

EMDR Fidelity Rating Scale (EFRS)

The Manual

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The complete EFRS (formatted for use in research), the EFRS manual (containing relevant information about the scale, with instructions for Clinicians, Raters, and Researchers), essential forms, an EFRS excel workbook with embedded scoring calculator, and a sample scoring workbook can be found and downloaded at <http://emdrresearchfoundation.org/emdr-fidelity-rating-scale> . These materials are available through a Creative Commons Attribution-NonCommercial-NoDerivatives License (<https://creativecommons.org/licenses/by-nc-nd/4.0/>).



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THE EFRS	
Part One	The EFRS Scoring Form
Part Two	The EFRS Manual
Part Three	The EFRS Clinician Forms
Part Four	The Blank EFRS Workbook
Part Five	The Sample EFRS Workbook

THE EMDR FIDELITY RATING SCALE

The **EMDR Fidelity Rating Scale** (EFRS) evaluates adherence to EMDR therapy's standard eight-phase treatment approach and three-pronged protocol (Shapiro, 2001, 2017). Originally developed for use in a study by van der Kolk et al. (2007), the scale was revised in 2017 after receiving feedback from Researchers and Raters who had used the scale.

The EFRS is a comprehensive rating instrument designed to assess treatment fidelity in a single EMDR session and adherence to the three-pronged protocol. The scale provides a breakdown of treatment components, with indicators for "acceptable" adherence, a rating system, and an easy-to-use scoring calculator. Fidelity ratings range from 0 (No Adherence) to 3 (Very Good Adherence), with a cut-off score of 2.0 for acceptable fidelity. The embedded scoring calculator in the EFRS Workbook automatically does the calculations for a number of different types of fidelity scores.

The EFRS was designed as an observer-rated research scale to be used in reviewing video recordings of actual treatment sessions. However, it can also be similarly used by an individual Clinician to monitor fidelity in his/her own treatment sessions. EMDR Consultants may also find the scale helpful when assisting Therapists in the development of their EMDR therapy skills.

The EFRS can be used in the evaluation of EMDR treatment sessions for any disorder or presenting problem in which standard EMDR procedural steps and the three-pronged protocol are used in addressing memories of adverse life experiences or current triggers eliciting distress. In addition to being established as an efficacious treatment for posttraumatic stress disorder (Watts et al., 2013; WHO, 2013), EMDR standard procedures have been successfully used for symptoms of depression (Gauhar, 2016), panic disorder (Faretta, 2013), chronic pain (de Roos et al., 2010), relational stresses (Reicherzer, 2011), performance anxiety (Maxfield & Melnyk, 2000), and many other problems.

Purpose

Adherence to a given treatment protocol, validated by fidelity ratings, is considered an essential component of any rigorous randomized clinical trial. The importance of EMDR treatment fidelity was demonstrated in a meta-analysis by Maxfield and Hyer (2002) who examined the relationship between research outcomes and methodological strengths and weaknesses. They used Foa and Meadows's (1997) Gold Standard Scale, a set of seven criteria, for assessing methodological integrity in treatment outcome studies. Maxfield and Hyer found that there was a significant relationship between EMDR treatment fidelity and treatment effect size, with treatment adherence the strongest predictor of outcome. Given the primacy of treatment adherence, the development of a comprehensive fidelity scale for EMDR therapy became a priority.

History

There were two EMDR fidelity rating scales, developed for research purposes, that existed prior to the development of this current scale. Neither of these earlier scales was published. Dr. Steven Lazrove developed a scale for use in an EMDR study conducted by van der Kolk et al. (1999) and Drs. William Zangwill and Howard Lipke developed a scale for use in a study conducted by Rothbaum (1997). That scale was also used in later studies such as those by Rothbaum et al. (2005) and Taylor et al (2003). More recently, other EMDR fidelity scales have been published (e.g., Leeds, 2009, 2016), including one for work with children and adolescents (Adler-Tapia & Settle, 2008, 2016).

The EFRS had its origin in 2001. Dr. Deborah Korn was asked to develop a comprehensive treatment manual and fidelity rating scale for an NIMH-funded study that compared the efficacy of three treatments for posttraumatic stress disorder: the SSRI, fluoxetine, EMDR, and pill placebo (van der Kolk et al., 2007). Both of the fidelity scales developed earlier (Lazrove, 1999; Zangwill & Lipke, 1997) were reviewed and carefully evaluated, in terms of strengths and weaknesses, prior to the start of development efforts on this new scale. Drs. Nancy Smyth and Francine Shapiro served as consultants in the development of this fidelity scale (Korn, Zangwill, Lipke, and Smyth, 2001). In 2007, Dr. Korn moved into the next phase of development, working with Drs. Francine Shapiro, Nancy Smyth, Louise Maxfield, and Robert Stickgold to create a more sophisticated and comprehensive fidelity evaluation instrument. A computerized scoring system was developed at that time. Another round of development came in 2009 when a basic user's manual, including instructions for Clinicians, instructions for Raters, and instructions for scoring, was created. The current version was completed in 2017, integrating feedback from Clinicians, Raters, and Researchers who had used the scale and scoring system and provided feedback over the years.

Table 1: EFRS Material

EFRS MATERIAL	
Part One	The EFRS Scoring Form - consisting of five Subscales
Part Two	The EFRS Manual - containing instructions for EFRS use
Part Three	The EFRS Clinician Forms - containing the <i>Single Session Summary</i> (SSS) Form and the <i>Treatment Plan Tracking</i> (TPT) Form
Part Four	The Blank EFRS Workbook - containing the embedded scoring calculator
Part Five	The Sample EFRS Workbook - illustrating scoring and the use of the embedded scoring calculator

EMDR TREATMENT FIDELITY

EMDR treatment fidelity is defined as adherence to EMDR’s standard eight-phase treatment procedures and the three-pronged protocol (Shapiro, 2001, 2107). Treatment fidelity is monitored in research studies to “enhance the accuracy and consistency of an intervention (and) to ensure it is implemented as planned and that each component is delivered in a comparable manner to all study participants over time” (Smith, Daunic, & Taylor, 2007, p.121). It is also strongly recommended that Clinicians monitor their own adherence to treatment in their own practices, and to facilitate this process, Shapiro has included the EFRS in her textbook (in press, Appendix C).

An important thing to keep in mind is that the fidelity is not measured by the Client’s response or the treatment outcome. Fidelity is a measurement of the Clinician’s adherence to the treatment procedures. A fidelity rating is not a measure of the skill of the Therapist or the success of the therapy. These can disagree in either direction: a therapy can be highly successful yet fail to follow the prescriptions of the therapeutic approach, or a therapy can be performed clumsily and unsuccessfully yet follow the procedures of the therapeutic approach precisely. If the Therapist followed the procedures precisely, even with a bad outcome, his/her Fidelity Score should reflect the adherence. Likewise, if the Clinician did not follow standard EMDR procedures, even if there is a wonderful outcome, his/her Fidelity Score should reflect the lack of adherence.

DESCRIPTION OF THE SCALE

The EFRS is designed to evaluate a Therapist’s adherence to EMDR therapy’s standard procedures, using five Subscales (see Table 2).

Single sessions are rated on the EFRS Scoring Form, using any/all of the following four Subscales. The Introductory (Intro Phases 1 & 2) and Adverse Life Experiences Processing (ALE Phases 3-8) Subscales assess adherence to the standard eight-phase treatment approach. The Future Template (FT) Subscale evaluates the Therapist’s use of the Future Template Protocol. The optional Resource Development and Installation (RDI) Subscale, allows for the evaluation of adherence when using the RDI protocol (Korn & Leeds, 2002).

The fifth subscale, the Three-pronged Protocol (TPP) Subscale, examines whether a Therapist appropriately addressed relevant past events, present triggers and symptoms, and future behavioral goals across the course of treatment.

Francine Shapiro’s (2001) textbook and the EMDR Institute’s Weekend 1 (Shapiro & Lalotitis, July 2017) and Weekend 2 (Shapiro & Lalotitis, January, 2017) Training Manuals were consulted in formulating items. All areas of uncertainty were discussed and confirmed in personal

communication with Francine Shapiro. The EFRS Scale is printed in her in press textbook, Appendix C.

