Consultation for EMDRIA Certification in EMDR: Best Practices and Challenges

Jennifer Madere
Intuitus Group Independent Professionals, Cedar Park, TX

Andrew Leeds
Sonoma Psychotherapy Training Institute, Santa Rosa, CA

Christine Sells
EMDR Center of Southern California, Newport Beach, CA

Christopher Sperling
Michelle Browning
Intuitus Group Independent Professionals, Cedar Park, TX

Post-graduate credentials in specific therapeutic models have become more common in recent decades and offer assurance of certain levels of expertise amid increased globalization. Since 1999, the Eye Movement Desensitization and Reprocessing International Association (EMDRIA) and the international EMDR community have worked to establish guidelines and standards for advanced designations in the provision of EMDR therapy. This article focuses on the consultation processes that are outlined in the requirements for clinicians seeking to apply for advanced designations in EMDR therapy. Within the individual and group consultation hours required, consultants operate in several roles, including educator and evaluator, toward addressing the needs of consultees and the requirements put forth by credentialing bodies. The needs of consultees pursuing advanced designations in EMDR therapy include education, documentation of consultation hours and skills attained, and recommendation for the advanced designation. This article provides recommendations and best practices for EMDRIA Approved Consultants who are challenged by the current EMDRIA Certification credentialing process. Challenges with implementation of EMDR Europe's Accredited Practitioner program are also addressed. Strategies are offered to reduce identified ethical concerns surrounding consultation for advanced designations, and to support the integrity of EMDR therapy as an evidence-based treatment model. Building upon the history of the advanced designations within EMDRIA and EMDR Europe, current requirements and the need for research to inform requirements, explicit guidelines, and objective standards are discussed.

Keywords: EMDR; consultation; EMDRIA certification; EMDRIA approved consultant; EMDR Europe practitioner; best practices

Eye movement desensitization and reprocessing (EMDR) therapy (Shapiro, 2018) is an internationally recognized psychotherapeutic approach (World Health Organization, 2013). Although standard EMDR therapy procedures and protocols are manualized, clinicians quickly learn that its application is complex. Participation in consultation focused on EMDR therapy is considered essential for the successful integration of EMDR therapy into clinical practice (EMDRIA, 2018a; Freitag & Swan, 2011; Leeds, 2016a; Shapiro, 2018). In general, the role of consultation during and beyond initial therapeutic training has been shown to enhance skills and therapist adherence to evidence-based treatment

 http://dx.doi.org/10.1891/EMDR-D-19-00052

administration (Bearman, Schneiderman, & Zoloth, 2017; Beidas, Edmunds, Marcus, & Kendall, 2012; Schoenwald, Sheidow, & Letourneau, 2004; Webster-Stratton, Reid, & Marsenich, 2014). Various theories of therapeutic consultation exist (Edmunds et al., 2013; Falender & Shafranske, 2016; Stoltenberg & McNeill, 2010), and the promotion of treatment fidelity and replication of treatment outcomes reported in the literature requires consultation specifically structured to develop conceptual, perceptual, and procedural skills as applied to a variety of contexts and individual clinical cases (McLeod et al., 2018).

The purpose of this article is to outline and discuss best practices and challenges for consultants and consultants-in-training (CITs) regarding the process for clinicians seeking the advanced designation of EMDRIA Certification in EMDR therapy or EMDR Europe Practitioner. While all authors are credentialed by EMDRIA as Approved Consultants (ACs), these topics apply internationally and will be referenced as globally as possible. Clinician roles and designations relevant to this discussion are defined as follows.

EMDR Certifications and Designations

Only mental health practitioners licensed for independent practice and specific pre-licensed clinicians may be admitted to EMDRIA-approved and EMDR Europe–approved EMDR training programs. These programs provide a minimum of 40–42 hours of lecture and practice, and 10 hours of individual or group consultation (see Table 1). Upon receipt of documentation of completion from an EMDRIA or EMDR Europe Approved Training Provider, these organizations state that clinicians may then refer to themselves as "EMDR Trained." Current requirements for EMDRIA designations can be found at www.emdria.org and for EMDR Europe at emdreurope.org.

Advanced Designations

Clinicians seeking an advanced designation must be "EMDR Trained." There are three advanced designations currently recognized by EMDRIA (Certified, Consultant-in-Training [CIT], and AC) and three recognized by EMDR Europe (Practitioner, Consultant, and Trainer). Table 1 summarizes the designations of EMDRIA Certified Therapist and EMDR Europe Practitioner and their requirements.

EMDRIA Advanced Designations. Beginning in 1999, an initial group of Consultants comprised of training facilitators within the EMDR Institute, Inc. (USA) were "grandparented" as ACs by EMDRIA. EMDRIA granted ACs the authority and responsibility to recommend clinicians to be certified through the consultation process. Before this, EMDR trained clinicians obtained EMDR consultation on an ad hoc basis only (Lichti, 2005). EMDRIA training curriculum standards were modified to require 10 hours of consultation in 2007 (EMDRIA, 2018a). The Consultation Packet for ACs and CITs was published in 2000. This packet provided optional materials and information to guide the consultation process toward certification and consultation-of-consultation for CITs working toward the designation of AC. A revision of this Consultation Packet was recently released to ACs and CITs (EMDRIA, 2019b). While no specific training programs exist for EMDRIA Certification, CITs, or ACs, prior efforts within EMDRIA have attempted to "to bring consistency to all of EMDRIA's educational programs and to promote the highest 'standard of care' through professional development programs, such as certification" (Freitag, 2018). A model for credentialing based on objective evaluation of core competencies was proposed (W. Freitag, personal communication, 2018; Freitag, Barrett, Errebo, & Morrow, 2014); however, it was not implemented due to various concerns, notably the cost of implementation (Forester Thacker, 2015).

