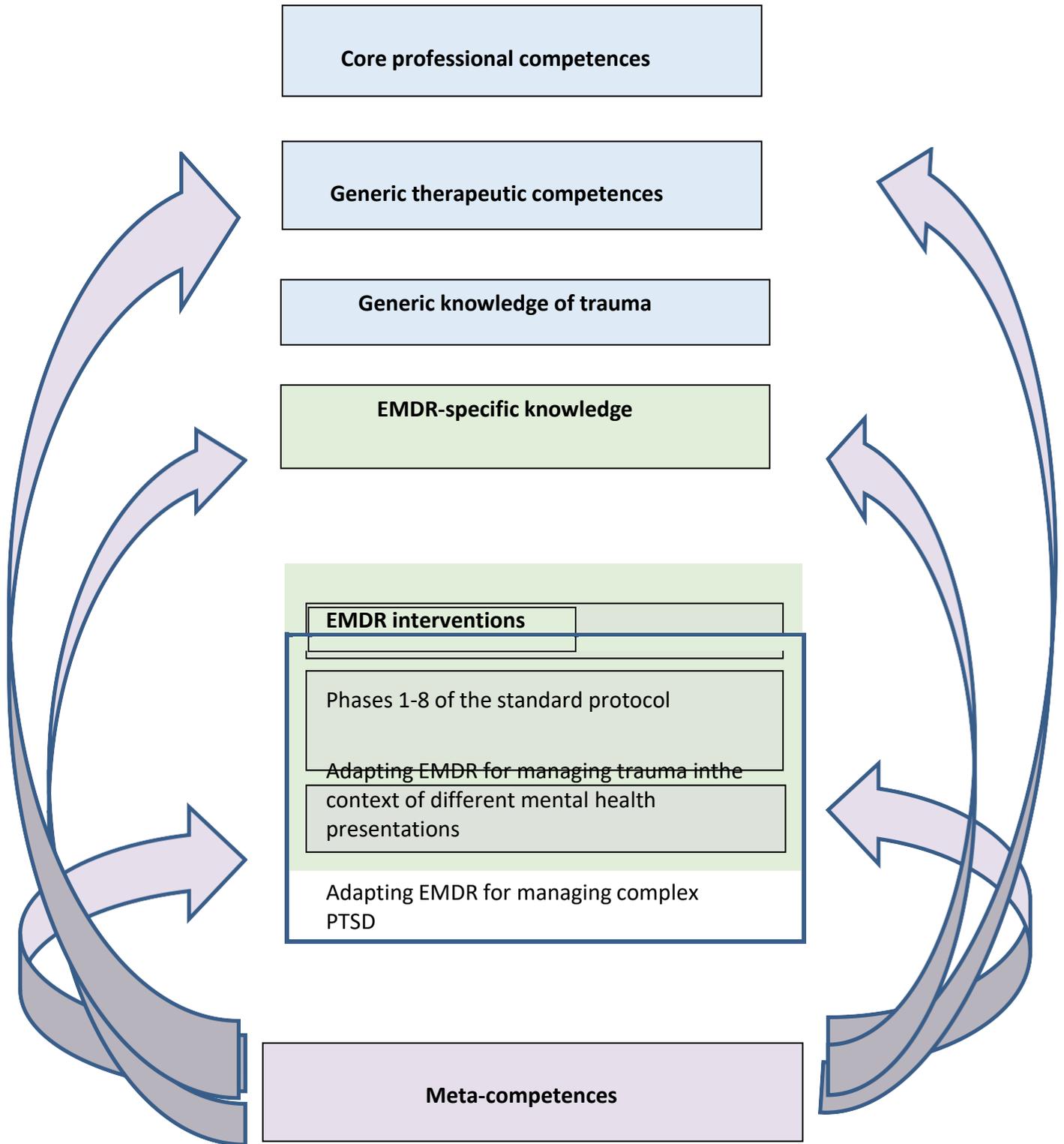
Meta-competences

Figure 1: Outline model for the Framework

Integrating knowledge, skills and attitudes

A competent worker brings together knowledge, skills and attitudes. It is this combination that defines competence; without the ability to integrate these areas,practice is likely to be poor.

Clinicians need background knowledge relevant to their practice, but it is the ability todraw on and apply this knowledge in clinical situations that marks out competence.
Knowledge helps the practitioner understand the rationale for applying their skills, to think not just about *how* to implement their skills, but also *why* they are implementing them. Beyond knowledge and skills, the clinician's attitude to and stance on an intervention is also critical – not just their attitude to the relationship with the client butalso to the organisation in which the intervention is offered, and the many cultural contexts within which the organisation is located (including a professional and ethical,as well as societal, context). All of these need to be held in mind because all have a bearing on the capacity to deliver interventions that are ethical, conform to professional standards, and that are appropriately adapted to the client's needs and cultural contexts.

The map of competences

Using the map

The map of competences is shown in Figure 2. In the map, the competences have been organised into the six domains outlined above and in Figure 1, and shows the different activities which, taken together, constitute each domain. Each activity is madeup of a set of specific competences. The details of these competences are not included in this report, but can be downloaded from the UCL website. (www.ucl.ac.uk/core/competence-frameworks).

The map shows how the activities fit together and how they need to be 'assembled' forpractice to be proficient.

Layout of the competence lists

Specific competences are set out in boxes.