Table 2: EFRS Subscales

EFRS SUBSCALES	
I. Introductory (INTRO) Subscale	Phase 1 - History-taking and Treatment Planning Section Phase 2 - Preparation Section Safe/Calm Place Exercise Section
II. Resource Development and Installation (RDI) Subscale (Optional)	
III. Adverse Life Experiences (ALE) Processing Subscale for past events and present triggers/symptoms	Phase 3 – Assessment Section Phase 4 – Desensitization Section Phase 5 – Installation Section Phase 6 - Body Scan Section Phase 7 – Closure Section Phase 8 – Reevaluation Section
IV. Future Template (FT) Subscale	
V. Three-pronged Protocol (TPP) Subscale	

INDIVIDUAL SUBSCALE DESCRIPTIONS

I. Introductory (Intro) Subscale- This Subscale, addressing Phases 1 and 2 of the standard EMDR procedures, evaluates adherence as the Clinician begins to work with a Client, typically in the first and/or second sessions, or subsequent sessions if extended preparation or additional history-taking is required. This Subscale has three sections, evaluating adherence to the protocol for 1) History-taking and Treatment Planning, 2) Preparation, and 3) the Safe/Calm Place Exercise. The Safe/Calm Place Exercise is a part of Phase 2 preparation work, but has a protocol of its own and therefore, a section devoted to its evaluation. Please note that the scale does not evaluate the process of formal psychological evaluation, the steps involved in making a diagnosis, and/or the provision of measurement inventories as these are addressed in different ways across research studies and clinical practices. Also, the scale does not attend to the ways in which the Therapist evaluates readiness for EMDR therapy as this is typically addressed by the Researcher in the recruitment stage of a study, prior to the start of treatment.

II. Resource Development and Installation (RDI) Subscale – This optional Subscale addresses the Resource Development and Installation Protocol (RDI; Korn & Leeds, 2002; Shapiro, 2017), developed as its own protocol, separate from the Standard EMDR Protocol. The RDI Protocol is typically only used if one’s Client needs additional stabilization or preparation, beyond the standard Safe/Calm Place Exercise, before moving on to phases focused on adverse life experiences (ALE) processing. It is used when a Client shows signs of more significant dysregulation and fears related to memories of adverse life experiences, associated triggers, and overwhelming negative affect. This Subscale is only used if the RDI Protocol has been utilized in the course of treatment. It is likely that the Subscale will be used to evaluate sessions early in the course of treatment, during the Preparation Phase. However, if a Clinician decides to use the RDI Protocol to restabilize a Client or strengthen his/her capacity to tolerate focused processing work during a later stage of treatment, this Subscale would be used in the evaluation of that session.

III. Adverse Life Experiences (ALE) Processing Subscale – This Subscale, addressing Phases 3 through 8 of the Standard EMDR Protocol, evaluates adherence as the Clinician focuses on processing a specific target (past event or current trigger/symptom) in a single session. This Subscale has six sections, evaluating adherence for the following phases: a) Reevaluation, b) Assessment (of a new target), c) Desensitization, d) Installation, e) Body Scan, and f) Closure.

The ALE Processing Subscale can be used repeatedly to evaluate sessions at different points in treatment in which the focus is EMDR processing. Targets may be past or present prongs of the three-pronged protocol – i.e., past adverse life experiences OR present triggers (e.g., receiving negative feedback, dealing with authority figures) or symptoms (e.g., nightmare imagery, anxiety or shame reactions, somatic complaints). Sessions devoted to installing future templates are not evaluated with this Subscale but instead, with the Future Template Subscale.

Ratings are conducted only if specific treatment components are included in a given session. That is, not all sections of the ALE Processing Subscale will be used for a given session as not all sessions will include every treatment component. The Assessment section is used only for assessment of a new target. The Reevaluation section is used only for evaluating processing sessions for a given target after the first. If there is an incomplete processing session, in which the Client does not get to a SUD score of “0” or “1”, the Clinician would not complete the Installation and Body Scan Phases, but would move directly to the Closure Phase.

IV. Future Template (FT) Subscale – This Subscale addresses adherence to the Future Template Protocol (not formally included in the 8 phases of the EMDR Standard Protocol). This Protocol, representing the third prong of the Three-pronged Protocol for comprehensive EMDR treatment, is typically used after relevant past targets and present triggers/symptoms have been addressed and resolved.

V. Three-pronged Protocol (TPP) Subscale – This Subscale addresses the question of whether the Clinician conceptualized, planned, and worked with the Three-pronged Protocol in mind. The Subscale evaluates whether the Clinician appropriately identified past, present, and future goals and then, subsequently processed the targets relevant to the identified presenting issue/s.

SCORES AND FIDELITY CRITERIA

THE SCORES

Fidelity is rated on a 4-point scale: 0 = no adherence, 1 = some adherence but inadequate, 2 = adherence acceptable, and 3 = adherence good.

With the exception of the Three-pronged Protocol subscale, which is scored on a dichotomous (yes/no) scale, all individual items are scored using this 4-point scale. Each item contains specific behavioral descriptors associated with a given phase or procedural step in the protocol. Scoring instructions are provided in this Manual in the *Instructions for Rater* section, page 23.

Critical Elements

Several items and section scales are considered **Critical Elements**. Fidelity on these components is seen as being particularly important to the integrity of EMDR therapy's standard eight-phase procedure and three-pronged protocol. The scores for these items/sections are given double weighting. (This weighting is done automatically by the embedded scoring calculator in the EFRS Workbook.)

Critical Elements include:

- Assessment section
- Desensitization section
- Installation section
- Item #2 in the History-taking and Treatment Planning section
- Items #11, #12, #13 in the Desensitization section

OVERVIEW OF SCORING

The Rater scores the relevant sections and subscales of the EFRS for a single therapy session, using the paper version of the EFRS. After completing the paper scoring, the Rater enters the scores into an unused worksheet in the EFRS Excel workbook. The workbook contains 10 worksheets, each devoted to either single session fidelity evaluation (involving one or multiple subscales) or Three-pronged Protocol evaluation (involving the TPP Subscale). Each worksheet has an embedded scoring calculator, which calculates the Single Session or Three-pronged Protocol Fidelity Score for the data entered on that worksheet. The workbook also contains a *Workbook Summary* page listing all the mean scores. The final page of the workbook, *Study Summary*, is used to calculate the Study Fidelity.

DETERMINATION OF FIDELITY

The EFRS can be utilized to determine fidelity within a research study, with multiple Clinicians and many Clients. It can also be used to evaluate the fidelity of the treatment provided by one Clinician to a single Client, for use in a single-case research design, or for consultation or self-monitoring. See Table 3.

Table 3: Examples of the Types of Application for the EFRS

	RESEARCH APPLICATION	SINGLE CLIENT APPLICATION
Number of Clients	Many	One
Number of Clinicians	One or more	One
Sessions Rated	Random selection	All
EFRS Workbook(s)	One or more	One (or more)
Produces	Single Session Fidelity Score Three-pronged Protocol Fidelity Score Study Fidelity Score	

Use Within a Research Study

The determination of fidelity by the EFRS in a research study is conducted by assessing the fidelity in a randomly selected sample of single treatment session recordings. A predetermined number of recordings (e.g., 10%) is randomly collected from each Clinician’s work with all of his/her Clients in the study. Each recording is scored by an independent Rater and entered into one or more workbooks, which automatically calculate the Single Session Fidelity Scores and the Three-Pronged Protocol Fidelity Scores. The Researcher then combines the scores from all the workbooks to produce the Study Fidelity Score. If this score is equal to or greater than 2.0, the study is deemed to have “Acceptable Fidelity”. (See Instructions for Researchers, page 10.)

Use for Consultation or a Single Case Study

The EFRS can also be used to evaluate the Clinician’s fidelity within a single case study or in consultation. In this application of the scale, each session with a single Client is rated, producing the Single Session Fidelity Score, and the application of the three-pronged protocol with that Client is rated, producing the Three-Pronged Protocol Fidelity Score. The workbook automatically calculates the Workbook Fidelity Score, which is the mean of all fidelity scores in the workbook. If the Workbook Fidelity Score is equal to or greater than 2.0, the Clinician is deemed to have “Acceptable Fidelity” with this one Client.

THE FIDELITY SCORES

Single Session Fidelity Score

The Single Session Fidelity Score shows the level of fidelity within a single session. After the item scores for the session are entered into the workbook on its own worksheet, the Single Session Fidelity Score is automatically determined by the embedded scoring calculator. It is reported at the bottom of each worksheet page. (See Sample Workbook, worksheets 1, 2, and 4 for examples.) Relevant scoring information is provided in the *Instructions for Rater* section of this Manual, page 23.

For those interested in the actual math – here is a description of how the Single Session Fidelity Score is calculated:

Each section score is the mean of the scored items (including double-weighted “critical” items) for that specific section. The EFRS contains 12 sections (see Table 2), with sections for each of EMDR therapy’s eight phases, the Safe/Calm Place Exercise, the Future Template Protocol, the optional RDI Protocol, and the Three-pronged Protocol.