EMDR Europe Advanced Designations. EMDR Europe established its current programs for Practitioner, Consultant, and Trainer in 2006–2008 (Farrell, 2019). The advanced designation of EMDR Europe Practitioner requires completion of an EMDR Europe–approved training in EMDR and 20 hours of "consultation/supervision." The first 10 of these hours may be counted from the 10 hours required during EMDR training. During the next 10 hours, the applicant obtains a new consultant who evaluates the applicant using a multi-item "EMDR Europe accredited practitioner competency-based framework" (EMDR Europe, 2018c). Before accruing hours of consultation toward an advanced designation of consultant, accredited practitioners must take an approved set of workshops lasting a minimum of 30 hours related to the practice of EMDR therapy and the standards for the consultation process. The EMDR Europe consultant application provides a comprehensive checklist of competency standards. This form must be completed and signed by the senior consultant. These advanced designations require evaluation

TABLE 1. EMDRIA Certification and EMDR Europe Practitioner Requirements

Credential Level	EMDRIA	EMDR Europe Member Country
Trained in EMDR	Completion of an approved training program with a minimum of 20 hours of lecture, 20 hours of practice, and 10 hours of consultation.	Completion of an approved training program with a minimum of 24 hours of lecture, 18 hours of practice, and 10 hours of consultation.
Certified or Practitioner	EMDRIA Certified (2018a)	EMDR Europe Practitioner (2018c)
Professional experience	Two years of pre and/or post licensure experience in field of professional license.	Two years of professional experience after licensure.
Hours of consultation (after completing an approved training)	At least 20 additional hours of consultation, 10 hours of which may be group consultation, and 15 hours may be with a CIT.	At least 10 additional hours of consultation. A combination of face-to-face, group, telephone, videoconferencing, and email is allowed.
Minimum time after EMDR training	No minimum time requirement.	A minimum one year of experience after training.
Extent and documentation of EMDR experience	Notarized statement of providing at least 50 EMDR sessions with at least 25 clients.	Signed statement reporting at least 50 EMDR sessions with at least 25 clients. Must be corroborated by consultant on a standardized form listing up to 30 client initials, presenting problem, date first seen, number of sessions, and treatment setting. Some experience must be directly witnessed (in vivo or on video) by the consultant.
Evaluation of proficiency	No explicit objective criteria.	Applicant must demonstrate competency in all areas of the Competency Framework. This includes over 50 procedural fidelity items, the AIP model, traumatology and EMDR therapy.
Letter of recommendation from Consultant	A general letter of recommendation from one or more Approved Consultants.	Explicit reasons must be given for recommending applicant.
General letters of recommendation	Two general letters of recommendation regarding professional utilization of EMDR in practice, ethics in practice, and professional character.	A second reference from a person in a position to comment upon applicant's professional practice and standing.
Continuing education after basic training	On initial application, 12 EMDRIA Credits on any subject matter.	None needed on initial application.

Note. CIT = Consultant-in-Training.

of in vivo, video, and written work samples. Work samples are rated against explicit criteria developed by credentialing committees (EMDR Europe, 2018a, 2018b, 2018c; Farrell, 2019).

In both EMDRIA and EMDR Europe, consultants are authorized to provide consultation services for those in training courses, for those seeking the Certification/Practitioner designation, and for those seeking consultant status. Table 2 outlines detailed criteria for the consultant designation. EMDRIA Approved Consultants are also eligible to become EMDRIA approved providers of training in EMDR therapy and to provide the 20 hours of lecture in approved trainings. In EMDR Europe, only designated trainers may provide this lecture material.

TABLE 2. Consultant Requirements and Responsibilities

	EMDRIA Approved Consultant (2016a, 2016b)	EMDR Europe Consultant (Supervisor) (2018a)
Authority	May provide consultation for those in training courses seeking Certification and Approved Consultant status.	May provide consultation for those in training courses seeking to become Practitioner and seeking Consultant status.
Duration of EMDR experience	Minimum of 3 years' experience after completing an approved EMDR training.	Minimum of 3 years' experience as an EMDR Europe Practitioner.
Extent of EMDR experience	Minimum of 300 EMDR sessions with a minimum of 75 clients.	Minimum of 400 EMDR sessions with a minimum of 75 clients.
Evidence of proficiency	Objective criteria of proficiency not defined or required. Complete 20 hours of consultation-of-consultation on use of EMDR in clinical practice by an AC.	Demonstrate competency in the provision of EMDR clinical consultation during a minimum of 20 hours.
Training course for providers of EMDR Consultation	A specific training course for consultant applicants is not defined or required by EMDRIA.	Obtain certificate of competency from an approved EMDR Europe Consultants training on behalf of an EMDR National Organization. Direct feedback is also provided to Consultant approving application.
Continuing education	On initial application, 12 EMDRIA Credits on any subject matter and in every subsequent 20-year registration period.	Minimum of 30 hours EMDR CPD since becoming an EMDR Europe Practitioner and is aware of current EMDR research.
Video or in-vivo documentation of EMDR and Consultation proficiency and signed recommendation.	Explicit criteria of observation and proficiency not defined or required by EMDRIA. Applicant submits one or more general letters of recommendation from AC(s) regarding the quality of providing consultation on EMDR to others. Letter may be based on oral or written work samples or on video or in-vivo observation.	Minimum of three video or in-vivo sessions: an EMDR clinical session, an individual EMDR clinical Consultation session, and a Group EMDR Consultation. Includes evidence of competency in defined issues of standard EMDR protocol and procedure, knowledge, and experience with eight listed specialty populations, skills in developing rapport and transfer of knowledge to consultees. Application is signed by the EMDR clinical Consultant or Trainer.
General letter(s) of recommendation	Submit two general letters of recommendation regarding professional utilization of EMDR in practice, ethics in practice, and professional character.	One letter of support from a colleague, consultation group member or clinic manager confirming applicant's experience with EMDR and adherence to the respective ethical guidelines.

Note. AC = approved consultant; CPD = Continuous Professional Development.

Consultants

At each stage of professional development, consultants play a vital role in helping consultees develop EMDR skills and knowledge, strengthen clinical skills, and assist them to integrate EMDR into clinical practice. Due to their central roles, consultants (and EMDR Europe Trainers) are depended upon to support the primary mission of EMDRIA and EMDR Europe, which is "to establish, maintain and promote the highest standards of excellence and integrity in EMDR practice, research and education" (Lichti, 2014). A consultant is expected to be a competent EMDR therapist, consultant, and instructor, and to be knowledgeable about new developments in the field of EMDR. Consultants are to be responsive to the clinical challenges in a wide range of consultees' cases,

organized, respectful of individual differences, provide information at or above the knowledge level of the consultee, and be able to deliver constructive criticism with empathy.

