Online EMDR for complex trauma: A feasibility trial of EMDR and AI-EMDR for attachment-informed complexity

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1. General information

1.1 Sponsor Details

Psychological Sciences Research Group, Faculty of Health and Applied Sciences, **University of the West of England**, Coldharbour Lane, Frenchay, Bristol, BS16 1QY

Principal Investigator: Christine Ramsey-Wade

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Research Associate/Fellow: TBD (likely to be 1-2 days per week during 12-month contract)

1.2 Funder Details

EMDR Association East Anglia Regional Group, contact: Joe Kearney, 188 Hall Road, Norwich, NR1 2PP, joe@beechmount.co.uk , 07962 966634

1.3 Collaborator Details

Mark Brayne, 1a Havelock Rd, Sheringham, Norfolk, NR26 8QD, mark@braynework.com 07711 888682

1.4 Role allocation

The Collaborator has reviewed the research protocol but will have no role in analysis, data interpretation, report writing or in the decision to submit the report for publication.

Recruitment, data collection and analysis will be led by the research associate, with the Principal Investigator providing support throughout the project, particularly around assessing fidelity, therapist communication, writing and dissemination.

The Collaborator will also help with adherence and integrity, assisting to collate protocols for the therapies under study, providing and supporting the assessment of participating AI-EMDR therapists against inclusion criteria, organising the provision of AI-EMDR supervision to ensure compliance with AI-EMDR protocols, and assisting with fidelity checks for the AI-EMDR arm of the study.

We look forward to collaborating with the Funder and the Scientific Research Committee of EMDR UK to enrol appropriately trained and qualified EMDR therapists, supervisor and independent assessor to the SP EMDR arm of the feasibility trial.

2. Study Summary

2.1 Project start date

1 April 2022

2.2 Project end date

1 April 2024

2.3 Aim

- To test the feasibility of a research study design for a future randomised controlled trial examining the efficacy of online Attachment-Informed EMDR and online standard EMDR for clients with attachment-informed complexity

2.3.1 Hypotheses and outcomes

The main hypothesis is that this design is feasible for a multi-site randomised controlled trial of variations of the EMDR standard protocol for clients with complex needs after traumatic experiences.

The randomised controlled trial design under study will seek to explore what is gained or lost by simplifying and developing the eight-phase protocol to allow a tighter and more creative focus on what might be termed the rewiring of early childhood experiences.

So, the primary research question is whether the proposed RCT design would be feasible for a full trial, seeking to test whether an explicitly attachment-informed approach to EMDR is at least as effective as the Standard Protocol in reducing and reprocessing stories of complex trauma.

The hypothesis of the RCT under study is therefore that AI-EMDR is not inferior to EMDR for clients with attachment-informed complexity, within a margin of tolerance.

The secondary aim of the RCT design under study is to capture preliminary outcome data on EMDR and AI-EMDR online for such complexity, since published data on online trauma-focused psychotherapy, or data comparing different EMDR protocols, is limited (Rydberg & Machado, 2020).

A further significant and valuable outcome of this project will be the collection of data on the feasibility and accuracy of the fidelity measures within the RCT design, one of which is a novel measure created for this project. To achieve this, demonstration that the novel measure can provide effective measurement of fidelity for AI-EMDR will be key, including blind rating and inter-rating validity.

2.4 Study design

Feasibility trial

2.5 Setting

UK private practices delivering EMDR and AI-EMDR online for clients with attachment-informed complexity.

2.6 Participants

Clients receiving EMDR and AI-EMDR online in the private sector.

2.7 Timeline

- Drawing up of contracts, writing job description and recruiting RA: April – August 2022
- Application for ethical approval of study materials/procedure: September - November 2022
- Study recruitment: November 2022 – February 2023
- Data collection and management: December 2022 – April 2023
- Data analysis: January 2023 – May 2023
- Knowledge exchange / impact activity, dissemination, writing up and submission for publication: July 2022– December 2023

2.8 Target sample size

While 10-12 patients per arm would provide useful data, such an *N* is likely to be over-powered – i.e., prediction from this sample size for a full RCT would have a larger margin of error.

Prediction would be more accurate with a sample size of 20-22 patients per arm, as this would reduce the error by 50%.

Therefore, to reduce the risk of this feasibility study being over-powered and to ensure adequate data from this study for a power calculation, the **target sample size per arm is 20-22 patients**. The recruitment period will be monitored throughout the study with this in mind.