The Single Session Fidelity Score is the mean of the section scores (including double-weighted “critical” sections), calculated for all rated sections. For example, a Clinician provides EMDR phases 3, 4, and 7 in her session, and receives a score of 2.4 for the Assessment section, 1.9 for the Desensitization section, and 2.3 for the Closure section. Because the Assessment and Desensitization sections are double-weighted Critical Elements, the Single Session Fidelity Score would be $(2.4+2.4+1.9+1.9+2.3)/5= 2.18$, indicating Acceptable Fidelity in that session.

Three-pronged Protocol Fidelity Score

The Three-pronged Protocol Fidelity Score is the score on the Three-pronged Protocol (TPP) Subscale. The Three-pronged Protocol Subscale is rated at the end of a Client’s treatment, using the *Treatment Plan Targeting (TPT) Form* (see pages 21-22). Scoring information is provided in this Manual in the *Instructions for Rater* section (pages 23-33). The item scores for this Subscale are entered into the workbook on their own worksheet, and the fidelity score is automatically determined by the embedded scoring calculator. The Three-pronged Protocol Fidelity Score is reported at the bottom of the worksheet page. (See Sample Workbook, worksheet 3 for example.) If the workbook contains Three-pronged Protocol Fidelity Scores for several Clients, then the mean Three-pronged Protocol Fidelity Score for the workbook is provided in cell B20 on the *Workbook Summary* page.

Workbook Fidelity Score

The mean fidelity for all ratings in the workbook is the Workbook Fidelity Score. It is automatically calculated on the *Workbook Summary* page. This page all shows the mean scores

for each section and Subscale evaluated in the workbook. See Figure 1 (page 15) for an example. The scores on this worksheet are automatically carried forward to the next worksheet which calculates the Study Fidelity.

Study Fidelity Score

The Study Fidelity Score is calculated on the *Study Summary* worksheet. It is the mean of all the Single Session and Three-pronged Protocol Fidelity Scores in all workbooks. The score is calculated after all ratings for all Clinicians are completed. The Researcher copies the Score Summary from the *Workbook Summary* page in each workbook into the *Study Summary* worksheet in one of the workbooks, where the embedded scoring calculator automatically determines the Study Fidelity Score. If there is only one workbook, the Study Fidelity Score is the mean fidelity within that workbook. (See Figure 2, page 16, for an example. Also, see Sample Workbook, worksheets 11 and 12 for an example.)

INSTRUCTIONS FOR RESEARCHERS

Please note, that although some of the following material pertains specifically to the logistics within a research study, many of the directions will be useful to a Consultant wishing to review and rate sessions of Consultees.

LOGISTICS

The logistics of evaluating fidelity in an EMDR study require careful planning, setting up of video equipment, instruction of Clinicians and Raters in use of relevant forms, ensuring transfer of the session recordings and forms to the Raters, and collection of ratings.

PROVISION OF TREATMENT

It is critical that you ensure that the Research Team, Raters, and Clinicians are on the same page regarding the subtleties of the EMDR standard procedures. The EFRS, with its five Parts, should be provided to everyone in the research study. You should discuss with them, prior to the start of the study, how certain items will be evaluated. For example, cognitive interweaves are described in a narrow sense by Shapiro (2001, 2017), yet they have been taught more broadly by other EMDR experts. Phase 8 (Re-evaluation) and the future template protocol have also been taught with slight variations across trainers over the years. The parameters used your study should be clear to all involved prior to the start of the study.

It is **strongly** recommended that you run a short trial prior to the official start of your study. Discussions about EMDR procedures and the use of the EFRS are not sufficient; an actual practice run is strongly advised. Even with an experienced clinical/research team, people need refreshers and time to get on the same page. In a trial, Clinicians can be rated and given feedback to ensure that fidelity requirements are clearly understood and able to be met. Similarly, Raters can discuss their questions and concerns with you, related to the use of the EFRS.

Unexpected Client/Participant Crises

Before starting your study, it is advisable to establish a procedure for handling a situation in which a Client presents for a treatment session with a new crisis (e.g., conflict with a partner). The study protocol should dictate how new Client crises are handled in the treatment session and how much session time can be allocated to problem-solving or stabilization. You should ensure that all Raters understand the provisions that are allowed for such situations.

Example: In some studies, the first 30 minutes of the session may be allocated to weekly update and managing new crises, with the remaining 60+ minutes allocated to providing EMDR therapy. In other studies, the focus is solely on the pre-established treatment plan, and new crises and life events are not addressed.

The study protocol should also include directions for handling severe crises, which may interrupt the treatment plan (e.g., suicidal or homicidal behavior/plan, psychosis, dangerous social situations). It is advisable to use a form for documenting and tracking such events.

Unscheduled Contact

It is advisable to establish procedures for managing unscheduled contact, in which the Client calls the Clinician between sessions for advice or assistance. Such contact increases the amount of therapeutic intervention being provided in the study. Some Researchers may decide that unscheduled contact is not allowed, others may permit it. All unscheduled contact should be documented for tracking and safety purposes.

INSTRUCTIONS FOR SAMPLING SESSIONS FOR RATING PURPOSES

It is imperative that all sessions be recorded and that a random sample be selected for rating. “Multiple sessions should be randomly selected from different phases of treatment” (Borrelli, 2011). Prior to commencing your research study, it is recommended that you decide what number and percentage of sessions will be sampled for rating purposes. For example, in the van der Kolk et al. study (2007), approximately 10% of the 210 study sessions were selected for review. Sessions were over-sampled to ensure the inclusion of at least 10% of sessions per Clinician and session type (e.g. INTRO, ALE, RDI, FT) in the fidelity assessment.

Example: A study provided 10 EMDR treatment sessions to 30 Participants, for a total of 300 sessions. There were three Clinicians, and each provided 100 sessions. The Researcher randomly selected 10% (n=30) of the overall session recordings for rating, with 10 from each Clinician.

It is worth noting that because of random sampling, no sessions or forms were rated for some Clients. For example, of the 10 recordings selected from the 100 conducted by one Clinician, three sessions were from Client #7, two sessions were from each of Clients #2 and #6, one session was from Client #10, and one TPT form was from each of Clients #3 and #5. No sessions or forms were viewed from Clients #1, #4, #8, and #9. (See Figure 2 for another example).

Choice-points: One Researcher might decide to ensure that, for each Clinician, the ten sampled sessions should contain two sessions chosen randomly for each Subscale: INTRO, RDI, ALE, and FT, as well as two TPT Summary Forms chosen for the TPP Subscale. Another Researcher might decide to ensure that, for each Clinician, there is one session chosen randomly for each Subscale: INTRO, RDI, ALE, and FT, and one TPT Summary Form for the TPP Subscale, and then select the other five recordings in a random manner.

INSTRUCTIONS FOR ORGANIZING THE WORKBOOKS

The EFRS workbook contains 10 worksheets for the ratings of 10 sessions or TPT forms. Each worksheet calculates the fidelity for one Single Session or Three-Pronged Protocol Subscale. Then the 11th worksheet, *Workbook Summary*, provides a summary chart of the entire workbook and the 12th worksheet, *Study Summary*, can be used to calculate the Study Fidelity Score across several workbooks. The workbook can be organized and used in a variety of ways.

Example 1: One Clinician, one Client

- A workbook solely for (all) sessions with one Client, provided by one Clinician. This application determines the Fidelity Score for that Clinician with that Client. Most commonly, this would be used for consultation or for a single-case study.

Example #1 Workbook									
Sheet 1	Sheet 2	Sheet 3	Sheet 4	Sheet 5	Sheet 6	Sheet 7	Sheet 8	Sheet 9	Sheet 10
Clin-1	Clin-1	Clin-1	Clin-1	Clin-1	Clin-1	Clin-1	Clin-1	Clin-1	Clin-1
P-1	P-1	P-1	P-1	P-1	P-1	P-1	P-1	P-1	P-1
Sn # 1	Sn # 2	Sn # 3	Sn # 4	Sn # 5	Sn # 6	Sn # 7	Sn # 8	Sn # 9	TPP

Note: Sheet = worksheet; Clin-1 = Clinician #1; P-1=Participant #1; Sn # = Session number; TPP= Three-pronged Protocol Subscale

Example 2: One Clinician, many Clients

- A workbook for random sessions with various Clients, provided by one Clinician. This application determines the Fidelity Score for that Clinician with multiple Clients. It could be used in Consultation or in a research study, where the Researcher wants to evaluate the fidelity for each Clinician providing therapy in the study.