Consultants fill two primary roles during consultation for Certification: (a) as educators, reviewing concepts, principles, and techniques taught in EMDR therapy training and covered in scholarly publications on EMDR therapy with regard to consultees' clinical cases; and (b) as evaluators of consultees' readiness for Certification in which Consultants are expected to provide (or withhold) a "recommendation" for Certification. During consultation hours, the Consultant is not to function as a "trainer" even if the same Consultant is also a training provider. Further, the consultant is explicitly not to function as a psychotherapist for the consultee, nor (generally) is the consultant serving as the consultee's legally mandated clinical supervisor.

When EMDR trained clinicians seek consultation toward Certification, Practitioner, and Consultant designations, they have three distinct needs. The first need is *education*—within the role of educator, consultants assist applicants toward professional development of their conceptual, perceptual, and procedural skills as EMDR clinicians. A parallel, primary need for CITs is to acquire skills in providing consultation. Second is the need is to obtain *documentation* of having completed the required number of hours of consultation. The third need is to receive a letter of *recommendation*—within the role of evaluator, a consultant may withhold or provide the applicant with a letter recommending the clinician for the advanced designation.

Consultants as Educators

Within EMDR therapy training, consultation intends to support clinicians "to safely and effectively integrate the use of EMDR therapy into their clinical setting" (EMDRIA, 2016a, p. 10); training efficacy decreases when clinicians fail to take advantage of consultation (Leeds, 2016a). EMDR clinicians work within a diverse breadth of disciplines: professional counselor, marriage and family therapist, social worker, psychologist, and psychiatrist are examples. Each discipline has its own licensing board, code of ethics, standards, and professional associations. Responsible consultants work to become familiar with the requirements of their consultees' discipline and to assist them in cross-checking requirements of their respective licenses and what EMDR professional organizations require.

Several challenges are intrinsic to the process of professional development in EMDR therapy. These involve acquiring conceptual knowledge, developing new perceptual and procedural skills, the nature of EMDR and its rapidly evolving research base, and the expanding range of clinical applications for EMDR therapy. EMDR involves a combination of highly manualized elements. Working in a manualized therapeutic framework can be challenging for clinicians previously trained in psychodynamic or humanistic psychotherapies (Dunne & Farrell, 2011). It also requires clinicians to develop a balance between the principle of staying "out of the way" to allow spontaneous reprocessing to unfold (Shapiro, 2018, p. 421), being alert and responsive to rapidly changing nonverbal elements, and being prepared to quickly select and offer appropriate interventions. Consultees must also learn how to recognize when to refrain from providing EMDR therapy for trauma reprocessing. EMDR training alone does not equip clinicians to diagnose or treat specific or complex conditions, and consultees ought to refrain from providing EMDR therapy to clients presenting with symptoms or problems for which the consultees lack the knowledge, specialized training, or professional experience to treat. What is a consultant to do when an applicant admits to treating a client for whom the applicant lacks the relevant specialized education, training, and experience? At a minimum, ethical guidelines require a frank discussion with the consultee regarding the risks to the client. The consultant may also recommend specialized training and scholarly resources.

Consultants as Evaluators

The designation of consultant confers the right and responsibility to provide documentation of individual or group consultation hours. In addition, the consultant designation confers the role of evaluator, which leads to withholding or providing a recommendation for the applicant to receive an advanced designation from EMDRIA or EMDR Europe. (See Table 3 for distinctions in the authority of a CIT.) In EMDR Europe, the consultant is directed to objectively assess and evaluate consultees, while encouraging consultees to answer their own questions using creative problem-solving (Freitag & Swan, 2009; Freitag & Thomas, 2004). Extensive written objective criteria on the EMDR Europe Practitioner application form provide a specific basis for granting or refusing approval of a candidate.

EMDRIA has not established explicit criteria for consultants to use in evaluating applicants. Within

TABLE 3. Consultant-In-Training

	EMDRIA (2018b, 2019a)	EMDR Europe
Declaration of intent	Must be and maintain status as Certified and complete CIT Declaration Form identifying AC(s) with whom CIT is working. Must complete AC application within five years.	Practices appear to vary by country.
Limited authority	May provide up to 15 of 20 hours toward Certification. May document hours of consultation, may provide a recommendation but this is insufficient without the applicant also receiving a recommendation from an AC.	[No information found.]

the consultation packet, ACs can find a non-required "Sample Evaluation Form" listing 17 scaled items and summary statements for strengths and weaknesses (EMDRIA, 2000). The recent revision of the consultation packet (EMDRIA, 2019b) states that ACs may determine requirements to be met prior to offering a recommendation for certification, which implies that a recommendation may be withheld if the ACs' predetermined requirements are not met. However, the use of evaluation tools or criteria has not been required as part of the application for EMDRIA certification. Without consistent standards to evaluate consultees and determine when (and when not) to recommend applicants, ACs operate from disparate standards regarding what and how education is offered, how consultees are evaluated, and who they recommend for certification (Freitag, 2012).

It is the responsibility of consultants to evaluate consultees' readiness for certification and to provide feedback about applicants' understanding and use of standard EMDR principles and procedures. Failing to do so may result in poor professional development of the consultee and potentially harm to clients. Consultants *and* consultees must be mindful and prepared to offer well-grounded measures to prevent harm to the client (American Psychological Association, 2017). When minimum requirements of consultation hours are met, but the consultant believes the consultee to be unprepared to competently administer EMDR therapy, is it ethical for consultants to supply the requested *recommendation*? Subsequent sections will continue to discuss this dilemma.

Consultation Is Not Supervision. While in some countries the terms "supervisor" and "supervision" are often used as equivalent to "consultant" and "consultation," these terms are not synonymous in the United States. For purposes of this article, "supervisor" refers to a senior clinician who provides a pre-licensed psychotherapy (or provisionally licensed) clinician with oversight as required by state law, and holds legal responsibility for services provided by the supervisee. Secondarily, a licensing board may require a licensee to obtain supervision for a period pursuant to an administrative settlement of a formal complaint. In this second role, the supervisor is generally not legally responsible for the services provided by the supervisee, but is required to *evaluate* the nature, scope, and manner in which the supervisee provides psychotherapy services according to administrative requirements. In either case, a supervisor may or may not offer expertise in a therapy model such as EMDR.