3 Introduction

3.1 Background

Eye Movement Desensitisation and Reprocessing (EMDR) is a well-established psychotherapy which aims to support clients to process adverse or traumatic life experiences, so that they can re-build their lives.

The original or Standard Protocol for EMDR set out eight treatment phases: history-taking, preparation, assessment (including exploring cognitions, beliefs and schemas around the event), desensitisation to the trauma, installation of processing, body scan, closure and re-assessment. Shapiro (2018) set out the 8-phase treatment model clearly in her original EMDR protocol, which will be used for the active control arm of the RCT design under study in this feasibility trial.

3.2 Rationale for current study

Recent research has called for re-evaluation of the traditional Standard EMDR Protocol, and whether EMDR can be delivered more simply, creatively, and effectively (Rydberg and Machado, 2020). The EMDR Council of Scholars (Laliotis et al., 2021) has set out the case for EMDR to be understood and practised as an integrative psychotherapy, adjusted and adapted according to the needs of more complex individual clients. For example, Farrell et al.'s 2020 paper on the Blind to Therapist protocol explores whether and how the eight-stage protocol could be adapted to clients who felt unable to verbally disclose their trauma, due to shame or fear of retribution. The aim of Farrell et al.'s study was to make EMDR more accessible to groups experiencing acute trauma due to war or genocide, who may not wish or be able to disclose the details of their traumatic experiences to their therapist.

In the Blind to Therapist study, to make EMDR more accessible to these underserved groups, verbalising cognitions about the event were bypassed, to allow a greater focus on the emotional and physical aspects of the memory while maintaining the client's privacy. Therapists in the Farrell et al. study focused on assessing the clients' emotional and physical trauma symptoms, while those undergoing the EMDR Standard Protocol assessed cognitions around the trauma as well. This small study found the Blind to Therapist protocol to be as effective as the Standard Protocol, and better tolerated by the target population.

This begs the question of the centrality of each aspect of the full Standard Protocol, and whether it is possible to modify (and complement) the original protocol while retaining its core components (Rydberg & Machado, 2020). Farrell et al acknowledged that something is lost in the Blind to Therapist protocol, as there is perhaps less clarity around the event or memory being processed (Farrell et al., 2020). Nonetheless, it made EMDR more accessible for under-privileged groups, and it retained all the core elements of EMDR – activation of the memory of the event, dual attention bilateral stimulation, and reprocessing of that memory - so that clients can recall events and experiences without re-living them. As shame can be a barrier to accessing trauma-focused psychotherapy (Cummings and Baumann,

2021), it is important to continue to research trauma-focused therapies that rely less on verbal accounts of traumatic experiences and the cognitions around this to make services as accessible and effective as possible.

Other adaptations of the original eight-phase EMDR protocol adopt a similar shift. Attachment-Informed (or Attachment-Focused) EMDR also bypasses the positive cognition in Phase 3, focusing equally on the emotional and physical components of adverse childhood experiences which are often at the heart of complex trauma. Explicit cognitive reframing of the event is left until after the client's root maladaptive attachment experiences have been processed. In addition, AI-EMDR offers the client a more comprehensive imaginal resourcing experience in Phase 2, as well as using proactive bridging (cf Floatback) in Phase 3 for target identification, a wider and richer range of imaginal interweaves in Phase 4, and a tight session structure to consolidate reprocessing of earlier-life attachment dysfunction. Clinical experience indicates that a simplified, relational and creative approach can enable a more rapid and deep connection to adverse attachment experiences in childhood, allowing the repair of events which may be key to the development of the client's current way of being in the world and their difficulties. The aim of AI-EMDR, therefore, is to integrate aspects of the self (aka Parts/Ego States) which emerged to survive difficult childhood experiences, and even to process trauma passed down through generations. AI-EMDR then, like Standard Protocol EMDR, is an integrative psychotherapy (Laliotis et al., 2021). However, to our knowledge, there have been no studies to date exploring EMDR for distress arising from developmental attachment deficits in early life, either in its Standard Protocol format or with attachment-informed modifications, nor any studies focusing on the delivery of these therapies for such complexity online. Indeed, as Rydberg and Machado noted in their 2020 review of EMDR as an integrative psychotherapy, very few studies have compared the Standard EMDR Protocol to any other specific protocol.