Example #2 Workbook									
Sheet 1	Sheet 2	Sheet 3	Sheet 4	Sheet 5	Sheet 6	Sheet 7	Sheet 8	Sheet 9	Sheet 10
Clin-2	Clin-2	Clin-2	Clin-2	Clin-2	Clin-2	Clin-2	Clin-2	Clin-2	Clin-2
P-7	P-6	P-9	P-7	P-6	P-10	P-8	P-6	P-9	P-7
TPP	Sn # 2	Sn # 8	Sn # 9	TPP	Sn # 6	Sn # 3	Sn # 2	Sn # 4	Sn # 1

Example 3: Many Clinicians, many Clients

- A workbook for random sessions with various Clients, provided by multiple Clinicians. This application determines the Fidelity Score for multiple Clinicians with multiple Clients. It would most commonly be used in a research study, where the Researcher is only interested in study fidelity and does not assess fidelity for individual Clinicians.

Example #3 Workbook									
Sheet 1	Sheet 2	Sheet 3	Sheet 4	Sheet 5	Sheet 6	Sheet 7	Sheet 8	Sheet 9	Sheet 10
Clin-2	Clin-3	Clin-1	Clin-1	Clin-3	Clin-2	Clin-2	Clin-3	Clin-1	Clin-2
P-7	P-12	P-1	P-4	P-14	P-10	P-8	P-14	P-3	P-7
TPP	Sn # 2	Sn # 8	Sn # 9	TPP	Sn # 6	Sn # 3	Sn # 2	Sn # 4	Sn # 1

Before you begin the rating process, you must decide how you want the workbooks to be organized. Certain planned analyses may be simplified by workbook organization. For example, if you want to compare fidelity between Clinicians, analyses would be simplified if each Clinician's ratings were in individual workbooks, with each Rater maintaining a separate workbook for each Clinician.

Provide instructions to the Raters about the workbook organization prior to transferring the recordings and forms. It is recommended that each workbook be given a specific number and purpose before being provided to the Rater. See Table 4 for an example, using Client/Participant and Clinician numbers for illustrative (not prescriptive) purposes.

Table 4: Example of Workbook Organization

Workbook #1	Rater-1	Clinician-1	Participants 1-5
Workbook #2	Rater-1	Clinician-2	Participants 6-10
Workbook #3	Rater-2	Clinician-1	Participants 11-15
Workbook #4	Rater-2	Clinician-2	Participants 16-20

INSTRUCTIONS FOR COLLECTING AND FORWARDING RECORDINGS AND FORMS

Step One: Identifying Information

Clinicians and Clients/Participants should be assigned anonymous identification numbers (e.g., Clin-2 and P15) so that their material can be collated throughout the study. Ensure that Clinicians label each recording with the following identifying information: Client/Participant number, Clinician code, session date and number, and an indication of the subscales relevant for rating (e.g., Introductory (INTRO), Resource Development and Installation (RDI), Adverse Life Experiences Processing (ALE), Future Template (FT)). For example, a recording may be labeled and electronically saved as P15, Clin-2, 5-5-17, Sess2, ALE.

Step Two: Forwarding Recordings and Forms to the Raters

After randomly selecting session recordings, forward each recording to the Rater, accompanied by its *Single Session Summary* (SSS) Form. After treatment is finished, provide the Rater with the *Treatment Plan Targeting* (TPT) Forms for the randomly selected Clients, so that he/she can score the Three-pronged Protocol (TPP) Subscale. If you want a more rigorous evaluation of the three-pronged protocol, you can ask the Rater to examine the information provided on all the SSS Forms for a given Client along with the information documented on the TPT Form.

INSTRUCTIONS FOR DETERMINING THE STUDY FIDELITY RATING

The Study Fidelity Score is the mean of all the Single Session and Three-pronged Protocol Fidelity Scores. This score is calculated after all ratings for all Clinicians are completed.

Step One: Collecting the Ratings

After the ratings are completed, ensure that you receive the completed workbooks from the Raters.

Step Two: Using the Workbook Summary Page

The second to last page of each workbook is the *Workbook Summary* page. It contains the scores from all of the worksheets in that workbook, including the section scores, the Single Session Fidelity Scores, and the Three-pronged Protocol Fidelity Scores. See Figure 1.

The Workbook Summary Page

Figure 1 shows the *Workbook Summary* page. This example workbook only contains sessions by Clinician 2, with ratings for eight session recordings and two *Treatment Plan Tracking* (TPT) Forms. (Note: these 10 evaluations were randomly selected and they are 10% of the 100 sessions that Clinician 2 provided to Participants P1-P10). The Figure also illustrates how the mean section scores are calculated for each of the rated sections. See also the Sample Workbook.

Step Three: Calculating Study Fidelity Score with Single Workbook

The last page of the workbook, *Study Summary*, is used to calculate the Study Fidelity. The Study Fidelity is the mean of all the Single Session and Three-pronged Protocol Fidelity Scores. For the study to have Acceptable Fidelity, the Study Fidelity Score must be equal to or greater than 2.0. Again, the Study Fidelity Score reflects the Clinicians' adherence to the protocols and procedures of EMDR therapy.

If there is only one workbook in the study (e.g., single case study, small sample, one Rater), then the Workbook Fidelity Score is also the Study Fidelity Score (Table 5). The Study Fidelity Score is shown in cell D6 on the *Study Summary* worksheet.

Step Four: Calculating Study Fidelity Score with Multiple Workbooks

If there are two or more workbooks in the study, then Workbook "Summary Scores" from the *Workbook Summary* page in each workbook must be copied and pasted into the *Study Summary* worksheet of a single workbook to create the Study Fidelity Score. Follow the directions on the worksheet. The embedded scoring calculator will then determine the Study Fidelity (Figure 2).

Figure 1: Workbook Summary Page

EMDR FIDELITY RATING SCALE											
WORKBOOK SUMMARY PAGE											
Session Number	Mean Score	WORKSHEET SCORES									
		1	2	3	4	5	6	7	8	9	10
Rater		Ra-2	Ra-2	Ra-2	Ra-2	Ra-2	Ra-2	Ra-2	Ra-2	Ra-2	Ra-2
Clinician Code		Clin-2	Clin-2	Clin-2	Clin-2	Clin-2	Clin-2	Clin-2	Clin-2	Clin-2	Clin-2
Client/Participant #		P10	P08	P08	P09	P01	P06	P05	P02	P03	P03
Session # (or TPT)	----	1	2	TPT	4	9	TPT	7	2	3	5
Hx & Tx Plan	2.20	2.20	•	•	•	•	•	•	•	•	•
Preparation	2.50	2.40	•	•	•	•	•	•	2.60	•	•
Safe/Calm Place	2.15	2.40	•	•	•	•	•	•	1.90	•	•
RDI	2.36	•	2.36	•	•	•	•	•	•	•	•
Reevaluation	2.22	•	•	•	2.33	•	•	2.33	•	•	2.00
Assessment	1.78	•	•	•	•	•	•	•	•	1.78	•
Desensitization	1.83	•	•	•	1.81	•	•	•	•	1.94	1.75
Installation	2.00	•	•	•	1.67	•	•	2.50	•	•	1.83
Body Scan	2.25	•	•	•	2.00	•	•	2.50	•	•	•
Closure	2.33	•	•	•	2.33	•	•	•	•	•	2.33
Future Template	2.25	•	•	•	•	2.00	•	2.50	•	•	•
Three-pronged	2.63	•	•	2.60	•	•	2.67	•	•	•	•
Session Fidelity	2.24	2.33	2.36	2.60	1.95	2.00	2.67	2.47	2.25	1.86	1.92

Figure 2: Study Summary Worksheet; Calculating Study Fidelity Score with Multiple Workbooks

STUDY SUMMARY										
<i>Is this the only workbook in your study (Yes/No)?</i>										no
<i>If not, are all other workbooks entered below (Yes/No)?</i>										yes
STUDY FIDELITY SCORE: 2.24										
Rater	Ra-2	Ra-2	Ra-2	Ra-2	Ra-2	Ra-2	Ra-2	Ra-2	Ra-2	Ra-2
Workbook #1										
Clinician	Clin-2	Clin-2	Clin-2	Clin-2	Clin-2	Clin-2	Clin-2	Clin-2	Clin-2	Clin-2
Client/Participant	P10	P08	P08	P09	P01	P06	P05	P02	P03	P03
Session #	1	2	TPT	4	9	TPT	7	2	3	5
Single Session Fidelity	2.33	2.36		1.95	2.00		2.47	2.25	1.86	1.92
TPP Fidelity			2.60			2.67				
Rater	Ra-1	Ra-1	Ra-1	Ra-1	Ra-1	Ra-1				
Workbook #2										
Clinician	Clin-1	Clin-1	Clin-1	Clin-1	Clin-1	Clin-1	Clin-1			
Client/Participant	P14	P12	P12	P11	P15	P14				
Session #	8	5	1	TPT	2	2				
Single Session Fidelity	2.22	1.76	2.43		2.67	1.93				
TPP Fidelity				2.50						

The Study Summary Page

Figure 2 shows the *Study Summary* worksheet in a workbook. In this study, 10 Participants each received 10 EMDR sessions from Clinician #2 and 5 Participants received 10 sessions from Clinician #1. The sampling rate was set at 10%, with 5 sessions rated for Clinician 1 and 10 sessions for Clinician 2.