In contrast, a consultant is providing peer consultation (EMDRIA, 2000), within a collaborative relationship (EMDRIA, 2019b), from a position of more experience with regard to EMDR therapy. Obtaining consultation from a more senior clinician is common in the field of psychotherapy. In many regulatory and professional association guidelines, licensees are ethically obligated to seek such consultation regularly. It is the assumption of the authors that the consultant (or CIT) *is not* also the current supervisor of the consultee, as these roles are different and distinct. Nonetheless, throughout the consultation relationship consultants may discover the limitations of their consultees in much the same way that supervisors do with supervisees (American Counseling Association, 2014). Identifiable instances that a regulatory board or a court of law may find a consultant responsible include (a) if a board /court can show where/ how a consultant influenced the choices of consultees' work with a client using clear directives; and (b) if the board/court can show that the consultant knows the identity of the client(s) (Leeds, 2016a).

Best Practices in Consultation

Consultants employ a variety of practices to define and bolster the process of consultation for advanced designations within their roles as educators and evaluators. These reflect consultants' efforts to incorporate evidence-based procedures and principles discussed within the international EMDR community, respond to various practical and ethical challenges, and uphold the integrity of advanced designations in EMDR therapy. Upon examining the literature, the authors' own practices and others known to the authors or known publicly (via web, conferences, listservs), commonalities emerge which are here referred to as *best practices*.

Consultation Agreement

Informed consent and a contractual agreement detailing roles and responsibilities of all parties is a vital part of any professional relationship. Within this agreement, the consultant defines roles and expectations of consultant and consultee throughout the consultation process. In addition, the agreement specifies practices (such as those described here), financial terms, and procedures that will be followed if consultant or consultee determines the need to end the professional relationship before or without the consultant's recommendation. The agreement defines the criteria by which the consultant will determine whether (or not) to provide a recommendation. Further elements include definition of ethical and legal obligations, such as differentiating between supervision and consultation and the consultant's obligation to report to licensing boards if serious concerns are identified. Separate agreements for individual and group consultation are common in order to specify what and how case material must be presented, or what criteria must be met for the consultant to consider consultation hours to be counted toward the advanced designation. Examples: EMDRIA Consultation Packet; Andrew Leeds (2016, pp. 336–337); Morrow (2012, 2015).

EMDR-Specific Case Presentation Form

Utilizing an EMDR-specific case presentation form, rather than allowing the consultee to present only case material orally or share only session summary forms in consultationrequires the consultee to prepare for group or individual consultation more thoroughly and provides the consultant with a behavioral work sample to track the consultee's work concretely in regard to Phase 1—History Taking and Treatment Planning. This case presentation form can be used independently as an assignment/requirement, or in conjunction with other work samples. A case presentation form provides objective information on which to provide feedback. The consultant may also request additional documentation or work samples. Examples: EMDRIA Consultation Packet; Barry Litt (2007); Christine Sells (Personal Communication, 2018); Andrew Leeds (2016, pp. 327–328).

Work Samples

Many consultants require clinical work samples demonstrating utilization and application of all eight phases and three prongs of the standard EMDR therapy protocol; however, consultants vary widely in exactly what work samples they require. Historically, verbal summary of EMDR therapy sessions (by consultees) appears to have been the most popular method used by consultants to evaluate readiness for the advanced designation of EMDRIA Certification, followed by written presentation (Lichti, 2005). Verbal summaries have the advantage of requiring the least effort from both consultees and consultants, but also carry the disadvantage of being most remote from the raw data of an EMDR therapy session and are easily distorted. For this reason, verbal summaries may be supplemented by more concrete work samples and documentation.

Work samples in a broad sense can include detailed written case presentations, EMDR protocol worksheets, assessment results, verbatim transcripts of EMDR sessions, audio recordings, and video recordings. Client-identifying information is to be omitted or redacted from all work samples. Some consultants require multiple video samples which can be rated for fidelity and can measure progress of the consultee over time. Recordings provide the fullest opportunity to evaluate consultees' knowledge and competency in utilizing EMDR therapy (Leeds, 2009). Examples/Resources: EMDRIA Consultation Packet: Sample permission forms; Andrew Leeds: Sample Consent to Video Record form (2016b, p. 332); outline of advantages and disadvantages of each type of work sample (2009).

Formal Assessment Measures

Evaluation of a consultee's knowledge and work samples is greatly enhanced by application of measures such as learning objectives and standardized fidelity checklists (Adler-Tapia & Settle, 2005; EMDR Europe, 2018c; Leeds, 2016a, 2016b; Morrow, 2012, 2015; Shapiro, 2018). Self-evaluation of work samples

is generally encouraged within consultation, in addition to feedback from peers in a group context. This allows the consultee to self-correct and consolidate knowledge into more effective practice of EMDR therapy. Conversely, self-evaluation of work samples can highlight concerns for the consultant that the consultee is not able or willing to self-correct, and may need remediation prior to recommendation. Use of learning objectives and fidelity checklists can facilitate objective evaluation of work samples, provide material for "pop quiz" knowledge tests, and can measure consultee progress over multiple work samples. Examples/Resources: Sample Consultation Evaluation Form (EMDRIA Consultation Packet, 2016b); Consultee Learning Objectives Checklist, for use at the beginning of consultation (Morrow, 2012, 2015); Fidelity Checklists for use within consultation and with work samples (Cooper, et al., 2019, pp. 40–50; Leeds, 2016a, pp. 355–363, 2016b); EMDR Fidelity Rating Scale, available on the EMDR Research Foundation website (Korn, Maxfield, Smyth, & Stickgold, 2017).

Structured/Closed Consultation Groups

In contrast to open/peer consultation or study groups, which are useful for general clinical support and sharing ideas, structured and/or closed consultation groups are appropriate when consultees are seeking advanced designations. Consultants are advised to require all consultees, at minimum, to present written case material demonstrating utilization of all eight phases and three prongs of the standard EMDR protocol (Shapiro, 2018). Evaluation via defined case presentations, review of behavioral work samples, and formal assessment measures ensure that all consultees both demonstrate *and* observe their peers applying EMDR therapy procedures and protocols. Example: Each participant should be required to present case material and a behavioral work sample (e.g., a near-verbatim transcript of reprocessing). While completing 10 hours of group consultation, each consultee should present at *least* twice or for a minimum amount of time (Leeds, Madere, & Sells, 2019; Madere, 2014).