Associations such as the EMDR International Association (EMDRIA) provide accreditation for EMDR training programmes which adhere to the core components of Shapiro's (2018) Standard Protocol (Laliotis et al., 2021). Accreditation therefore provides a key indicator of adherence and integrity. The AI-EMDR protocol under study in this project has been approved by EMDRIA, and therapists delivering the AI-EMDR intervention arm will be required to have undergone practical EMDR Association UK-approved workshops in its delivery. A copy of the AI-EMDR protocol can be found in Appendix 1.

It is also paramount that the two interventions are clearly differentiated in this study, and that adherence to protocol is monitored closely. Fidelity to both Standard EMDR and AI-EMDR will be measured for both therapist cohorts by EMDR Europe-accredited and AI-EMDR-trained consultants acting as independent assessors, in conjunction with the EMDR accredited practitioners, using the EMDR Fidelity Rating Scale (FRS; Korn et al., 2018). Participating therapists will be asked to complete the FRS Single Session Summary (SSS) form immediately after each session. The original SSS form will be used for the EMDR arm (see Appendix 2), and an amended version of the SSS, with appropriate additional criteria relating to the distinctive AI-EMDR elements of that arm, has been pioneered for this study

(see Appendix 3). This self-assessment tool will provide a simple and feasible manipulation check. Participating therapists will be asked to submit a recording from their current practice prior to data collection, to enable familiarisation with the coding system. 10% of sessions will then be randomly selected and assessed by therapists and the independent assessors using the FRS, with the aim of achieving a Study Fidelity score of 2.0 or greater.

As this is a pilot feasibility trial, the number of sessions per client will be limited to 10. This number of sessions has been selected as it was found to be the mean number of sessions for trauma-focused therapy for c-PTSD in a recent systematic review and meta-analysis (Coventry et al., 2020). Some clinicians have found EMDR and AI-EMDR to be effective for clients experiencing trauma-based complexity within 10 sessions; there are also some findings indicating that a longer course of therapy may be needed for this population (Laliotis et al., 2021; Van der Kolk et al., 2007). This pilot trial will provide an opportunity to provide data on whether this design could collect sufficient data to indicate effectiveness.

4. Objectives

The aim of this study is to conduct a pilot feasibility trial testing an RCT design examining the efficacy of online AI-EMDR and EMDR with clients experiencing distress arising from maladaptive early life attachment experiences. This would indicate whether further, larger, randomised and controlled studies of the efficacy of AI-EMDR or EMDR for complex trauma, using this model, are warranted.

The specific features and objectives of the design under study are to:

- Recruit five therapists specialising in standard EMDR and a further five who are additionally trained in AI-EMDR, who agree to work to established protocols for each intervention, i.e., Shapiro's eight-phase Standard Protocol for EMDR, and Attachment-Informed modifications to that protocol clustered around six core AI-EMDR principles now widely practised in the UK (Brayne, 2021; Parnell, 2013; Dworkin, 2005; Appendix 1).
- Therapists will have completed an approved (carrying EMDR Association UK or EMDR International Association CPD points) training in Attachment Informed EMDR and/or EMDR, work in private practice online and have a current caseload of clients with a complex trauma history, indicating experience and expertise, to ensure equivalent experience and qualifications of practitioners in both arms. A recording of a recent client session, made with consent, will be submitted to the supervision team to screen therapists for their ability to provide protocol coherent EMDR, and to provide training in using the EMDR Fidelity Rating Scale.

- A call for consenting client participants will be circulated via Jiscmail, EMDR UK email distribution lists, and other contacts within the EMDR community, with the aim of recruiting 40-44 client participants. Therapy will be offered low-cost (£65 per session), with project funding used to top up session fees to £80 per session for participating therapists. Interested clients will submit questionnaires to the research team assessing trauma symptoms and complexity/resilience to determine whether they meet the study criteria for complex trauma. Clients who do not meet the required level of complexity will be offered therapy via an independent provider (EMDR Focus).
- After baseline data has been collected, participants will be randomised in blocks in alternating order to receive either the Standard Protocol (SP) EMDR or AI-EMDR, both delivered online, and allocated to therapists.
- Therapists will collect baseline data from clients before commencing treatment and at each session for 10 sessions.
- Pre and post qualitative survey data from clients on their experience of the therapy will also be collected by the research team.
- Therapists will be provided with free online group supervision, including a pre-study meeting, to incentivise participation and to ensure adherence to protocols. Two pro bono Consultants will each lead one supervision groups per arm. The two supervision groups will meet every three weeks, with consultants available for support between meetings.
- Consent will be collected from participants for all sessions to be recorded for research purposes, and therapists will complete a Single Session Summary (SSS) form, appropriate to their arm, after every session.
- One pro-bono independent assessor for SP EMDR will also be recruited to the study team, alongside the study collaborator, who will act as the independent assessor for the AI-EMDR arm of the trial, again ensuring equivalent experience and qualifications of the assessors for both arms.
- Before data collection, the collaborator will carry out work to validate the AI-EMDR fidelity checklist, by leading work to test the blind and inter-rating validity of the measure within his own community of practice