This workbook (Workbook #1) contains worksheets for Clinician 2's sessions. A second workbook (not shown) contains worksheets for Clinician 1's sessions. The summary chart for Clinician 1 was copied by the Researcher into rows 20-25 in Clinician 2's workbook. The embedded scoring calculator averaged the scores for the single sessions and TPP scores, determining the Study Fidelity Score, which is shown in cell D6.

Step Five: Conducting Other Analyses

Many other analyses are possible. For example, within your study, you could compare the Clinician Fidelity Score for EACH Clinician to ensure that there were no significant differences in the way that the treatment was provided. (See Table 4.) You could also use the EFRS scale for research purposes. For example, you could dismantle EMDR therapy and compare the outcomes of EMDR with and without a certain component or prong (e.g., future template).

Table 5: Focus of Fidelity Evaluation

Focus of Fidelity Evaluation	Number of Clients	Sessions	Number of Clinicians	Number of Workbooks
Fidelity of one Clinician with one Client?	1	All	1	1
Fidelity of one Clinician across multiple Clients?	Multiple	Random	1	1 or more
Fidelity of 2+ Clinicians across multiple Clients?	Multiple	Random	2+	2 or more

INSTRUCTIONS FOR CLINICIANS

As a Clinician in a research study, you should be sure to understand how your adherence to EMDR therapy's eight-phase treatment approach and Three-pronged Protocol will be evaluated by Raters. You are encouraged to discuss any concerns regarding treatment provision and procedures with your Researcher prior to starting the study.

There are two brief forms that you must complete after each session. These forms provide information and context to assist the Rater who is evaluating the session. The Forms can be found in EFRS Part Three: The Clinician Forms.

- The *Single Session Summary* (SSS) Form is completed at the end of each treatment session. It allows you to indicate what treatment was provided in the session that you just completed.
- The *Treatment Plan Tracking* (TPT) Form is initially completed during History-taking and Treatment Planning and is updated at the end of each treatment session. It allows you to document the Client's presenting issues and associated past, present, and future targets and asks you to identify the sessions in which these issues and targets are addressed.

It is essential that you fill these forms out carefully. For example, if you indicate that you provided a treatment element (e.g., Body Scan) but did not actually do so, your session will be rated on that item, and given a score of "0", inadequate. If you decided not to address a particular treatment element (e.g., Body Scan), you can indicate on the SSS Form that it was omitted and explain your reasoning, so that the Rater can have this information when evaluating your session.

INSTRUCTIONS FOR CLINICIANS COMPLETING THE SINGLE SESSION SUMMARY (SSS) FORM

You should be aware that, in most research studies, the Rater does not view the full course of treatment with a single Client. Instead, the Rater will probably only see and rate one or two of your sessions with any one Client, and those sessions may be out of order. This means that the Rater will have no contextual information about how any session fits into the full course of treatment. Therefore, it is essential that, on the SSS Form, you provide the Rater with all the information that he/she may need to understand the treatment that you provided in the session.

Step 1: Identifying Information

At the top of the *Single Session Summary* Form, record the session number, the date of the session, your Client/Participant's identification number (e.g. P12), and your code (e.g., Clin-2). This information will let others know, for example, that you, Clinician #2, are sending a recording for Client/Participant #12, showing the 4th session recorded on 5/10/16.

Step 2: Single Session Summary (SSS) Form Completion

Within the form, check the box for the section/s showing which procedural steps you addressed in the session: Introductory (INTRO), Resource Development and Installation (RDI), Adverse Life Experiences (ALE), and/or Future Template (FT). If there are subsections within the main section, check the box indicating which steps were provided. If you did not address a step, leave the box blank. Also add, in the space provided, the title/name of the target that was processed.

Follow the instructions below for each of the relevant procedural sections.

Introductory (INTRO) Subscale

If you engaged the Client in history-taking and treatment planning, preparation tasks, or the calm/safe place exercise in the session, check the box next to Introductory Phase (INTRO) on the *Single Session Summary* Form. Check the boxes for the specific introductory tasks covered in the session; History-taking and Treatment Planning, Preparation (which includes psychoeducation about EMDR therapy, self-management skill-building, instructions, metaphors, distance and speed, stop signal), and/or Safe/Calm Place Exercise. Check boxes for all tasks or steps covered. If you did not address a task, leave the box blank. See Figure 3 for an example of addressing History-taking and Treatment Planning and Preparation but not the Safe/Calm Place Exercise.

Figure 3: Example of the Single Session Summary (SSS) Form for Introductory Phases

- | |
|--|
| <p>I. <input checked="" type="checkbox"/> Introductory (INTRO)</p> <p><input checked="" type="checkbox"/> History-taking and Treatment Planning</p> <p><input checked="" type="checkbox"/> Preparation</p> <p><input type="checkbox"/> Safe/Calm Place Exercise</p> |
|--|

Resource Development and Installation (RDI) Subscale

If the session involved the use of the Resource Development and Installation Protocol as part of the Preparation Phase (or as needed later in treatment), check the box next to Resource Development and Installation (RDI). There are no check boxes for specific tasks for this section.

Adverse Life Experiences Processing (ALE) Subscale

If you engaged the Client in Reevaluation, Closure, or one or more tasks related to EMDR processing, check the box next to Adverse Life Experiences (ALE) Processing and then, check off whether you addressed a past or present target. Give the past or present target a title (headline/description) so that there is a way to track any work related to this target across sessions. For ease of tracking, it is recommended that you use the same “titles” here that you used in the *Treatment Plan Tracking* Form. For example, a past target “title” might be: “Sexual Abuse by Father - Age 8 – In Basement”. A present target “title” might be: “Seeing Father at Family Gathering”. Next, check a box to identify whether you

engaged the Client in Assessment (of a new target), Reevaluation (of a previous target), Desensitization (of a target), Installation (of a positive cognition), Body Scan, or Closure procedures in the session. Only check boxes for actual treatment components included in a given session. See Figure 4 for an example.

Figure 4: Example of Single Session Summary Form for ALE Processing

<p>II. <input checked="" type="checkbox"/> Adverse Life Experiences (ALE) Processing:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Past - Target Title <i>Sexual abuse by father (age 8) in basement</i> <input type="checkbox"/> Assessment (of new Target) <input checked="" type="checkbox"/> Re-evaluation ((if previous EMDR trauma processing session) <input checked="" type="checkbox"/> Desensitization <input type="checkbox"/> Installation <input type="checkbox"/> Body Scan <input checked="" type="checkbox"/> Closure

Future Template (FT) Subscale

If the session involved the use of the future template protocol, check the box next to Future Template (FT). If you addressed a future target/goal, give it a title so that there is a way to track any work related to this target across sessions. For example, a future template target “title” might be: Assertively Setting a Limit with Father. There are no check boxes for specific tasks for this section.

Step 3: Modifications to the Protocol

If you *consciously decided* to modify or adapt the protocol during the session, or were unable to adhere to the protocol for some reason (e.g. poor affect tolerance, dissociation, stop signal, rigid defenses, unable to get an adequate Negative Cognition), check “Yes” in the Modifications to the Protocol” section of the form. Describe the modifications you made and your reasons for these clinical or practical modifications. Raters will take these explanations into account when evaluating your fidelity to the protocol.

Step 4: Additional Comments

You can offer any other comments relevant to the session at the bottom of the *Single Session Summary* Form. Keep in mind that the Rater may only be viewing this one session, and may have no contextual information about your treatment plan or conceptualization. It is recommended that you provide any information that you think the Rater will need to understand the treatment that you provided and the clinical decisions that you made in this session.