Written Documentation

In addition to retaining a signed consultation agreement, consultants should keep documentation such as dates of consultation, work samples, evaluation methods used, results of evaluations, and any recommendations given or need for remediation observed. These practices support clarity, consistency, and complete coverage of all eight phases and three prongs of EMDR therapy within the hours of consultation. Contacting and documenting contact with any consultants who have previously provided consultation to the particular consultee seeking an advanced designation is also advised. This can mitigate potential redundancy and serve to guard both the consultant and consultee against unnecessary risks of the challenges, ethical concerns, and liability as discussed in this article.

Integration of Other Standards and Concepts

Taking seriously their roles of educator, evaluator, and essential gatekeeper, some consultants have adopted standards and concepts put forth by other credentialing bodies. While many criteria for accreditation as an EMDR practitioner by EMDR Europe are similar to those outlined for EMDRIA Certification, two main differences are clear: the EMDR Europe Accredited Consultant must directly witness the applicant's EMDR work, and must use the EMDR Europe competency framework document (EMDR Association United Kingdom and Ireland, 2012, in Farrell & Keenan, 2013). Some EMDRIA consultants have adopted the requirement of video/in vivo work samples within consultation toward certification (while also addressing the ethical concerns identified below).

Consultants who are also trained in clinical supervision may apply related approaches within EMDR consultation, including stage-of-development concepts such as the integrative developmental model of supervision (Stoltenberg & McNeill, 2010), and competency-based approaches (Falender & Shafranske, 2016; Lichti, 2005, 2014). Keeping in mind the distinction between supervisor and consultant roles, training in these approaches may bolster consultants in their role, especially in the absence of other defined methods of educating and evaluating consultees.

Further Challenges Related to Evaluation

Variation in the methods utilized in consultation, and lack of objective standards or mandated assessment criteria within EMDRIA advanced designations ultimately leads to inconsistency in the level of knowledge and competency of those delivering EMDRIA Approved EMDR Trainings. Due to the limited scope of this article, particular challenges related to evaluation and gatekeeping will now be discussed.

When (Not) to Provide a *Recommendation*

Regarding a letter of recommendation, EMDRIA states (EMDRIA, 2016b) that "The letter should include *an evaluation statement* [emphasis added] from the AC recommending approval of your Certification application. The letter should include the exact number of hours of consultation toward certification that you received from the AC. The letter should explicitly state whether the hours were individual or group hours and state how many of each if you received both." This requirement raises questions about the nature of the consultation relationship. In the United States such evaluations are typically conducted by clinical supervisors to meet the needs of an external authority. Thus, this requirement may expose ACs to a range of potential legal liabilities due to the potential perception that the services being provided are similar to those of "clinical supervisors" (Adler-Tapia, personal communication, 2016).

Several questions arise regarding the crafting of "an evaluation statement" and how to decide when to provide and when to withhold a letter of *recommendation*. ACs must determine whether a recommendation will be provided to every applicant who has completed the 20 hours of consultation with them, how many hours of consultation must be completed to provide a recommendation, and how to manage situations in which the consultee has previously completed hours of consultation with another AC without receipt of a recommendation. When ACs make use of the various available Fidelity Rating Scales (e.g., Adler-Tapia & Settle, 2005; Leeds, 2016a, Shapiro, 2018), they may identify areas in which applicants have failed to integrate material from the required text (Shapiro, 2018) or the EMDRIA definition of EMDR (2012). When concerns arise regarding the conceptual, perceptual, and procedural skills needed to safely and effectively apply EMDR therapy, ACs may suggest or require remedial steps such as attending an EMDRIA approved "review course" and are advised to outline processes of remediation in their consultation agreement.

Non-EMDR Concerns That Could Affect a *Recommendation*

As licensed psychotherapists, all consultants have ethical guidelines for how to respond to potential concerns or violations. Weak psychotherapy skills may prevent the applicant from developing and maintaining a therapeutic framework adequate to address issues-related traumatic stress syndromes. Ethical and legal issues may be present, such as applicants who are practicing beyond the scope of their education, training or professional experience, or admitting to subtle or overt forms of insurance fraud. These are actual experiences that have arisen repeatedly in the authors' experiences while providing consultation; it is unclear whether a Consultant has the right or obligation to withhold a recommendation in such cases, especially if the presenting scenario is not spelled out in the consultation agreement.

EMDR Europe Standards and Related Challenges

EMDR Europe offers objective guidelines and explicit standards for consultants to use in evaluating consultees applying for the advanced designation of practitioner. This competency-based framework uses a form which requires the consultant to evaluate the applicant on a list of specific criteria and requires the applicant to provide video recordings of actual EMDR therapy sessions. However, criteria for what constitutes a passing score or when the consultant should withhold a letter of approval is not published.

Two problematic issues are noted regarding implementation of a similar system in the United States. First, use of a detailed form for evaluation based on video recordings may increase the extent to which ACs could be perceived by third parties as functioning as "clinical supervisors." Consultees may tell their client that the AC has advised a specific intervention based on the video recording, which would increase the risk of the perception of legal responsibility for the applicant's clinical work (Adler-Tapia, personal communication, 2016). Second, when a consultant evaluates an applicant as failing to adequately demonstrate the required material, they face a potential risk for being sued by the applicant for restraint of trade if the applicant believes that ACs want to protect their general status and financial gains by providing hours of consultation.

Documentation of Hours

When earning group consultation hours, EMDRIA (2016a) states that there may be a maximum of eight participants; this is reiterated in the revision of the Consultation Packet (EMDRIA, 2019b). Past EMDRIA guidelines have permitted ACs to count "individual hours" when applicants present their case material in a group setting, thereby allowing consultees to receive credit for group consultation hours in which they are entirely silent. Recent changes specify that individual consultation hours may be earned in a group setting

that includes no more than three consultees, the group meets for at least 90 minutes, and no consultee can accrue more than 30 minutes of individual consultation per group meeting (EMDRIA, 2019b).