- Once data collection has commenced, a randomly and blindly selected session recording will be submitted to the independent assessors for a fidelity check during the data collection period, to scrutinise adherence and inform the supervision process. Fidelity scores will be collated into the study ERFS workbooks to measure fidelity to protocols throughout. Feedback will be provided to supervisors to improve practice and adherence.
- Supervision sessions will also be recorded for research purposes. The independent assessors will also view one recording of a supervision session per arm, to check fidelity, providing feedback to the supervisory team as appropriate.
- Therapy can continue after 10 sessions, using whatever approach is felt most appropriate, as negotiated independently between therapist and client.

5. Features of the feasibility trial

5.1 Data protection

All good practice guidelines for research from the University of the West of England, the Health and Applied Sciences Faculty Research Ethics Committee, and the British Psychological Society will be observed.

5.2 Inclusion/exclusion criteria

As the trial design under study focuses on attachment-informed complexity, trauma symptoms will be assessed at recruitment using the Short Post-traumatic Stress Disorder Rating Interview (SPRINT-8) and the International Trauma Questionnaire (ITQ), which maps onto the World Health Organisation's ICD-11 definition of complex trauma (Cloitre et al., 2018). The ITQ was selected as the primary measure for this study due to its capacity to detect attachment-informed trauma within presentations arising from the absence of repair following difficult early experiences. The Brief Resilience Scale (BRS-6) will also be used, as an impaired ability to rebound from stress is a common feature of attachment-informed complexity. Interested client participants whose scores meet ITQ criteria for complex trauma (i.e., evidence of symptoms of both PTSD and Disturbance in Self-Organisation) and clinical cut-off scores on the BRS-6 and the SPRINT-8 will be admitted into the study:

- Maximum score of 2.99 on the Brief Resilience Scale (BRS-6; Smith et al., 2008)
- Meeting the minimum diagnostic criteria on both the Post-Traumatic Stress Disorder and Disturbances in Self-Organisation subscales of the International Trauma Questionnaire (Cloitre et al., 2018)

- Minimum score of 14 on the Short Post-traumatic Stress Disorder Rating Interview (SPRINT-8; Connor and Davidson, 2001)

Formal diagnoses of c-PTSD will not be required, as this pilot study is primarily focused on testing the research design, with a secondary focus on reductions in symptomatology. Interested client participants who do not meet these criteria, i.e., who do not meet the threshold required on every questionnaire, will be referred to an independent company for support (EMDR Focus).

Interested participants who are currently suicidal or judged to be high risk will also be excluded. All interested participants will also be asked to complete the Public Health Questionnaire (PHQ-9) at recruitment. If this screen or their initial therapist assessment indicates a high level of risk, clients will also be immediately referred for more targeted support outside of the study.

5.3 Recruitment

The project team will create appropriate recruitment emails, which can be circulated to existing mailing lists of appropriately trained therapists. Draft emails will be included in the application for ethical approval for the study to the University of the West of England Faculty Research Ethics Committee (FREC). Appropriate participant information sheets, consent forms and demographics forms will be created. All therapists will be experienced in managing risk and supporting clients who have experienced trauma.

5.4 Publicising the study

Research will be promoted through the EMDR East Anglia and AI-EMDR networks and through other methods (e.g., EMDR UK mailing lists and JISCMail), as defined by the Funder and Collaborator and as set out in the FREC application.

5.5 Data collection method

Information sheets, consent forms, demographics forms, and psychometric data will all be circulated and collected via the UWE Qualtrics account, to ensure data protection and cloud storage. Qualitative and demographic questions will include levels of training and qualification / accreditation in mental health / EMDR for therapists and explore clients' personal experiences of EMDR for complex trauma. All measures will be administered pre and post 10 sessions of EMDR, as well as after every session, to ensure a complete data set in case of attrition or missed sessions, and to collect data on changes over time.