INSTRUCTIONS FOR CLINICIANS COMPLETING THE TREATMENT PLAN TRACKING (TPT) FORM

The *Treatment Plan Tracking* Form (TPT) is updated by the Clinician at the end of each session. See Figure 5 for an example. On this form, the Clinician is able to:

- Identify and track the presenting issues of a Client/Participant
- Identify and track the past, present, and future targets identified as relevant to specific presenting issues
- Note the session(s) in which identified targets are addressed

There may be one or multiple presenting issues over the course of treatment; the TPT Form provides a page for each presenting issue.

Step 1: Identifying Information. At Start and End of Treatment

Prior to the first session, at the top of the *Treatment Plan Tracking* (TPT) Form, record your Client/Participant's identification number (e.g. P12), your code (e.g., Clin-2), and the date of the first session. Upon completion of treatment, record the date of the last session and the number of sessions completed. This information lets others know, for example, that Client/Participant #12 received eight sessions, starting April 18, 2016, and finishing June 13, 2016.

Step 2: Identifying Presenting Issues

During or after a History-taking/Treatment Planning session, write the presenting issue on the top line of the TPT Form, by providing a descriptive title for the issue. If there are multiple presenting issues, start a new page for each one. For example, on page 1, the presenting issue might be "flashbacks of car accident at age 25", on page 2, it might be "fear of intimacy (related to history of sexual abuse by father)". See example, Figure 5.

Step 3: Identifying Targets Related to Presenting Issues during History-taking /Treatment Planning

During or after a History-taking/Treatment Planning session, on the relevant page, list the potential targets associated with a specific issue, by providing a descriptive title (headline/description) for each target. You will have collected this information during history-taking, using direct questioning or the floatback/affect scan technique. List one or more past, present, and future targets identified as relevant for each presenting issue. In the column labeled, *Identified in Session #*, write the number of the session in which the target was first identified. See example, Figure 5.

Step 4: Adding Presenting Issues and Targets in Subsequent Sessions

Add new targets or information to the form at any point in treatment when/if new details are obtained or if issues/targets are further clarified. As above, in the column labeled, *Identified in Session #*, write the number of the session in which the target was first identified. Similarly, a new presenting issue can be started on a new page, listing additional targets to be addressed during treatment.

Step 5: Noting Targets Processed in Each Session

After each session, write the session number beside the targets processed in that session. See Figure 5. The Figure also shows examples of how you can communicate additional information to the Rater about the processing of targets.

Step 6: Additional Comments

Include any additional comments that might help a Rater to better understand the decisions that you made in identifying presenting issues and choosing targets to process.

Figure 5: Example of Completed Treatment Plan Tracking (TPT) Form

PRESENTING ISSUE #1: <u>Flashbacks of a Car Accident at Age 25</u>					
TARGETS		Identified in Session #	Processed in Session #		
Past	other car running a red light and approaching head-on	1	3	4	
Past	being lifted into an ambulance	1	4		
Past	policeman's comments	1	4*		
Past	her car on fire	3	4*	5	
Present	request to attend an event that requires driving on a highway	1	6		
Present	reports of accidents in the news	1	6		
Present	nightmares thematically related to the accident.	1	X		
Future	comfortably and calmly driving on the highway	1	7		
Future	remaining calm when hearing about accidents on the news	1	X		
Future	remaining calm when passing accidents on the roadway	1	7		
COMMENTS: * = this memory emerged during processing of ambulance memory and was resolved in that session "X" = no processing was specifically done for these targets, as symptoms were eliminated as a result of earlier processing.					

INSTRUCTIONS FOR RATERS

Ratings of session recordings are made using the EFRS Scoring Form and then copied into the Blank EFRS Workbook. As noted earlier in this manual, the EFRS is a comprehensive rating instrument designed to assess treatment fidelity in single EMDR therapy sessions and adherence to the three-pronged protocol. The scale provides a breakdown of treatment components, with indicators for “acceptable” adherence, a rating system, and an easy-to-use scoring calculator. Fidelity ratings range from 0 (No Adherence) to 3 (Very Good Adherence), with a cut-off score of 2.0 for acceptable fidelity. The embedded scoring calculator in the EFRS Workbook automatically does the calculations for a number of different types of fidelity scores.

RATING CONSIDERATIONS

An important thing to keep in mind is that the Client’s response does not determine the fidelity of the treatment. A fidelity rating is not a measure of the skill of the Therapist or the success of the therapy. They can disagree in either direction: a therapy can be highly successful yet fail to follow the prescriptions of the therapeutic approach, or a therapy can be performed ineptly and unsuccessfully yet follow the procedures of the therapeutic approach precisely. If the Therapist followed the procedures precisely, even with a bad outcome, his/her Fidelity Score must reflect the adherence. Likewise, if the Clinician did not follow standard EMDR procedures, even if there is a wonderful outcome, his/her Fidelity Score must reflect the lack of adherence.

SCORING ITEMS ON THE EFRS

All EFRS items (except for those in the Three-pronged Protocol Subscale) are rated on a 4-point scale, 0 = no adherence, 1 = some adherence but inadequate, 2 = adherence acceptable, and 3 = adherence very good. Each item represents a specific procedural aspect of the EMDR Standard Protocol.

A score of “0” means that the Clinician completely failed to address a given procedural step in his/her work with the Client. A score of “1” means that the Clinician included or attempted to include a given procedural step, but failed to do it adequately or completely; adherence is somehow limited, questionable, and “inadequate”. A score of “2” means that the Clinician clearly included this step in his/her work with the Client, and although adherence was not 100%, it was “acceptable”. A score of “3” means that adherence to the protocol was “very good”. See Figure 6.

Never leave any item blank when you are scoring a section.

Figure 6: Example of Scoring on the EFRS

History-taking and Treatment Planning (HTP)					
1.	Gathers relevant history (according to framework provided in treatment manual).				
	0	1	②	3	NA
2.	* Identifies possible EMDR processing targets (past, present, and future).				
	0	1	2	③	NA
3.	Appropriately uses the “affect scan/floatback technique”, if information is not obtained from direct questioning, to identify past events related to current disturbance.				
	0	1	2	3	Ⓝ
4.	Proposes and discusses treatment plan (focused on past adverse life experiences (ALE), current triggers, and future goals) with Client.				
	0	1	②	3	NA

Critical Items

You will notice in Figure 6, that Item #2 is starred with an asterisk. An asterisk is used to indicate critical items or sections. The EFRS contains critical elements, sections or items that have been identified as essential to fidelity if done adequately. You do not need to do any extra work with these elements – the embedded scoring calculator in the workbook will assign these a double weight when calculating the fidelity.

Procedural Step Examples

Some items identify a particular procedural step and then list examples of what this step might include or what this step might look like to you, the Rater. The examples are followed by a plus “+” and a minus “-” sign. Mark “+” if this behavior is seen in the clinical session being reviewed and “-” if there is no sign of this behavior in the work. The list of various behaviors is included to help you evaluate whether there was adherence for a given procedural step and to track what you see in the session recording. The pluses and minuses do not affect the fidelity rating. Items with such multiple examples include Item #2 in the Preparation section of the Introductory Subscale, Item #10 in the Safe/Calm Place Exercise section of the Introductory Subscale, Items #4 and #14 in the RDI Subscale, Items #2 and #3 in the Reevaluation section of the ALE Processing Subscale, Items #4 #10, and #11 in the Desensitization Section of the ALE

Processing Subscale, and Item #1 in the Closure section of the ALE Processing Subscale. The Clinician does NOT need to receive a “+” on any or most examples to be rated as adhering to the protocol.

DIFFERENCES BETWEEN SCORES OF 0, NA, AND BLANK SECTIONS

Scores of “0”

A score of “0” is given when a particular step or procedure is not addressed at all, although its provision is necessary and part of the standard EMDR protocol in the situation being rated. For example, a Clinician completed Phase 5 of EMDR, with SUD=0 and VOC=7, but skipped the Phase 6 Body Scan, going immediately to Phase 7 Closure. No explanation (like “not enough time for body scan” or “Client became unexpectedly activated and needed assistance with regulation”) for the omission was provided. Consequently, all items in the Body Scan section would be scored as “0”. See Table 6. See also Sample Workbook, worksheet 7 for an example of omitting the Closure procedure. See also Sample Workbook, worksheet 8, for example of incomplete Safe/Calm Place and skipping Assessment of negative and positive cognitions and VOC.