Scope of Consultation Hours

EMDRIA states that for hours to be counted toward Certification, consultation must be "EMDR-focused"; however, the scope of "EMDR-focused" can be ambiguous, particularly in cases where the majority of a consultee's caseload may invite or require modification to standard EMDR therapy procedures. The revised packet (EMDRIA, 2019b) states "Standard EMDR therapy means maintaining fidelity to EMDR therapy's eight phase, three-pronged approach (Shapiro, 2018)." These procedures, as described in textbooks by Shapiro (1995, 2001, 2018) and in the EMDRIA definition of EMDR therapy (EMDRIA, 2012), are the focus of EMDR Therapy Training. They have been evaluated in numerous randomized controlled studies with children and adults (Adler-Tapia & Settle, 2009; Bisson et al., 2013; Wilson et al., 2018) and accepted in national and international treatment guidelines (International Society for Traumatic Stress Studies, 2018; National Collaborating Centre for Mental Health, 2018; World Health Organization, 2013). Based on the principle that applicants must demonstrate knowledge and skills with standard EMDR procedures during hours to be counted for certification, a community standard has emerged among many ACs that time spent consulting on modified or alternative EMDR procedures not be counted.

At times, ACs may devote a significant portion of consultation sessions to didactic review of conceptual or procedural material to address deficiencies in understanding of essential concepts, principles, or procedures. Thus, consultants may fail to balance their roles of educator *and* evaluator. Thus, it has been possible for applicants to request/receive didactic review during 10 individual consultation hours and to sit silently during all 10 group hours and then receive both documentation of required hours and a recommendation.

Record Keeping

Consultants are required by EMDRIA only to maintain records of dates, hours, and type of consultation earned toward advanced designations (EMDRIA, 2000, 2019b). Best practices would include that complete records also contain evaluations regarding aspects of the applicant's knowledge of EMDR theory and procedures and fidelity in application for all eight phases and three prongs. The authors have observed that some consultees begin consultation with one consultant, stop after a few hours, resume with a different consultant years later, and request documentation of consultation hours years after they occurred. The recent Consultation Packet suggests that documentation of consultation hours toward EMDRIA advanced designations must be maintained by the AC for 5 years after that consultation concludes (EMDRIA, 2019b).

In summary, several intrinsic and extrinsic challenges are faced by applicants and consultants, while identification and application of consistent standards internationally also pose significant challenges. Widely varying practices and situations as outlined by Freitag and Swan (2009) may reasonably yield the conclusion that advanced designations have little consistent or objective significance (Freitag, 2012). ACs may mitigate many of these concerns by employing the practices outlined above, particularly the utilization of a comprehensive consultation agreement.

Ethical Issues

Advanced designations may be interpreted by the public and other clinicians to indicate that the holder has reached a higher level of proficiency. However, the above indicates this interpretation may not necessarily be true and raises several additional ethical concerns.

Within the role of evaluator, consultants are gatekeepers (Farrell, 2013). As gatekeepers, consultants promote and protect professional standards; they asses and guide consultees' interactions with their clients and gauge consultees' internal operations (Homrich & Henderson, 2018). When consultants are committed to maintaining consistent objective standards of implementation of EMDR therapy, this benefits the integrity of EMDR and the psychotherapy community as a whole, and the principle of client safety is upheld. However, in both EMDR Europe and EMDRIA systems, no hierarchy of checks and balances exists to confirm that consultants are signing off on clear, objective, and valid signs of competency by applicants. Rather, consultants are on an honor system to objectively evaluate and report on applicants' competency. When there is direct payment by a known applicant to a known consultant, circumstances potentiate doubts about objectivity and ethical quandaries.

Even without directly providing psychotherapy, consultation hours can involve exploring clinical challenges that can include consultees' countertransference experiences. If individual consultation sessions

focus on intimate details of consultees' lives, the consultant may cross the boundary into providing psychotherapy. Doing so creates the ethical dilemma clinicians know as a dual relationship.

EMDRIA requires consultees to bring actual cases to consultation (EMDRIA, 2000), and consultees are expected to demonstrate their knowledge of EMDR therapy using actual clinical work examples (EMDRIA, 2019b). The authors observe that some applicants practice EMDR therapy in a peer setting similar to practicum within EMDR therapy training; should this meet the EMDRIA's standard for discussion of actual cases? What if applicants practicing in this setting select "made-up" issues? When the issues are real, paired practice by applicants creates dual relationships between consultees. Ethical standards direct clinicians to be cautious to avoid the risk of harm from multiple relationships (American Psychological Association, 2017). Paired practice may also present another ethical difficulty—how to discuss actual cases with the consultant without compromising the confidentiality of the other applicant.

When considering the recording of EMDR therapy sessions to present in consultation, it is the responsibility of the consultant *and* consultee to fully understand ethical issues involving the recording of clinical sessions for evaluation. Consultants and consultees must be clear and prepared to speak to what is stated in their Consent to Video Record form and Authorization to Release Confidential Information form. Plans must be in place for security regarding such data and focused in three areas: (a) ethics mandated by their regulatory board(s) and professional association(s); (b) legal requirements of their respective licensing board(s); and (c) local laws governing video recording.

Recommendations

While surveys have gathered data regarding how consultation is conducted (Freitag & Swan, 2009) and traits of consultants (Morrow, 2015), no research appears to have been conducted regarding the nature or effectiveness of consultation for advanced designations in EMDR therapy since Lichti's (2005) article. Research regarding the effectiveness of the best practices outlined above is needed to guide well-meaning clinicians toward consistent professional development and treatment outcomes. Formation of consistent standards and practices will solidify the next phase of the evolution of advanced designations in EMDR therapy.

Overall, proposed standards have recommended that candidates for EMDRIA Certification demonstrate (a) a knowledge base of EMDR therapy principles, protocols, and procedural skills (Freitag, 2012; Leeds, 2016a; Shapiro, 2001, 2018); (b) ability to conduct the standard reprocessing procedural steps from memory, while showing good fidelity (Adler-Tapia, & Settle, 2005; Leeds, 2016a); and (c) ability to apply EMDR and achieve clinical results commensurate with treatment outcome results reported in scientific literature on EMDR therapy (Leeds, 2009, 2016). A recent survey of current and recent EMDRIA members affirms the need for: "1) clarification and uniformity to certification requirements, 2) standards for practice at levels of credentialing, and 3) making the certification process more meaningful" (EMDRIA, 2018b). The revision of the EMDRIA Consultation Packet offers an initial step toward consistency in the consultation process for advanced designations by clarifying roles and expectations of consultants and consultees but does not require consistent objective criteria for offering or withholding a recommendation (EMDRIA, 2019b).