5.6 Consent

The Qualtrics survey will incorporate a participant information sheet, privacy notice and consent form. The participant information sheet will detail the purpose of the study, the research team, data storage policy and confidentiality procedures. Fully informed consent will be gained from each participant prior to joining the study, with multiple opportunities

offered to contact the research team to answer any questions. All participants will also be informed of their right to withdraw their data at any point, for any reason, for up to one month after data collection is completed.

5.7 Data collection period

Data to be collected over a minimum period of 6 months in autumn 2022 – winter 2023. Therapists will be incentivised to take part through the provision of free, fully accredited group supervision for their caseload during the trial. Financial support will also be provided to therapists, for providing low-cost therapy to clients, as part of this trial. Participants will be recruited independently, via online calls. If the target sample size is not achieved within this data collection period, this will be reflected on as appropriate within the feasibility data set.

5.8 Randomisation

This study will test the feasibility of a 1-1 blocked randomisation procedure for any future randomised controlled trials. After baseline data has been collected, participants will be randomised in blocks in alternating order. This will ensure that equal numbers are allocated to each arm of the study. Due to the small sample size of this pilot, no attempt will be made to stratify the samples on severity.

Commented [CRW1]: Need to clarify what blinding, if any, will be part of this randomisation procedure. Do we mean blind alternating allocation, true randomisation, etc?

5.9 Analysis

The main study hypothesis will be tested in many ways across the research process, including but not limited to:

- The effectiveness of the recruitment process
- Level of interest from participants in the study
- The number of eligible participants recruited
- The willingness of participants to be randomised
- The effectiveness of the data collection method
- The level of fit between the selected outcome measures and the study aims
- Data completion rates
- Negative outcomes
- Whether additional sessions were needed after data collection was completed, and if so, how many

Data on indicators of feasibility will be displayed graphically.

Within the RCT design under study, outcome data from each group will be compared against each other at the end of the study. An ANCOVA will be conducted to search for any indications of preliminary efficacy of EMDR and AI-EMDR for attachment-informed complexity.

Any qualitative questionnaire data on the experience of the different interventions will also be collated and analysed alongside the feasibility data, using a content level reflective thematic analysis method. A CONSORT diagram will be constructed before data collection and analysis, to ensure transparency and robustness of the study design.

6 Data handling and record keeping

All participants will be assigned a Participant Identification Number to protect their anonymity. Data will be stored and shared through the secure UWE OneDrive, and will not be shared over email, to ensure that participant confidentiality is always protected. All data will be destroyed once dissemination plans are completed.

7 Managing risk

A risk assessment has been completed and uploaded to Worktribe alongside this draft research proposal.

As stated earlier, all therapists will be experienced in managing risk and supporting clients who have experienced trauma. Interested participants who are currently suicidal or judged to be high risk will be excluded from the study for health and safety reasons. All interested participants will be asked to complete the Public Health Questionnaire (PHQ-9) at recruitment. If this screen or their initial therapist assessment indicates a high level of risk, clients will be referred for more targeted support outside of the study.

Should an adverse event occur during therapy, supervisors will be available for extra support and consultation to ensure participant safety. All participants will be informed of the procedure for making a complaint at any time during the study in the participant information sheet. Complaints will be managed by the research team on a case-by-case basis. Qualitative data will be solicited from all participants, including participants who choose not to complete their therapy or drop out from the study, as their views could hold especially important learnings for this feasibility study. Participants who choose to withdraw from the study prematurely will therefore be contacted by the study team for feedback and support and offered follow up care with an independent provider (EMDR Focus). A clear framework for the management of risk during therapy will be agreed with the independent provider and collaborator before data collection commences.

This feasibility study will be covered by the UWE clinical trial insurance policy.

8 Dissemination and impact

Results will be disseminated via internal and external events and a publication in a peer-reviewed journal, a copy of which will be shared with the sponsor.

The research will aim to increase the evidence base and thus the availability of appropriate therapies for clients with a complex trauma history.

9 Ethical approval

Before data collection commences, an application for ethical approval for this study will be submitted to the FREC, including this research proposal, participant information sheets, consent forms, privacy notices, copies of all psychometrics, and recruitment material. Data collection will not begin until any required amendments are completed and approved.

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Appendix 1: AI-EMDR protocol

AI-EMDR SIMPLIFIED PROTOCOL

Phase 1: Case Conceptualisation

- How did this person get to be the way they are?
- How learned to affect-regulate/self-soothe?
- What's the story? (Think 4 Levels of Trauma).