Table 6: Examples for Items Scored as “0” or “NA” and Sections Scored as “0” or “Blank”

Example: Body Scan (section in ALE Processing Subscale) not addressed		
Context	Omission	Score
Phase 5 completed, SUD=0, VOC=7	Inappropriate	Score each item as “0”
Phase 5 completed, SUD=0, VOC=7, Therapist provided good explanation for omitting Body Scan	Appropriate	Score each item “NA”
Phase 5 incomplete at end of session	Appropriate	Leave section blank
Example: Floatback (Item #3 in History-taking and Tx Planning section) not utilized		
Context	Omission	Score
Did not identify past event related to present disturbance	Inappropriate	Score item as “0”
Able to identify past event related to present disturbance	Appropriate	Score item as “NA”

Scores of “NA”

If you decide that a particular omitted step was not necessary with a given Client, you can mark that item as NA (Not Applicable). An example of this would be Item #11 in the Desensitization section of the ALE Processing Subscale: *If material is stuck or looping, Therapist intervenes appropriately.* If there was no evidence of looping or “stuck” processing in a session, the

Clinician would not be expected to intervene. Item #11 would therefore be marked as NA. Another example is Item #3 in the History-Taking and Treatment Planning section of the Introductory Subscale: *Appropriately uses the “affect scan/floatback technique”, when necessary, to identify past events related to current disturbance.* If the Client was able to quickly and easily identify the earlier event(s) associated with his/her symptoms, the Therapist would not need to use the “affect scan/floatback technique” to identify potential targets. Item # 3 would therefore be marked NA. See Figure 6 and Table 5 for examples. Also see Sample Workbook, worksheets 1, 4, and 10.

Blank Section

If there is a section within the subscale that was not addressed in the session (e.g., because of a lack of time), simply leave that section blank. For example, when rating the Introductory Subscale, if the Therapist only completed History-taking and Treatment Planning, but did not address Preparation during the session, score the History-taking and Treatment Planning section and leave the Preparation section blank. See Table 6. See Sample Workbook for an overview of completed and blank sections.

Blank Item

Never leave any item blank when you are scoring a section.

Clinical Examples of Scoring Incomplete Sections or Sections Entirely Not Addressed

Clinician #1 did not start the Safe/Calm Place in her preparation session. Her Safe/Calm Place section is left blank and is not scored.

Clinician #2 started the Safe/Calm Place but did not complete it during his session. Clinician #2 explained on the Single Session Summary (SSS) Form that he had been unable to complete the intervention because he had run out of time. The items which he completed in the Safe/Place section are scored, and the remainder are marked NA.

Clinician #3 started the Safe/Calm Place. She completed only half of the Safe/Calm Place intervention and then went on to do the Assessment. She gave no explanation for the incomplete Safe/Calm Place intervention. The items which she completed in the Safe/Place section are scored, and the remainder are marked 0. The Assessment section is marked normally. See Sample Workbook, worksheet 8.

INSTRUCTIONS FOR RATING A SINGLE SESSION

Using the Clinician’s Single Session Summary Form

Raters are sent a session recording for review. On this recording is a single session with a single Client. The recording is accompanied by a *Single Session Summary* (SSS) Form. This Clinician checklist is meant to provide you, the Rater, with information about the content and focus of the session recorded. Look at the *Single Session Summary* Form to determine what Subscales and what sections of the Subscales, you will need to use in reviewing that recording on your Scoring Form.

For example, a Clinician checked off that he focused on Introductory phases in his session. More specifically, he completed History-taking and Treatment Planning as well as Preparation in this session. To rate this session, you would turn to the Introductory Subscale on the Scoring Form and prepare to complete the History-taking and Treatment Planning AND Preparation sections. If the Clinician checked off Adverse Life Experiences (ALE) Processing (Present Triggers and Symptoms) and Re-evaluation, Desensitization, and Closure, you would turn to the ALE Processing Subscale and prepare to complete the Reevaluation, Desensitization, and Closure sections.

If the Clinician did not check all relevant sections on the *Single Session Summary* Form, but provided treatment in these areas, you should score all sections and Subscales as if they had been checked. Then write “NOT IDENTIFIED ON SSS FORM” on the top of any Subscale that was scored, but not checked by the Clinician, and next to any section of a Subscale scored, but not checked by the Clinician.

In contrast, if a section was checked on the *Single Session Summary* Form, but was not, in fact, addressed in the session, you should rate all items in that section “0” (no adherence), and write “NOT ADDRESSED IN SESSION” next to the section title on the scale (which is next to the section check box). If none of the sections checked for a given Subscale were addressed by the Clinician, write “NOT ADDRESSED IN SESSION” at the top of the Subscale.

Rating a Single Session (Using INTRO, RDI, ALE, and FT Subscales)

Step 1:

The *Single Session Summary* Form has four parts, labeled with Roman numerals I–IV. If the Clinician addressed the topics of a given part, he/she will have checked the box next to the bold-faced title of the section. For each part so marked, find and pull out the appropriate Subscale from the EFRS Scoring Form. Individual Subscales are one to five pages in length.

Step 2:

Complete the Scoring Form header at the top of each Subscale you have pulled. Copy Client #, Clinician Code, Session #, and Date of Session from the *Single Session Summary* Form. Enter today’s date for the Date of Review. Enter Rater 1 or 2 (or 3, 4, etc.) for your Rater #.

Step 3:

Part I and III of the *Single Session Summary* Form each has a series of check boxes. Each check box matches a section on your Subscale scoring form. Place your own check marks in the boxes on your Subscale scoring form that match the boxes checked on the Clinician's *Single Session Summary* Form. (This marks the sections in each Subscale that you need to complete.) Refresh your memory by reviewing the items that you will be scoring for each section of the Subscales.

Step 4:

Now begin to review the recording of the session.

Step 5:

As you listen, confirm that you have the Subscale appropriate for the portion of the recording that you are reviewing (*e.g.*, Introductory Subscale), and keep this in front of you.

Step 6:

Identify the section of the Subscale being addressed (*e.g.*, Preparation), and quickly remind yourself of the items to score (*e.g.*, 1. Offers a coherent explanation/rationale for EMDR, 2. Offers clear instructions to Client about his/her role ... 5. Establishes metaphor).

Step 7:

Review this portion of the recording. As you do so, mark provisional scores for each item. For example, the Clinician may have offered some instructions to the Client about his/her role, but did so inadequately (*Score = 1*). Mark these in pencil. Be sure to mark "NA" (not applicable) for an item when you feel that the Clinician did not need to address that particular procedural step. In other words, if the step is not relevant for a given Client, mark "NA". See example in Figure 6, page 24.

Step 8:

As you continue to review the session recording, update these scores as appropriate. For example, later in this portion of the session, the Clinician may have offered additional instructions, justifying a score of 2 or even 3. (In most cases, the final score will be the highest score you mark along the way.)

Step 9:

When the recording moves on to another portion of the protocol, locate the Subscale appropriate for this portion. Review this portion of the session by repeating *Step 5* through *Step 7*. Repeat this for each portion of the protocol addressed in the session.

Step 10:

When the end of the session is reached, go back and enter "0" (no adherence) for all items that have not been given any provisional scores, unless a score of "NA" (not applicable) is more appropriate.

Step 11:

You will discover that you often will want to go back and review the entire recording, or parts of the recording, one or more times. This is normal when attempting to complete fidelity scales.

Keep going back and reviewing until you feel confident that your ratings are as accurate as you can get them.

INSTRUCTIONS FOR RATING THE THREE-PRONGED PROTOCOL SUBSCALE AT THE END OF TREATMENT (Using the Three-pronged Protocol (TPP) Subscale and the Treatment Plan Tracking (TPT) Form)

This Subscale differs from the other Subscales, which are used to evaluate the Clinician's performance and treatment adherence during a single session. The Three-Pronged Protocol Subscale is completed when therapy is finished and determines whether the Clinician conceptualized, planned, and worked with the Three-pronged Protocol in mind during the entire course of treatment. It assesses whether the Clinician adequately identified past events, present triggers/symptoms, and future goals relevant to a particular presenting issue, and whether these targets were comprehensively addressed. The purpose here is not to evaluate performance, or to assess the quality of treatment conceptualization. The purpose of this subscale is simply to determine if the Clinician adhered to the framework of the Three-pronged Protocol.

This Subscale uses the information collected on the *Treatment Plan Tracking* (TPT) Form and provided to you upon the completion of treatment. The Subscale has six items, which require simple No/Yes evaluation. See Figure 7 for an example. The embedded scoring calculator scores these as 0 or 3

Step 1: Enter Identifying Information

Complete the header at the top of the Three-Pronged Protocol Subscale. Copy Client/Participant # and Clinician Code from the TPT Form. Enter today's date for the Date of Review. Enter Rater 1 or 2 (or 3, 4, etc.) for your Rater #.