Most competence statements start with the phrase, 'An ability to…', indicating that thefocus is on the clinician being able to carry out an action.

Some competences are concerned with the knowledge that a practitioner needs so that they can carry out an action. In these cases, the wording is usually, 'An ability todraw on knowledge…'. The sense is that clinicians should be able to draw on their

knowledge, rather than having knowledge for its own sake (hence, the competencelies in the application and use of knowledge in the furtherance of an intervention).
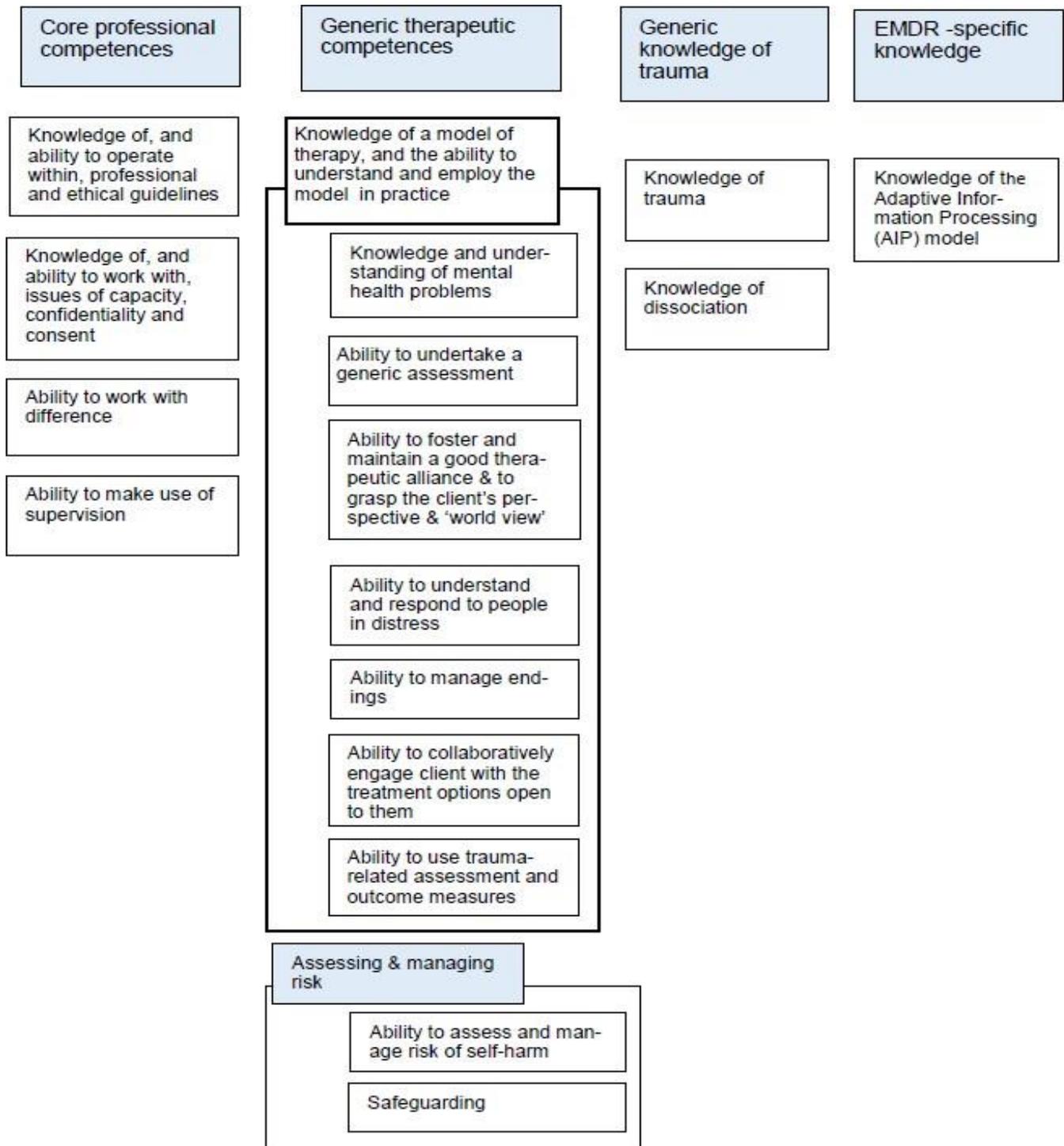
As far as possible, the competence descriptions are behaviourally specific, and so arethere to identify what the clinician needs to do to execute the competence.

Some of the boxes are indented, when a high-level skill is introduced and needs to be'unpacked'. In the example below, the high-level skill is being 'collaborative and empowering'; the indented boxes that follow are concrete examples of what the clinician needs to do to achieve this.

An ability to work in a manner that is consistently collaborative and empowering, by:
translating technical concepts into plain language that clientscan understand and follow
taking shared responsibility for developing agendas and session content

The competences in indented boxes will make most sense if the clinician holds in mindthe high-level skill that precedes them. So, regarding the first indented box of the above example, although using plain language is always a sensible thing to do, there is a very good conceptual reason for emphasising its use here: it will impact on (and, therefore, contribute to) clients' sense of collaboration in and engagement with the therapy process. Bearing in mind that the conceptual idea behind an action should give the clinician a 'road map', and reduce the likelihood that they apply techniques by rote.