Phase 2: Preparation:

Special/Calm/Peaceful/Safe Place. (SP)

- *Location, real or imaginary, where you can imagine feeling relaxed, at peace, calm…*
- *Notice what you can see (colours, quality of the light, sky, clouds, time of day, landscape…)*
- *Notice what you can hear / touch / sense (air on your skin, ground beneath you) / smell / taste.*

Knee taps/EMs/buzzers/headphones (>>>).

As they tap, maybe *notice where it feels good in your body and breathe into that space. Let me know when you have a good sense of that.* ("Nod", "Say When"). #HASHTAG/Cue Word? Tap that in too.

Resource team. *Real/imaginary, human/animal, historical/contemporary, from own experience, history, literature, mythology, religion, Hollywood, fairy tales…*

3 x Nurturing Figures: *Qualities of Kindness, Gentleness Tenderness, Compassion, Care…* Identify all, then, inviting each to step forward in turn tap in 1 by 1.

3 x Protector Figures: *Strength, Determination, Courage, Steadfastness, and yes, Ferocity…*

1+ Wise Figure: *Just Wisdom: Indivisible*

Tap in as team *(w/awareness of SP in background)*

Presenting Issue *e.g. If there's one thing you could change today, in the time we have.*

Phase 3 Assessment/Targeting:

Picture/ image of most intense (charged/worst?) moment. Curiosity: what is the most appropriate point.

1. IMAGE *What image goes with that?*
2. EMOTION *Connecting with that image, what's the emotion (or what are you feeling)?*
3. BODY *Where's that happening in your body?*
4. BELIEF *What's the thought or belief about yourself that goes with that? (e.g. I'm….)*

If bridging, if no picture but just a feeling, can bridge from impulse/emotion/ body sensation. *Shape, size, colour, temp hot/cold, vibration high/low, texture hard/soft, rough/ smooth.*

NB NO BLS at this point.

Then, Bridge (cf Floatback). (Exact words)

1. *Drop (or trace it) back in time.*
2. *Go back as far as you can.*
3. *Very first place you land.*
4. WAIT!! (Maybe, rpt *VERY 1st place.*)

How old are you? Where are you?

Note whether Target, Portal, Stepping Stone.

Re-Target, positioned in space and time. (Same Sequence as bridge.)

- **Image/Emotion/Body/Belief: Go!**

Now, connecting with all of that (can remind if needed), notice what/ let whatever happens. >>>

Phase 4: Desensitisation/Repairing

Sets not too long or short. (Baseline 30"). Track client.

What are you getting? What do you notice?

- If things moving, *Go with That/Notice That.*
- When narrative unfolding, *Follow That.*
- Think about That *in response to an insight.*
- If a new emotion, *Stay with That.*

Interweaves: e.g.

- Inquiry. Truth. Sorting. Education. Curiosity.
- Video. Zoom out/Rewind/Play.
- Repair/Rescue, but only once affect & meaning fully accessed, or ending session.
  1. *What does the child need?*
  2. *Who can do that?*
  3. *Would you like to imagine that?*

Important regularly, esp when in doubt, to return to target. *What getting now?*

Phase 5: Installation/Tapping In

SUDs to a zero. *Any distress left?* If stuck at 1 or more, *What's keeping it there?* >>> Once emotions clear, identify PC. *What's the belief about yourself that goes with that now? VoC to 7? Holding target as get it now, tap in. >>>*

Phase 6: Body Scan

Note the target and the new PC. *Scan body. Any disturbance?* If ANY sensation, tap till resolves.

Phase 7: Closure.