Step 2: Determine the Presenting Issue that will be the Focus of Evaluation

Read through all the pages of the Treatment Plan Tracking (TPT) Form to get an overview of the treatment provided. Determine which presenting issue has the most prongs with identified targets, and the most targets addressed in treatment. Select that presenting issue to respond to the questions in this Subscale. In other words, choose the presenting issue that was most extensively addressed in the course of treatment. You will be keeping this presenting issue in mind as you evaluate whether the therapist properly attended to past, present, and future targets in his/her work with the client/participant.

Step 3: Determine Whether Clinician Followed the Three-pronged Protocol in Identifying Presenting Issues and Relevant Targets

For Items #1, #2, and #3, determine if the Clinician listed, at least one target (title/description) for each of the three prongs (past, present, and future) related to the selected presenting issue. If

so, score items as “Yes”; if not, score as “No”. If the Clinician states that an attempt was made to identify a target, but the Client was unable to do so, or uninterested in doing so, score as NA.

Figure 7: Completion of the Three-pronged Protocol Subscale

1. For a specific presenting issue, appropriately identifies target(s) related to past adverse life experiences.	No	<input checked="" type="radio"/> Yes	NA
2. For the same presenting issue, appropriately identifies target(s) related to current triggers or symptoms.	No	<input checked="" type="radio"/> Yes	NA
3. For the same presenting issue, appropriately identifies target(s) related to future behaviors and goals.	<input checked="" type="radio"/> No	Yes	NA
4. For the same presenting issue, processes relevant past adverse life experience(s), using the standard EMDR protocol.	No	<input checked="" type="radio"/> Yes	NA
5. For the same presenting issue, processes relevant associated present trigger(s)/symptom(s), using the standard EMDR protocol.	No	Yes	<input checked="" type="radio"/> NA
6. For the same presenting issue, installs future template(s) relevant to client’s desired behaviors and goals.	<input checked="" type="radio"/> No	Yes	NA

Step 4: Determine Whether the Clinician Followed Through with the Processing of Targets Identified in the Three-pronged Treatment Plan for a Specific Presenting Issue

For the selected presenting issue, determine if the Clinician addressed ALE processing for past, present, and future targets. If processing was provided, score the relevant items as “Yes”; if not, score as “No”. Please read the Clinician’s comments to better understand his/her case conceptualization and decision-making. The Clinician may not have been able to complete work on all three prongs for various reasons (not enough time, Client was unable to tolerate the work, a given target or trigger no longer required attention after processing other targets). If so, score as NA.

Note, if you are unclear about the information provided on the *Treatment Plan Targeting* (TPT) Form, you can ask the Researcher to forward all of the *Single Session Summary* (SSS) Forms for a given Client to you. This will allow you to have more information for rating purposes.

USING THE EFRS WORKBOOKS

The EFRS workbook contains 10 worksheets, each devoted to either fidelity evaluation for a single session (involving one or multiple subscales) or Three-pronged Protocol evaluation (involving the TPP Subscale) for the entire treatment. Each worksheet has an embedded scoring calculator, which calculates the Single Session or Three-pronged Protocol Fidelity Score from the data entered on that worksheet. The 11th worksheet is the *Workbook Summary* page, which lists all the subscale and fidelity scores in the workbook, automatically copied from the first ten worksheets. The final (12th) page of the workbook is used to calculate the Study Fidelity Score. If data only from the current workbook are included, the Workbook Fidelity Score is calculated.

General Directions for Using the Workbook

- (1) **DO NOT** fill in any cells other than those in green at the top of the spreadsheet (for identifying information) or in blue (for Intro, ALE, and FT subscales) and purple (for TPP subscale).
- (2) **DO NOT** edit, delete, or fill in any other cells. All other cells (e.g., the “Mean” section score in the pink cell at the end of each line, and the Single Session Fidelity Score or Three-Pronged Protocol Fidelity Score in green and pink at the bottom of the sheet) are filled in automatically, based on the information you enter in the green and blue cells. Note that deleting the formula in any green or pink cell may create problems with the embedded scoring calculator. See Trouble Shooting section on page 35 for instructions on remedying this problem.
- (3) Prior to starting the rating, you should have received instructions from the Researcher about how he/she wants the workbooks to be organized. (See pages 12-13). The workbooks can be set up to contain ratings for a single Client, a single Clinician, or for a random selection.

(4) If the Researcher sends you more than 10 recordings/forms that would belong to that workbook, simply start a second workbook.

(5) Each single session is scored on its own individual worksheet.

(6) The Three-pronged Protocol Subscale is scored on its own worksheet.

(7) It is very possible that you will not score sessions in chronological order. This is not a problem. If the “Recording 4” spreadsheet is for a session that came before the session scored on the “Recording 3” spreadsheet, this will be clear from the session dates, entered in the green cells at the top of the two spreadsheets.

INSTRUCTIONS FOR TRANSFERRING SCORES TO THE WORKSHEET

Step 1:

After scoring the first session for a specific Client, the Rater creates an EFRS Workbook to hold the scores. This is done by copying the file “Blank Scoring Form.xls”, and saving it with a new name. The name should reflect the content of the workbook. For example, if all ratings in the workbook will be for Clinician #2, the file “name” could be the Clinician’s code (e.g., Clin-2) and your Rater’s number – i.e., Clin-2 R#2.xlsx. If the ratings will be for multiple Clinicians and random sessions, the file name could be the number of the workbook and your Rater’s code (e.g., Book-1 R#2.xlsx).

Step 2:

Open the Excel workbook (e.g. Book-1 R#2.xlsx file), and click on the tab at the bottom corresponding to the worksheet number. For example, if this is the first recording/form in the book, click on “WS 1”.

Step 3:

Fill in the green cells at the top of the spreadsheet (Figure 8), using the information written at the top of the *Single Session Summary Forms* and the EFRS Scoring Form.

Figure 8: Adding Identification Information in Worksheet

Client/Participant #	P15
Clinician Code	Clin-2
Session # (or “TPT”)	1
Date of Session (or “TPT”)	7/4/16
Rater #	Ra-2
Date of Review	12/1/16

Step 4:

For each Subscale, there are one to six rows on which to enter your scores. The Subscales are separated by solid lines and are located in rows 12 through 31. For each Subscale, there is one row for each section of the Subscale, with each row having as many blue cells as there are items in the section. For example, there are three lines on which you enter your scores for the Introductory Subscale, corresponding to the three sections of the Subscale. The “Preparation” line (line 13) has five blue cells, corresponding to the five items in the Preparation section of the Subscale.

Step 5:

Copy the scores you entered on the paper Rating Scale into the blue cells in the worksheet. Do not enter anything on the lines corresponding to those portions of the protocol that were not covered in the session. Do fill in *all* the blue cells on any line that refers to a portion of the protocol that was covered. You will notice that the scores you enter for weighted items and sections appear in red. You will also notice that the embedded scoring calculator automatically calculates the mean score for each subscale in the pink column, as well as the mean score for each section. See Figure 9.

Figure 9: Copying Scores into the Worksheet

	ITEM NUMBER												Score
	1	2	3	4	5	6	7	8	9	10	11	12	
<i>I. Introductory (INTRO) Subscale</i>													
History Taking and Treatment Planning	1	2	3	3									2.20
Preparation	2	3	2	1	0								1.60
Safe/Calm Place Exercise	2	3	2	2	1	2	0	2	NA	NA			1.75
													1.95

Step 6:

Double-check your work. Are all scores entered correctly? Check the *Workbook Summary* page, and make sure that no section is rated as “0” unless that was your intention. Unintentional section ratings of “0” indicate that the formula in the scoring calculator has been deleted. See Trouble shooting section below for directions on addressing this problem.

Step 7:

Save the workbook and close it.

TROUBLE SHOOTING

Accidentally deleting one of the calculator cells (O12 -O31) on one of the individual Worksheets (Worksheet 1-10).

This problem will be evident on the *Workbook Summary* page with a score for “0” as a mean for that section.

This problem can be easily remedied by copying the calculator column from an unused worksheet and pasting it into the corrupted worksheet. Here are the steps:

1. Locate a sheet on which the calculations are all intact.
2. Copy the column of pink cells P12:P31, and paste it into cell P12 on the corrupted spreadsheet.

Accidentally deleting the calculator cell (B34) on one of the individual Worksheets (Worksheet 1-10).

This problem will be evident on the *Workbook Summary* and *Study Summary* pages with a score for “0” for Single session Fidelity.

1. Go to an uncorrupted worksheet, copy the pink cell B34, and paste it into cell B34 on the corrupted spreadsheet.

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