A competence framework for eye movement desensitisation and reprocessing (EMDR) therapy

Core professional competences	Generic therapeutic competences	Generic knowledge of trauma	EMDR -specific knowledge

Core professional competences

- Knowledge of, and ability to operate within, professional and ethical guidelines
- Knowledge of, and ability to work with, issues of capacity, confidentiality and consent
- Ability to work with difference
- Ability to make use of supervision

Generic therapeutic competences

- Knowledge of a model of therapy, and the ability to understand and employ the model in practice
  - Knowledge and understanding of mental health problems
  - Ability to undertake a generic assessment
  - Ability to foster and maintain a good therapeutic alliance & to grasp the client's perspective & 'world view'
  - Ability to understand and respond to people in distress
  - Ability to manage endings
  - Ability to collaboratively engage client with the treatment options open to them
  - Ability to use trauma-related assessment and outcome measures

Generic knowledge of trauma

- Knowledge of trauma
- Knowledge of dissociation

EMDR -specific knowledge

- Knowledge of the Adaptive Information Processing (AIP) model

Assessing & managing risk

- Ability to assess and manage risk of self-harm
- Safeguarding

EMDR interventions

Meta-competences

EMDR meta-competences

Initial phases of EMDR

EMDR processing phases

Phase 1: AIP-informed history-taking, case formulation and treatment planning

Phase 2: Preparation

Phase 3: Assessment of target memory

Phase 4: Desensitisation

Phase 5: Installation of positive beliefs

Phase 6: Body scan

Phase 7: Closure

Phase 8: Re-evaluation

Adapting EMDR for managing trauma in the context of different mental health presentations
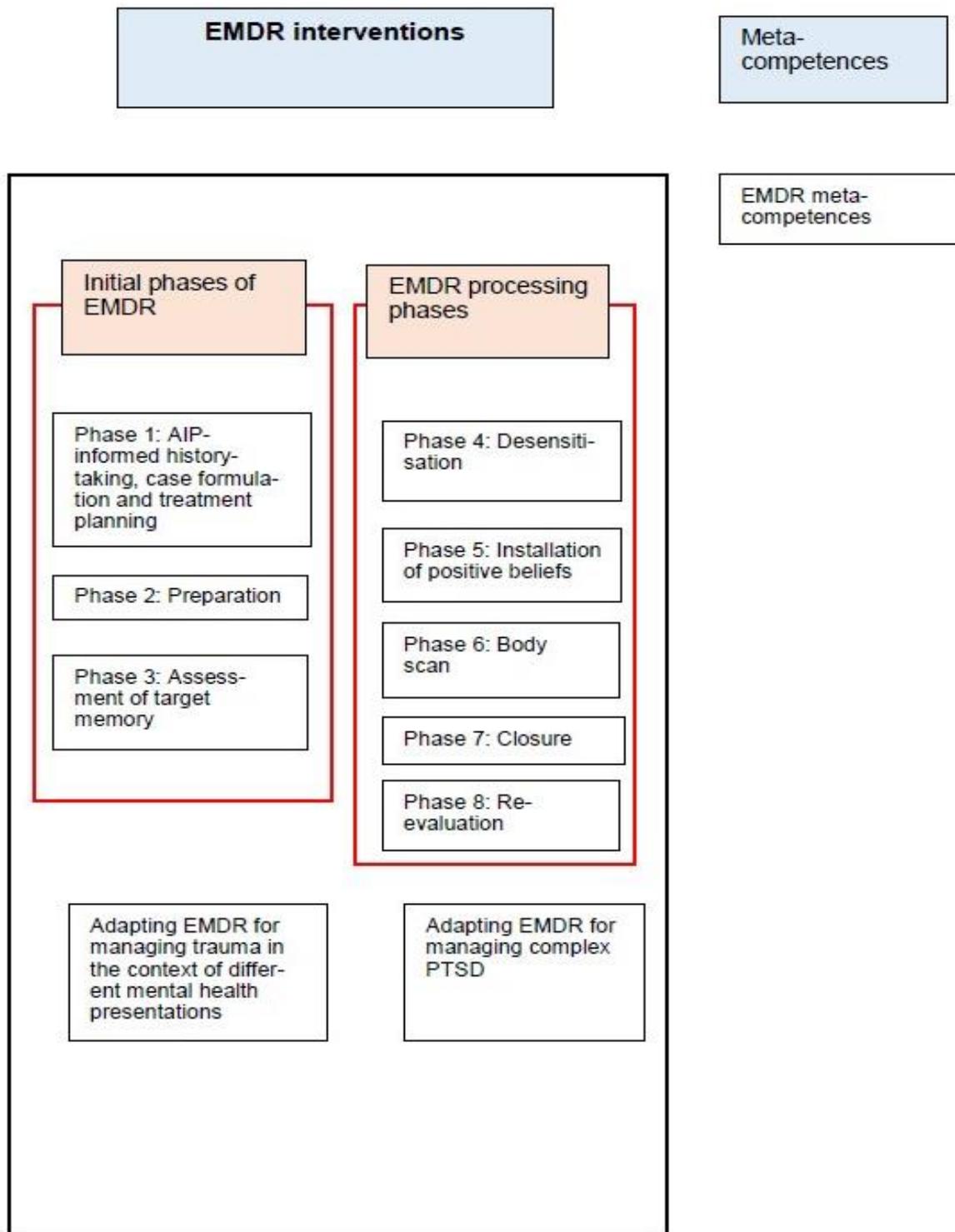
Adapting EMDR for managing complex PTSD

Figure 2: The map of EMDR therapy competences

The contribution of training and supervisionto clinical outcomes

Elkin (1999) highlighted that when evidence-based therapies are 'transported' into routine settings, there is often considerable variation in the extent to which training and supervision are recognised as important components of successful service delivery. Roth, Pilling and Turner (2010) examined 27 major research studies of CBT for depressed or anxious adults, identifying the training and ongoing supervision associated with each trial. They found that trialists devoted considerable time to training, monitoring and supervision, and that these elements were integral to treatment delivery in clinical research studies. It seemsreasonable to suppose that these elements make their contribution to headline figures for efficacy – a supposition obviously shared by the researchers themselves, given the attention they pay to building these factors into trial design.