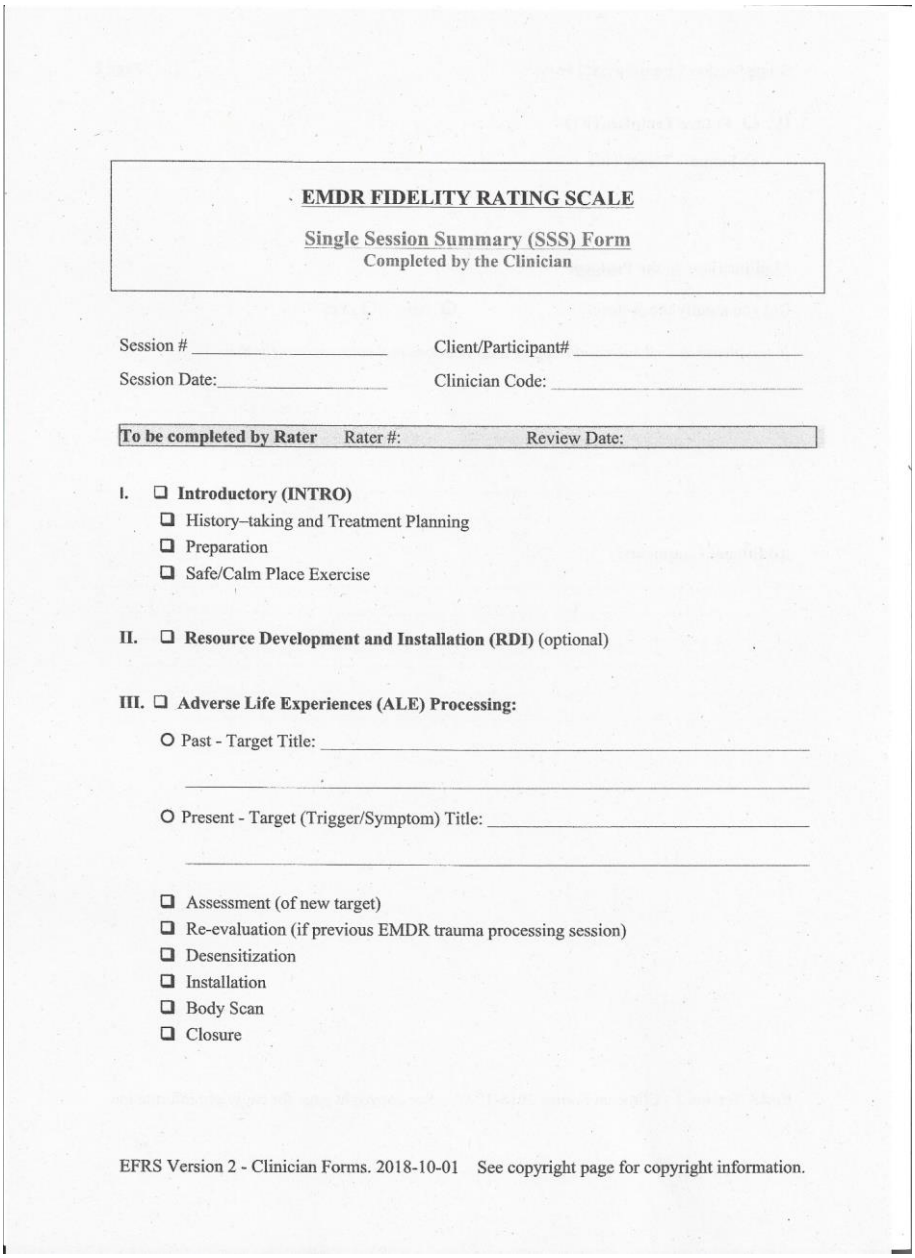
Return via key "stepping stones" to initial bridging point in the client's present. Check the PC / tap in. Conclude with check on future template, and tap that in too.

Phase 8: Re-evaluation.

Check last session's /previous target. How is that now? New target?

Appendix 2: Fidelity measure for SP EMDR

The Single Session Summary Form from the EMDR Fidelity Rating Scale (Korn et al, 2018)



EMDR FIDELITY RATING SCALE

Single Session Summary (SSS) Form
Completed by the Clinician

Session # _____ Client/Participant# _____

Session Date:_____ Clinician Code: _____

To be completed by Rater Rater #: Review Date:

I. ❑ **Introductory (INTRO)**
- ❑ History–taking and Treatment Planning
- ❑ Preparation
- ❑ Safe/Calm Place Exercise

II. ❑ **Resource Development and Installation (RDI)** (optional)

III. ❑ **Adverse Life Experiences (ALE) Processing:**
- O Past - Target Title: _____
- O Present - Target (Trigger/Symptom) Title: _____
- ❑ Assessment (of new target)
- ❑ Re-evaluation (if previous EMDR trauma processing session)
- ❑ Desensitization
- ❑ Installation
- ❑ Body Scan
- ❑ Closure

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IV. ❑ Future Template (FT)

