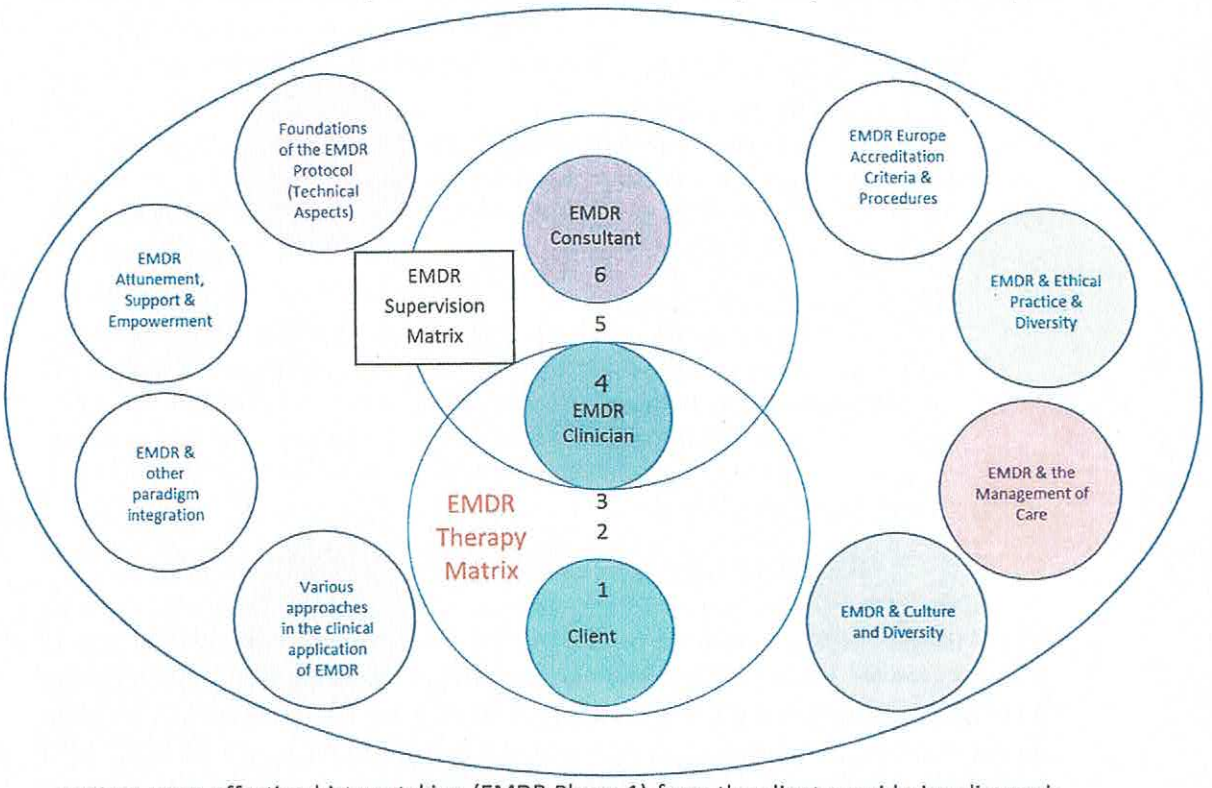
Systems Approach to Supervision (Holloway, 1995); Process Model (Hawkins & Shohet, 2000); the EMDR Clinical Supervision Process Model (Farrell, 2013; adapted from Hawkins & Shohet, 1989/2012) specifically relates to all the core attributes involved in EMDR as a psychotherapeutic intervention. This is outlined further in figure 2.

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

Mode 1 – EMDR Clinical Supervision Session Content – The primary focus on this aspect



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

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

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

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

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

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

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

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

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