It may be unhelpful to see the treatment procedure alone as the evidence-basedelement, because this divorces technique from the support systems that help to ensure the delivery of competent and effective practice. This means that claims of implementing an evidence-based therapy could be undermined if the training and supervision associated with trials is neglected.

Applying the Framework

This section sets out the various ways that the Framework can be used, and describes the methods by which these may be achieved. Where appropriate, itmakes suggestions for how relevant work in the area may be developed.

Commissioning EMDR training

In relation to training, the Framework identifies the mix of generic therapeuticcompetences and EMDR-specific competences that a competent practitionerneeds to demonstrate.

A core professional training in a psychological therapy and experience of delivering the therapy is a prerequisite for entry into EMDR foundation training. This is in line with the training and background of EMDR therapists employed inthe clinical trials which have demonstrated the efficacy of EMDR therapy, and isconsonant with the accreditation standards of EMDR Association Europe.

Supervision

Supervision is critical to maintaining fidelity to the EMDR model and to assure itseffective and safe delivery. EMDR therapists should be supervised by individuals

with sufficient training in, and experience of, EMDR, and services will need toensure that supervisors meet these criteria.

Used in conjunction with the competence framework for supervision, the Framework is potentially a useful tool to improve the quality of supervision of EMDR. It does this by focusing the task of supervision on a set of competencesthat are known to be associated with the delivery of effective treatments. Supervision commonly has two aims – to improve outcomes for clients and to improve the performance of practitioners. The Framework will support both these,through:

- providing a structure by which to identify the key components of effective practice
- allowing for the identification and remediation of suboptimal performance.

The Framework can achieve this through its integration into professional trainingprogrammes and through the specification for the requirements for supervision inboth local commissioning and clinical governance programmes.

Commissioning services

The Framework can contribute to the effective use of healthcare resources by enabling commissioners to specify the appropriate levels and range of competences that need to be demonstrated by workers to meet identified local needs. It could also contribute to the development of more evidence-based systems for the quality monitoring of commissioned services by setting out a framework for competences that is shared by both commissioners and providers,and which services could be expected to adhere to.

Service organisation – the management and delivery of services

The Framework represents a set of competences that (wherever possible) areevidence based, and it aims to describe best practice for the activities that individuals and teams should follow to deliver interventions.

Although further work is required on the competences' utility and on associatedmethods of measurement, they should enable:

- the identification of the key EMDR competences that a practitioner needs
- the likely training and supervision competences of people managing and delivering the service.

Because the Framework converts general descriptions of clinical practice into a set of concrete specifications, it can link advice for the implementation of EMDR(as set out in National Institute for Care Excellence or Scottish Intercollegiate

Guidelines Network guidance, or National Service Frameworks, along with othernational and local policy documents) with the interventions that are delivered.

Further, this level of specification carries the promise that the interventions delivered within NHS settings will be closer in form and content to those of the research trials on which claims for the efficacy of specific interventions rest. In this way, it could help to ensure that evidence-based interventions are likely to beprovided in a competent and effective manner.

Clinical governance

Effective monitoring of the quality of services provided is essential if service users are to be assured of optimum benefit. Monitoring the quality and outcomesof interventions is a key clinical governance activity; the Framework allows providers to ensure that EMDR interventions are provided at the level of competence that is most likely to bring real benefit by allowing for an objective assessment of clinician's performance.

Concluding comments

This report describes a model that identifies the activities that characteriseeffective delivery of EMDR and locates them in a 'map' of competences.

The work has been guided by two overarching principles. First, the Framework stays close to both the evidence-base and expert professional judgment, meaning that an intervention carried out in line with the competences described in the model should be close to best practice, and therefore is likely to result in better outcomes for service users. Second, it aims to have utility for the people who use it, clustering competences to reflect how interventions are delivered, andtherefore facilitating their use in routine practice.

Putting the model into practice – as an aid to curriculum development, training, supervision, quality monitoring or commissioning – will test its worth, and indicatethe ways in which it needs to be developed and revised. However, implementation needs to be holistic: competences tend to operate in synchrony, and the model should not be seen as a 'cook book'. Delivering effective interventions involves the application of parallel sets of knowledge and skills, andany temptation to reduce it to a collection of disaggregated activities should be avoided. Clinicians need to operate using clinical judgment in combination with their technical and professional skills, interweaving technique with a consistent regard for the relationship between themselves and service users.

Setting out competences in a way that clarifies the activities associated with a skilled and effective practitioner should prove useful for clinicians training in, anddelivering, EMDR therapy. The more stringent test is whether it results in more effective interventions and better outcomes for clients.