Two main directions are clearly available within the history, standards, and practices described above: formation and implementation of objective standards and explicit guidelines, and uniform adaptation and application of competency-based practices. Interrater reliability (Borelli, 2011; Cooper et al., 2019) and a designated training program for applicants to become consultants could be embraced as part of a transition to the implementation of objective criteria with fidelity rating. The responsibility of gatekeeping at each level of training and credentialing is essential to protect the public, the mental health profession (Homrich & Henderson, 2018), and the integrity of EMDR therapy. If consultants continue to function in a gatekeeping role, development of a standardized advanced training program that prospective consultants would complete prior to providing consultation would support new consultants in fulfilling this role.

Practitioners and consumers of EMDR therapy benefit from a robust body of research that has established the efficacy of EMDR and has produced an increasing demand for EMDR in practices and agencies worldwide. Responsible, well-trained consultants will protect the integrity of this legacy and of advanced designations in EMDR therapy. Consistent, defined, and applied standards for these advanced designations are needed to support the reputation of EMDR therapy and to continue the healing its practitioners offer to our world.

REFERENCES

Adler-Tapia, R., & Settle, C. (2005). *EMDR fidelity treatment manual: Children's protocol*. Hamden, CT: EMDR HAP.

Adler-Tapia, R., & Settle, C. (2009). Evidence of the efficacy of EMDR with children and adolescents in individual psychotherapy: A review of the research published in peer-reviewed journals. *Journal of EMDR Practice and Research*, *3*(4), 232–247. https://doi.org/10.1891/1933-3196.3.4.232

American Counseling Association. (2014). *ACA code of ethics*. Alexandria, VA: Author.

American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct* (2002, Amended June 1, 2010, and January 1, 2017). Retrieved from http://www.apa.org/ethics/code/index.aspx

Bearman, S. K., Schneiderman, R. L., & Zoloth, E. (2017). Building an evidence base for effective supervision practices: An analogue experiment of supervision to increase EBT fidelity. *Administration and Policy in Mental Health and Mental Health Services Research*, *44*(2), 293–307. https://doi.org/10.1007/s10488-016-0723-8

Beidas, R. S., Edmunds, J. M., Marcus, S. C., & Kendall, P. C. (2012). Training and consultation to promote implementation of an empirically supported treatment: A randomized trial. *Psychiatric Services*, *63*(7), 660–665. https://doi.org/10.1176/appi.ps.201100401

Bisson, J., Roberts, N. P., Andrew, M., Cooper, R., & Lewis, C. (2013). Psychological therapies for chronic Post-Traumatic Stress Disorder (PTSD) in adults (Review). *Cochrane Database of Systematic Reviews*, *2013*(12), CD003388. https://doi.org/10.1002/14651858.CD003388.pub4

Borelli, B. (2011). The assessment, monitoring, and enhancement of treatment fidelity in public health clinical trials. *Journal of Public Health Dentistry*, *71*(1), 52. https://doi.org/10.1111/j.1752-7325.2011.00233.x

Cooper, R. Z., Smith, A. D., Lewis, D., Lee, C. W., & Leeds, A. M. (2019). Developing the interrater reliability of the modified EMDR fidelity checklist. *Journal of EMDR Practice and Research*, *13*(1), 32–50. https://doi.org/10.1891/1933-3196.13.1.32

Dunne, T., & Farrell, D. (2011). An investigation into clinicians' experiences of integrating EMDR into their clinical practice. *Journal of EMDR Practice and Research*, *5*(4), 177–188. https://doi.org/10.1891/1933-3196.5.4.177

Edmunds, J. M., Kendall, P. C., Ringle, V. A., Read, K. L., Brodman, D. M., Pimentel, S. S., & Beidas, R. S. (2013). An examination of behavioral rehearsal during consultation as a predictor of training outcomes. *Administration and Policy in Mental Health and Mental Health Services Research*, *40*, 456–466. https://doi.org/10.1007/s10488-013-0490-8

EMDR Europe. (2018a). *Criteria for the certification of EMDR standard training within Europe (June 2018)*. Retrieved from http://www.emdr-romania.org/images/Certification-of-EMDR-Standard-Training-within-Europe-July-2nd-2018.pdf

EMDR Europe. (2018b). *EMDR Europe accredited clinical supervisor/ consultant competency based framework*. Retrieved from http://emdr-europe.org/wp-content/uploads/2018/06/EMDR-Europe-Consultant-Competency-Framework.pdf

EMDR Europe. (2018c). *EMDR Europe accredited practitioner competency-based framework*. Retrieved from http://emdr-europe.org/wp-content/uploads/2018/06/EMDR-Europe-Practitioner-Forms.pdf

Eye Movement Desensitization and Reprocessing International Association. (2000). *EMDRIA consultation packet*. Austin TX: EMDR International.

Eye Movement Desensitization and Reprocessing International Association. (2016a). *EMDR certification in EMDR | FAQs*. Retrieved from https://emdria.site-ym.com/page/emdrcertificationfaq?

Eye Movement Desensitization and Reprocessing International Association. (2016b). *EMDRIA consultation packet*. Retrieved from https://emdria.site-ym.com/page/51?

Eye Movement Desensitization and Reprocessing International Association. (2018a). *Basic training curriculum requirements*. Retrieved from https://c.ymcdn.com/sites/emdria.siteym.com/resource/resmgr/basictraining/BTCRequirments.pdf

Eye Movement Desensitization and Reprocessing International Association. (2018b). *Consultant-in-training declaration form*. Retrieved from https://www.emdria.org/general/custom.asp?page=citdeclaration

Eye Movement Desensitization and Reprocessing International Association. (2018c). Member survey responses: Supporting practitioners. *EMDRIA Magazine*, *23*(3), *23*.

Eye Movement Desensitization and Reprocessing International Association. (2019a). *Approved consultant/consultant in training frequently asked questions*. Retrieved from https://www.emdria.org/page/accitfaq

Eye Movement Desensitization and Reprocessing International Association. (2019b). *EMDRIA consultation packet*. EMDR International Association Online Community.

Falender, C., & Shafranske, E. (2016). *Supervision essentials for the practice of competency-based supervision*. Washington, DC: American Psychological Association.

Farrell, D. (2013, September). *Enhancing competency in EMDR through effective clinical supervision and consultation*. Presentation at the 18th EMDR International Association Conference, Austin, TX.

Farrell, D. (2019, June 29). *History of EMDR Europe's programs for credentialing*. Interview with Derek Farrell by Andrew M. Leeds PhD Saturday, Krakow, Poland.