O Future – Target Title _____

Modifications to the Protocol

Did you modify the protocol? ❑ No ❑ Yes

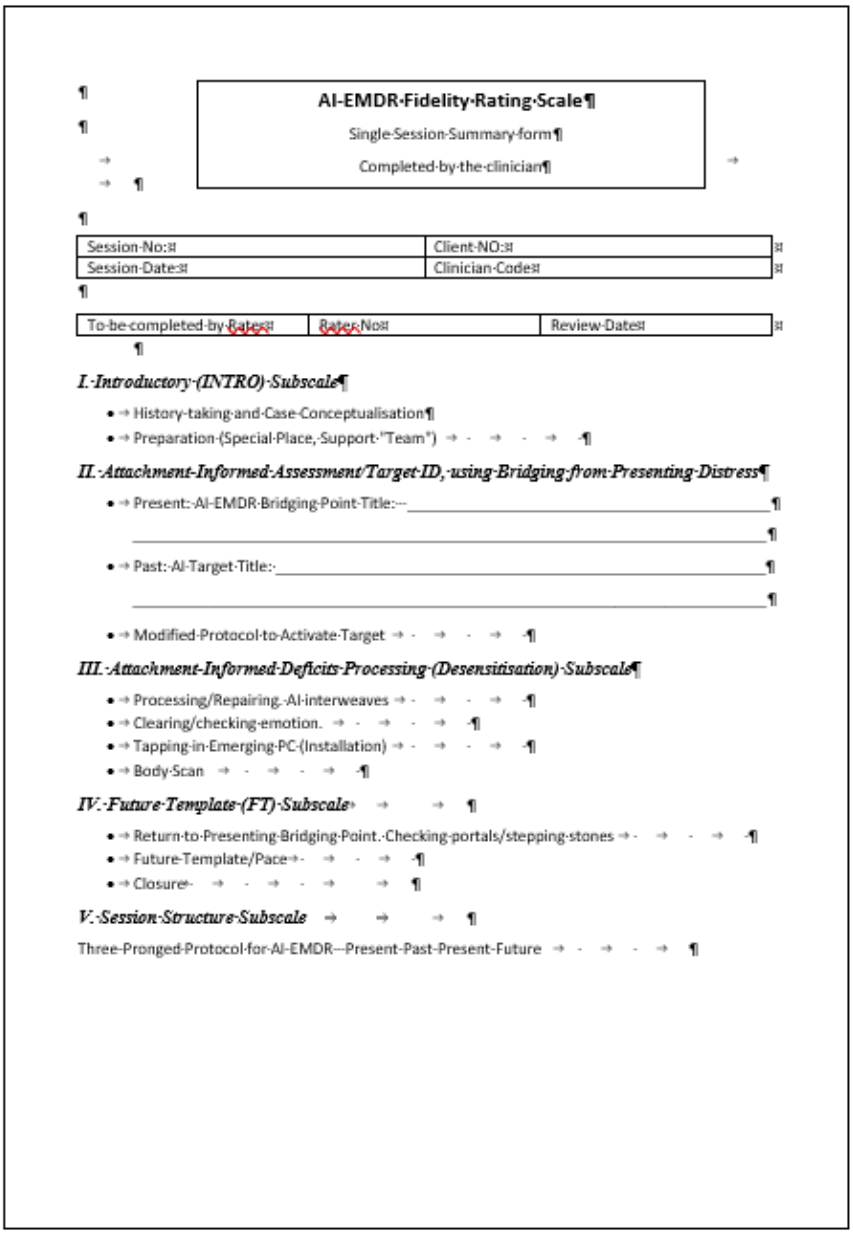
If yes, please describe the nature of the modifications and your reasons for them.

_____
_____
_____
_____
_____
_____

Additional Comments:

_____
_____
_____
_____
_____
_____

Appendix 3: Fidelity measure for AI-EMDR



AI-EMDR Fidelity Rating Scale

Single Session Summary form

Completed by the clinician

Session No:	Client NO:
Session Date:	Clinician Code:

To be completed by Rater:	Rater No:	Review Date:

I. Introductory (INTRO) Subscale

- History taking and Case Conceptualisation
- Preparation (Special Place, Support "Team")

II. Attachment Informed Assessment/Target ID, using Bridging from Presenting Distress

- Present: AI EMDR Bridging Point Title: _____
- Past: AI Target Title: _____
- Modified Protocol to Activate Target

III. Attachment Informed Deficits Processing (Desensitisation) Subscale

- Processing/Repairing AI interweaves
- Clearing/checking emotion.
- Tapping in Emerging PC (Installation)
- Body Scan

IV. Future Template (FT) Subscale

- Return to Presenting Bridging Point. Checking portals/stepping stones
- Future Template/Pace
- Closure

V. Session Structure Subscale

Three Pronged Protocol for AI EMDR—Present Past Present Future