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Competency framework documents (accreditation forms)
Advice from the Accreditation Committee

The first edition of this book contained full copies of each of the accreditation forms used by the EMDR Association UK. This second edition does not include them for the following reasons:

- There are now more forms and to include them all would take up a considerable amount of space in this book.
- The forms can be easily downloaded and printed from the Association's website if necessary.
- Forms may be updated and there is a danger of an out-of-date form being used if it is published in this book.

However, there follows a summary of these forms and some general points regarding how to complete the forms as of October 2021 when this book was printed:

The general page regarding EMDR accreditation can be found on the EMDR Association website as follows:

- www.emdrassociation.org.uk/become-an-accredited-therapist/accreditation
- or by starting from the Home Page and then clicking 'For Professionals' → 'Accreditation'

For **Practitioner Accreditation** there are separate forms for:
- Practitioner Accreditation. There are now two options as follows:
  - Original Practitioner form
  - New 'Algorithm' form (you can also download an additional Algorithm spreadsheet for automatic scoring)
- Child and Adolescent (C&A) Practitioner Accreditation

For **Consultant Accreditation** the same form is used for Generic Consultants as for C&A Consultants with a separate second form for the second reference.

For **re-accreditation** (5 years after accreditation or previous re-accreditation) as either a Practitioner or Consultant, click on the 're-accreditation' box on the Accreditation page of the website. Then scroll down and click on 'Re-accreditation criteria updated Aug 2021 (PDF)' which will open the form to be completed.

It should be noted that each application for accreditation/re-accreditation should be a single document or folder prior to submission to the association administrators. and it is for this reason that these forms have been created in order for this to be done as easily as possible.

The accreditation committee are all experienced EMDR Consultants working on a voluntary basis. They prefer not to read a vast document but nor do they want to see a reference for accreditation that just says, 'yes, yes, yes, done that, yes ....' The committee want to see that you know your supervisee, their work and have witnessed their competence.

The forms in use in October 2021 were designed on a Mac and intended to be used with free pdf software on Windows or Apple devices. If you do have paid pdf software, please do not allow the text to run beyond the box provided on the form. There is a page at the end for additional information, but the boxes have generally been sized, not just to fit on the page harmoniously, but to be large enough to take the expected amount of text.

If you are asking your supervisees to draft their own reference, be sure that you warn them that they do not have to write an essay proving their competencies. The fact that you are agreeing to put them forward means they have already demonstrated to you they are ready/close to ready. Ask them to be succinct and draft it on a Word document so that you can go over it together. You can then edit it and take forward the main points you both agree on. Make sure it will fit in the box provided, then cut and paste it onto the form.

Please be aware that once the document is signed, it cannot be edited, so make sure and leave signing to the end.

NHS EMDR Consultant Support Group

A UK wide NHS EMDR Consultant support group was set up in 2021 under the auspices of the EMDR Association. There are representatives from primary and secondary care services as well as CAMHS and other NHS services in the group.

The aim of the group is to provide a forum for the support of, and exchange of information between, any EMDR accredited Consultants who work in the NHS and private Consultants who supervise EMDR therapists who work in the NHS.

Members can bring any NHS EMDR related issue, including issues relating to accreditation, training, supervision, new initiatives, omissions, research and new developments to the group for discussion and input. It is also envisaged that if NHS England or NICE, for instance, introduce a new initiative, which relates in some way to EMDR, that the group can provide a unified response, hopefully with the backing of the EMDR Association.

We meet quarterly on a Thursday evening. The group is a vibrant, well attended one. Feedback so far is that meeting in this way helps individual Consultants feel less isolated.

If you wish to become a member of the group, please email **carolynstone@btinternet.com** in the first instance.

EMDR NEW SUPERVISEE CHECKLIST
Marian Tobin

All New Supervisees:

- Core Professional background; current registration/accreditation

- EMDR Trainer, ensure Europe accredited trainer

- Date of completion of EMDR Training – certificate

- Current clinical work context statutory, voluntary, private

- CPD to date

- Working towards becoming an accredited practitioner?

Supervisee working towards EMDR Practitioner accreditation:

- All the above

- Name of previous EMDR Accredited clinical supervisor

- Number of cases, clinical activity to date, signed by previous supervisor

- Clinical specialism

- C&A – check child training, requires C&A consultant supervision

- CPD- EMDR & other

- Conference attendance

- EMDR activity; regional group, peer group, etc

- Obtain evidence of clinical competence, current video material

Supervisee working towards EMDR Consultant accreditation:

- All the above

- Clinical activity to date, signed by previous supervisor

- Supervision received

- Provision of clinical supervision – individual & group

- Ensure understanding regarding the standing of their supervision, cannot be counted towards supervisees accreditation

- Obtain evidence of clinical competence, current video material

- EMDR specialism, is supervision provided within supervisees area of knowledge/expertise

- C&A - check child training, requires C&A consultant supervision

- Date of consultant training and certificate or feedback list

- EMDR activity: regional group, peer group, publications, presentations etc

- Understanding of accreditation process, competency framework

- CPD - EMDR & other

- EMDR National/European conference

- Consultant Day

NB: Applications for accreditation as a practitioner or consultant must have client case list(s)signed by an EMDR Consultant

New Supervisee Accredited Practitioner/Reaccreditation:

- Name of previous EMDR Consultant clinical supervisor

- Date of Practitioner Accreditation

- Current hours of clinical practice

- EMDR specialism/ clinical expertise

- EMDR Activity: Research, SIG, Peer/Regional Groups etc

- CPD, EMDR Conference

New Supervisee Accredited Consultant/ Reaccreditation:

- Name of previous EMDR Consultant clinical supervisor, potential second reference

- Date of Consultant Accreditation

- Current hours of clinical practice

- Current provision of clinical supervision – individual /group

- EMDR specialism/ clinical expertise

- EMDR Activity: Research, SIG, Peer/Regional Groups etc

- CPD, EMDR Conference, EMDR Consultant Day

Supervision – Case Presentation (Sian Morgan)

Complete each question as it applies to your case. If you have not yet started processing using EMDR, complete the first 5 sections.