Farrell, D., & Keenan, P. (2013). Participants' experiences of EMDR training in the United Kingdom and Ireland. *Journal of EMDR Practice and Research*, *7*, 2–16. https://doi.org/10.1891/1933-3196.7.1.2

Forester Thacker, D. (2015). *Letter to EMDRIA members.* Unpublished letter.

Freitag, W. (2012). *Setting standards using the core competency model—An example*. Presentation at the 17th EMDR International Association Conference, Washington, DC.

Freitag, W. (2018). Unpublished EMDRIA newsletter article from the chair of the EPPD Task Group.

Freitag, W., Barrett, J., Errebo, N., & Morrow, R. (2014). *Defining new credentialing standards: Current status of the work of the EMDRIA professional development subcommittee*. Presentation at the 20th EMDR International Association Conference, Denver, CO.

Freitag, W., & Swan, S. (2011). *EMDR consultation: Comprehensive review & new directions*. Presentation at the 16th EMDR International Association Conference, Anaheim, CA.

Freitag, W., & Thomas. R. (2004). *Make consultation count*. Presentation at the 9th EMDR International Association Conference, Montreal, QC.

Homrich, A. M., & Henderson, K. L (Eds.). (2018). *Gatekeeping in the mental health professions*. Alexandria, VA: American Counseling Association.

International Society for Traumatic Stress Studies. (2018). *PTSD prevention and treatment guidelines methodology and recommendations*. Retrieved from https://istss.org/clinical-resources/treating-trauma/new-istss-prevention-and-treatment-guidelines

Leeds, A. (2016a). *A guide to the standard EMDR therapy protocols for clinicians, supervisors, and consultants* (2nd ed.). New York, NY: Springer Publishing Company.

Leeds, A. (2016b). Appendix A: Fidelity checklists. In *A guide to the standard EMDR therapy protocols for clinicians, supervisors, and consultants* (2nd ed.). New York, NY: Springer Publishing Company. Retrieved from https://www.springerpub.com/standard-emdr-therapy-protocols-for-clinicians-supervisors-consultants-2e-supplemental-materials

Leeds, A. M. (2009, August). *How to use work samples and case documentation in remote EMDR consultation*. Presentation at the 14th EMDR International Association Conference, Atlanta, GA.

Leeds, A. M., Madere, J. A., & Sells, C. (2019, September). *Consultation for EMDRIA certification: Challenges, ethics, and best practices*. Presentation at the 24th EMDR International Association, Garden Grove, CA.

Lichti, J. (2005, September). *The EMDR consultation process: Findings & fine-tuning the future.* Presentation at the 10th EMDR International Association Conference, Seattle, WA.

Lichti, J. (2014, May). *EMDR consultation: Preparing for the new.* Presentation at the EMDR Canada Annual Conference, Quebec City, QC, Canada.

Litt, B. K. (2007). *Case presentation format for EMDR consultation*. Retrieved from http://www.barrylittmft.com/

Korn, D. L., Maxfield, L., Smyth, N. J., & Stickgold, R. (2017). *EMDR Fidelity Rating Scale (EFRS)*. Retrieved from https://emdrresearchfoundation.org/emdr-fidelity-rating-scale

Madere, J. (2014, August). *Group consultation for EMDRIA certification: 8 session outline*. Unpublished paper, presented to a group of local EMDRIA Approved Consultants, Austin, TX.

McLeod, B. D., Cox, J. R., Jensen-Doss, A., Herschell, A., Ehrenreich-May, J., & Wood, J. J. (2018). Proposing a mechanistic model of clinician training and consultation. *Journal of Clinical and Psychological Science and Practice*, *25*, e12260. https://doi.org/10.1111/cpsp.12260

Morrow, R. (2012). *Essential skills for EMDR consultation*. Presentation at the 17th EMDR International Association Conference, Washington, DC.

Morrow, R. (2015, August). *Developing your best consultation practice this year*. Presentation at the 20th EMDR International Association Conference, Philadelphia, PA.

National Collaborating Centre for Mental Health. (2018). *Post-traumatic stress disorder (PTSD): Guidance*. Retrieved from https://www.nice.org.uk/guidance/ng116

Schoenwald, S. K., Sheidow, A. J., & Letourneau, E. J. (2004). Toward effective quality assurance in evidence-based practice: Links between expert consultation, therapist fidelity, and child outcomes. *Journal of Clinical Child and Adolescent Psychology*, *33*(1), 94–104. https://doi.org/10.1207/S15374424JCCP3301

Shapiro, F. (1995). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures* (1st ed.). New York, NY: Guilford Press.

Shapiro, F. (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures* (2nd ed.). New York, NY: Guilford Press.

Shapiro, F. (2018). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures* (3rd ed.). New York, NY: Guilford Press.

Stoltenberg, C., & McNeill, B. (2010). *An integrative developmental model for supervising counselors and therapists* (3rd ed.). New York, NY: Taylor & Francis.

Webster-Stratton, C. H., Reid, M. J., & Marsenich, L. (2014). Improving therapist fidelity of evidence-based practices: Incredible years program. *Psychiatric Services*, *65*, 798–795. https://doi.org/10.1176/appi.ps.201200177

Wilson, G., Farrell, D., Barron, I., Hutchins, J., Whybrow, D., & Kiernan, M. D. (2018). The use of Eye-Movement Desensitization Reprocessing (EMDR) therapy in treating post-traumatic stress disorder—a systematic narrative review. *Frontiers in Psychology*, *9*, 923. https://doi.org/10.3389/fpsyg.2018.00923

World Health Organization. (2013). *Guidelines for the management of conditions that are specifically related to stress*. Geneva, Switzerland: Author.

Disclosure. Andrew Leeds receives income from published books on EMDR therapy, for the training of licensed professionals in EMDR therapy, and for providing consultation to EMDR therapists. Jennifer Madere, Christine Sells, Christopher Sperling, and Michelle Browning receive income for

the training of licensed professionals in EMDR therapy, and for providing consultation to EMDR therapists. The authors may receive income from workshops regarding provision of EMDR consultation.

Funding. The authors received no specific grant or financial support for the research, authorship, and/or publication of this article.

Correspondence regarding this article should be directed to Jennifer Madere, Intuitus Group Independent Professionals, 1464 E. Whitestone Blvd. Ste. 2001, Cedar Park, TX 78613. E-mail: jennifer@intuitus-group.com