Supervision Question:

1. Problems and Symptoms
- What problems and symptoms does the client have?
- Onset – when did they start?
- Has the client experienced similar problems in the past?

2. Current Situation
- What brings the client for treatment now?
- What is the client's present life situation e.g. work, relationships, social networks etc?

3. History (brief summary relevant to symptoms and problems)
- Family background
- Trauma history

4. Case Formulation
- The client's understanding of why they have the problem
- Your assessment of the client's problem

5. Treatment Plan
- **What are the client's goals?**
- **What are the probable EMDR targets?**

6. Preparation: Safe Place, Resources etc.

7. EMDR Target   (for supervision)

Worst part (image or other)

Negative Cognition

Positive Cognition

VOC

Emotions

SUDS

Body Sensations

What type of BLS? Eye movements, tapping, auditory or tactile

Process:

Give a brief description of what happened in the EMDR process and outcome

© *Sian Morgan 2012*

Some notes on EMDR supervision in groups

Robin Logie

In my experience, providing EMDR supervision in groups can be both rewarding for the supervisor and enriching for the supervisees. Here are some notes, specific to EMDR, on what one needs to consider when providing EMDR supervision in a group setting.

Types of groups
Firstly, one needs to consider what type of group one will be running. This will depend on a number of factors including:
- the developmental stage of the supervisees in terms of their experience of EMDR
- the demands of the context in which the group has been set up
- the time pressures and demands of each particular group meeting

Proctor (2008) describes four types of groups as follows
1. Authoritative group - supervision <u>in</u> a group
2. Participative group - supervision <u>with</u> a group
3. Co-operative group - supervision <u>by</u> the group
4. Peer group – <u>not</u> supervision

In the **Authoritative Group**, the supervisor provides supervision to each supervisee in turn whilst the other supervisees are primarily observers and learners during this process. In other words it is, in fact, individual supervision with an audience.

In a **Participative Group**, the supervisor still takes prime responsibility for supervising each therapist. However, s/he also actively directs group members to co-supervise each other and comment upon each other's presentations.

In a **Co-operative Group** it the group itself which is providing the supervision. The supervisor's role is as a facilitator and supervision monitor. In the context of EMDR supervision, it should be noted that the supervisor must still take responsibility for ensuring that comments by members of the group are in accordance with EMDR protocols. In addition, as an evaluator in relation to accreditation, the supervisor will also be assessing the group members in terms of their understand of the protocol during this process.

A **Peer Group** is one in which no individual is taking on the responsibility of supervisor. Although one individual may act as chair or coordinator (a role which might revolve around the group) this person holds no responsibility as a supervisor. Such groups exist in some regions of the UK under the auspices of the EMDR Association. It should be noted that peer group supervision cannot be counted towards accreditation even if there is an EMDR Consultant present at the meeting.

The type of group that one runs will depend on a number of factors as summarised above. Firstly, one needs to consider the developmental stage of the therapists one is supervising. If, for example, the therapists have not yet completed their basic 7/8-day training in EMDR

or have only recently completed it, an Authoritative Group might be the most effective format as trainees will still be learning basic EMDR protocols and would be floundering if they were expected to comment upon each other's cases. However, in my experience, even with such groups, an element of a Participative Group can often be valuable, and I would not preclude other members of the group from commenting when one of their colleagues is presenting a case. Generally speaking, however, one would expect that, the more experienced one's supervisees are, the more appropriate it will be to run a Participative or Co-operative Group. In particular, if the group consists mainly of Consultants or Consultants-in-training, a Co-operative group would assist them in learning and practicing the skills of supervision.

A second consideration would be the context in which the group has been set up. If, for example, the group has been commissioned and funded by an NHS Trust and the contract explicitly specifies the way in which supervision will be conducted, it may be necessary to stick to running the group as an Authoritative Group.

A third consideration relates to time pressures. If, for example, the group normally works in a Co-operative way but, on a particular occasion, the supervisees have a greater than usual number of cases to discuss, there simply may not be sufficient time to involve the whole group in discussing each case and the group may need to resort to becoming an Authoritative one for the purposes of this particular meeting.

Contracting

In a group situation, it is necessary for increased formality in terms of the way in which the group is organised. Here is a list of things that the supervisor may need to consider when starting a new group:
- Ground rules & protocols
        Confidentiality, attendance, handling absences and lateness
- Role & expectations of group members
- Role and expectation of supervisor
- Expectations of stakeholders
- Structure of meetings
- Additional individual supervision. Might this be required in relation to accreditation?
- Assessment process
- Review process

Setting the group climate

Again, for groups, more care needs to be taken than for individual supervision to enable group members to feel safe. Ways of enabling this might be for:
- Participants to share hopes & fears about the group
- Supervisor to share their hopes & fears (acting as a role model)
- Asking supervisees what has been helpful of difficult about previous experiences of groups/supervision.
- Establish ground rules
- Sharing strengths and areas that supervisees need to develop
- 'What you need to know about me, for me to get the most and give the most to this group is....' (Hawkins & Shohet, 2012)

Agenda setting

At the start of each session, a few minutes needs to be set aside for agenda setting. I will therefore go round everyone in the group and ask each person to briefly say what they need to present and whether it might be a complex case which will take some detailed discussion or, perhaps, just a straightforward question about the EMDR protocol. I will prioritise time for 'emergencies', in other words, cases for which that the supervisee feels totally out of their depth and for which supervision is a matter of urgency. If the agenda is packed, an agreement might be made at the start to revert to an Authoritative Group in a group that is usually Participative or Co-operative.

<div align="center">

PROTOCOL FOR EMDR GROUP SUPERVISION
(Robin Logie, 2015)

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This specific protocol for group supervision was devised specifically for EMDR supervision in a Co-operative Group. It would not be my usual way of carrying out group supervision, but it serves to demonstrate a way in which the group can immediately be incorporated into the supervision process. This protocol has been demonstrated at several UK Consultants Trainings on which I have taught as well as at a regional event in Devon, for a group of EMDR Consultants in Belgium and at a workshop on supervision at the EMDR Europe conference in The Hague in 2016.

1. **Preamble** (can be reduced or omitted at subsequent meetings of the group)

   "Today we are all supervisors. In EMDR, the protocol allows processing to occur spontaneously. Similarly this supervision protocol should allow supervision to occur spontaneously through the interactions of members of this group. As the facilitator of this group I will only intervene if the process becomes stuck or the group needs to learn something specific about the EMDR protocol. If I do intervene, as with a cognitive interweave in EMDR, I will attempt to say the minimum necessary in order for the process of supervision to move forward."

   "In a moment I will ask one of you to volunteer a supervision question. Before you tell us any more about your client, I will ask members of the group what they would need to know about your client in order to help you with this supervision question. I will then invite the supervisee to respond with more information and ask group members to respond until the supervisee feels their question has been answered. We will then discuss what we have learned and ensure that we understand the theory that underlies this learning point."

2. Ask a member of the group to provide a supervision question (SQ). (If the supervisee starts to give information about the client or the statement does not actually constitute a question, continue to prompt the supervisee until they produce an actual question.) Repeat the SQ to ensure that you have understood it correctly and everyone is clear what the question is.

3. Ask the rest of the group: "What do we need to know in order to answer this question and help [supervisee's name]?" Make sure that everyone in the group has responded.

4. Ask supervisee to respond and provide further information. (Interrupt if the information appears irrelevant to the SQ or they are providing unnecessary detail. Remind the supervisee what information the group needs in order to help them answer their question.)

5. Ask group members to comment upon the information provided. This might involve asking further questions, ideas about the formulation or possible ways forward with the therapy. If the issue is an emotional/relational one rather than a technical one, ask, "what are people feeling/noticing/experiencing right now?"

6. Repeat 3, 4 and 5 until the supervisee appears to have resolved their issue and indicates that their SQ has been answered.

7. Check with supervisee that they feel their question has been answered and they know where they are going with this particular client.

8. Summarize what has been learned. Outline the theory behind what has been learned.

As a general rule, do not comment unless:
- you are sure that no-one else in the group knows the answer
- a group member's comment is off-protocol
- a group member's comment is inappropriately critical
- you are running out of time

Think of your intervention like cognitive interweaves i.e. 'stay out of the way' if the process is working well and only intervene if things become stuck, go off course or time is short.

Hawkins, P., & Shohet, R. (2012). *Supervision in the Helping Professions (4th Edn).* Maidenhead, UK: Open University Press.

Proctor, B. (2008). *Group Supervision. A guide to Creative Practice (2nd edition).* London: Sage.

EMDR Therapy Consultation/Supervision Agreement

Jo Scott

Sample contract

The purpose of this agreement is to establish a clear understanding of the expectations of consultation/supervision.

I provide EMDR consultation and supervision to mental health professionals and therapists who have attended Parts 1 – 4 of their basic training in EMDR therapy and who wish to develop their skills in using this approach with children, adolescents and adults. If required this can also include supporting EMDR therapists through the Accreditation process to become an EMDR Practitioner or EMDR Consultant. Consultation/supervision can be on an individual or group basis to mental health professionals from a variety of disciplines, who may be employed by NHS Trusts, other organisations, or who are in private practice. It can be provided 'in person' or 'on-line' and is usually on a 4 – 6 weekly basis.

Expectations and responsibilities of Consultation/Supervision:

- EMDR consultation/supervision should be regarded as a specialist supervision, additional to any clinical or case management supervision required by the therapist's employer, organisation or core profession. As an EMDR Consultant I do not hold clinical responsibility or liability for a supervisee's cases. As qualified and accredited mental health professionals they practice within their own professional codes of conduct and ethics and are accountable for their own practice.

- My role is to help the supervisee understand the technical aspects of integrating EMDR into the overall case conceptualization and treatment plan and to enhance their understanding of the theoretical and practical application of EMDR. This will also involve exploring and identifying with them any possible risks or contra indicators for using EMDR at a particular time or in a particular situation, in order to enhance the service offered to the client and to ensure their welfare.

- The content of consultation/supervision will focus on the acquisition of knowledge, case conceptualization and clinical skills within the EMDR therapy model and protocol. This will take the form of a variety of strategies, including constructive feedback, guidance and advice, reflective practice and consideration of the therapeutic relationship and engagement issues.

- To keep the consultee/supervisee informed of trainings, research and new developments within the EMDR and trauma related field, including identification of ongoing CPD.

- The consultee/supervisee will be expected to complete and email a Supervision Case Presentation form to the Consultant/Supervisor **prior** to the supervision session in order to clarify the supervision question and enhance the learning experience.

- If undertaking the Accreditation process the consultee/supervisee will also be expected to submit video recordings of some therapeutic sessions, or arrange for the Consultant to directly observe their practice, as per the Accreditation criteria.

Confidentiality

- All professional and clinical issues discussed are confidential and are not to be discussed outside of the supervision session. The exceptions to this are to prevent the risk of serious harm, or if required to do so in compliance with the law.
- All cases or professionals discussed during supervision must be anonymised.
- Where video recording of sessions take place this must be agreed with and have the informed, written consent of the client. Arrangements must also be made to destroy any recordings. The supervisee is responsible for ensuring this process is followed.

Practicalities/Cancellation Policy/Fee

- Individual sessions will be either 30 or 60 minutes (as agreed)
- Group sessions will be 2 hours, with no more than 4 supervisees.
- Fees for supervision are £……… (as agreed) and to be paid by
- BACS (individual) or by invoice (monthly in arrears for organisations).
- <Supervisor's Name>…………Bank a/c: 1234567, Sortcode: 12-34-56
- Cancellation arrangements are: 24 hours notice or full fee is payable

Consultee/Supervisee's Information:

- Core profession and registered body:……………………………………
- …………………………………………………………………………….
- Level of EMDR Training/qualifications and date obtained ……………..
- ……………………………………………………………………………
- ……………………………………………………………………………
- If wishing to work towards Accreditation the supervisee will need to supply copies of EMDR certificates (basic and C & A)
- **Contact details** :
- Name…………………………………….
- Email…………………………………… Mobile:………………………

Signed…………………………EMDR Consultee/Supervisee. Date…………

Signed…………………………EMDR Consultant/Supervisor. Date……......

Books on clinical supervision: An annotated bibliography

Robin Logie

In the course of initial research for the witing of a book on EMDR supervision, I have identified the following key texts in relation to clinical supervision.

It should be noted that much of the literature on clinical supervision comes from the traditions of psychodynamic psychotherapy and counselling. It is interesting to note that even the literature on CBT supervision still draws heavily on concepts that were developed in the world of psychodynamic psychotherapy and counselling. This is, perhaps, because such modalities have more to say about the therapeutic relationship and correspondingly, the supervisory relationship.

Supervision in Clinical Practice (3rd Edition). Joyce Scaife (2019). Routledge.
This is a key UK textbook written by a clinical psychologist which covers the main issues in relation to clinical supervision including specific issues such as ethical dilemmas, diversity and the use of technology in supervision.

Supervision in the Helping Professions (5th Edition). Peter Hawkins & Aisling McMahon (2020). McGraw Hill.
The first four editions of this book were written by Peter Hawkins and Robin Shohet, the first one being in 1989. This is another key text which has dominated the supervision literature in the UK for the last 30 years. In particular, it outlines the '7-eyed' model of supervision described in articles this workbook by Farrell et al and by Logie.

Supervising the Counsellor 3rd Edition). Steve Page & Val Wosket (2015). Routledge
This is another key UK text on clinical supervision. It discusses supervision in terms of a cyclical model with five stages (Contract, Focus, Space, Bridge, Review).

Fundamentals of Clinical Supervision (6th Edition). Janine Bernard & Rodney Goodyear (2019). Pearson.
This is a key textbook on supervision in North America. Detailed and comprehensive, it discusses different models of supervision in depth. Unlike the UK texts above, it covers more detail regarding the evaluation of supervision which is clearly a key role for EMDR Consultants.

The Wiley International Handbook of Clinical Supervision. Edward Watkins & Derek Milne (Editors) (2014). Wiley.
Running to more than 600 pages, with 51 contributors from around the world, this provides an in-depth picture of the current status of supervision research worldwide and in the context of different therapeutic modalities.

Effective Supervisory Relationships. Best evidence and Practice. Helen Beinart & Sue Clohessy (2017). Wiley.
This UK book looks specifically at the supervisory relationship. It helps the supervisor to set the right conditions for supervision to be effective and also covers how to prevent and manage difficulties within the supervisory relationship.

Supervisor Training. Issues and Approaches. Penny Henderson (Editor) (2009). Karnac. After covering the general topic of supervisor training, this book goes into detail about such training for therapists in different therapeutic modalities.

CBT Supervision. Sarah Corrie & David Lane. (2015). Sage.
The other books described thus far are generic in terms of therapeutic modalities, although much of the theory is drawn from the psychotherapy and counselling traditions. For EMDR supervision I believe we also need to look at the literature from more structured therapies such as CBT. This down-to-earth practical book from the CBT tradition guides the reader with a structured way of providing supervision, for example by utilising the Supervision Question as we are trained to do in EMDR.

Group supervision. A Guide to Creative Practice (2nd Edition). Brigid Proctor. (2008). Sage.
This is the key text, specifically on providing supervision in groups.