# A DUTY OR A JOY? AN INTERPRETIVE PHENOMENOLOGICAL ANALYSIS OF EMDR THERAPISTS' EXPERIENCE OF CONTINUING PROFESSIONAL DEVELOPMENT (CPD); AND WHAT THEY THINK THEY NEED TO KNOW.

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# Abstract

This research set out to explore the experience of EMDR therapists in undertaking Continuing Professional Development (CPD) events and what knowledge they believe they need to acquire beyond standard training. 12 Eye Movement Desensitisation and Reprocessing (EMDR) practitioners were interviewed about their training, their CPD experience and the extent to which they plan this, along with what they think practitioners need to know. Of the 12 interviewees, four were trained but not accredited practitioners, four were accredited and four were consultants. They were asked what other information they believe they need, and what they think about the idea of a structured programme of CPD. Semi-structured interviews of between an hour and an hour and a half were conducted and recorded. Data were analysed using Interpretive Phenomenological Analysis (IPA) (Smith et al., 2009). Ten themes were identified. Results indicate that the practitioners interviewed do largely benefit from and enjoy their CPD, finding it largely a joy rather than a duty, although there were some elements of the latter. Most participants in the study were not making a specific CPD plan and may possibly benefit from doing so: the themes around what they believe an EMDR therapist needs to know encompassed both technical knowledge and beliefs around the therapeutic relationship. The results indicate some criticism of current structures of training and CPD.

There were varying responses to the idea of a structured programme of CPD, and to the personal development plan discussed.

Products from the research include a CPD course, a Conference presentation and a new Personal and Professional Development Plan.

# Chapter 1. Introduction.

In this study of the experiences of Eye Movement Desensitisation and Reprocessing (EMDR) practitioners with regard to Continuing Professional Development (CPD), I will explore practitioners' experience of CPD and what they believe they need to learn after EMDR basic training, using IPA as a methodology.

I would first like to introduce myself before introducing my own background in EMDR and CPD to establish my part in the research and my interest in both activities.

I am a 66-year-old, white, cis-gendered, currently able-bodied woman. I was born in the north-west of England to a working-class family but would currently be seen as middle-class. I have lived in Kent for over 40 years and feel at home here. I have worked first as a counsellor and then a psychotherapist for over 30 years and have been in private practice since 1995. I largely identify as an integrative psychotherapist and have trained in various models including Sensorimotor Psychotherapy, Coherence Therapy, Thought Field Therapy and an MSc in Integrative Psychotherapy. I am currently a trainer, a facilitator in EMDR training, a supervisor, a practitioner, a supervisee and sometimes still a trainee.

I first trained in EMDR in 2002 and initially, I was a little sceptical about its efficacy. I had heard about EMDR in a Diploma course I undertook on Post Traumatic Stress counselling in the mid-1990s and it sounded nonsensical to me. I thought that waving one's fingers in front of a client's face could not be therapeutic. I very quickly discovered that EMDR was a great deal more than that and, having had my own satisfactory experience as a client, I began to integrate it into my work.

My interest in CPD is older than my interest in EMDR. I have been a consumer of CPD for over 30 years and a provider for 15. I am very interested in how practitioners acquire

knowledge, how they decide what they need to know and learn, and relatedly, how organisations provide learning and CPD opportunities.

When I began the DPsych I wondered whether to focus my research on CPD, or EMDR. As time progressed, I decided that I could combine the two and I developed my research question as follows:

What is EMDR therapists' experience of CPD, how much do they plan it, what do they think they need to know, and how satisfied are they with their CPD?

This question is interesting to me as it concerns a growing practice in a small and fairly new community of therapists. EMDR was established in 1987 and has only been well known in the UK for about 20 years. It has already become quite organised, with an established (albeit short) training, and a structure from trained therapist, to accredited practitioner, to consultant and then possibly trainer. My research question is, I believe, also pertinent in that there is no current research on pedagogy in EMDR and what people need to learn through CPD beyond standard training.

EMDR itself is a highly manualised therapy but it has already created large manuals of different ways to utilise the basic protocol. There is, therefore, quite a wide scope already for CPD activities and a lot of material that practitioners might feel they need to know.

EMDR accredited practitioners are required to have 75 hours of CPD over 5 years, as well as additional CPD requirements from their other accrediting bodies. The CPD must be specific to EMDR and cannot be online training (until 2020, when the pandemic changed this, in theory, for a temporary period). These hours, however, can usually be counted as part of the requirement for other accrediting bodies.

Unlike most psychotherapy organisations in the UK, the EMDR Association awards CPD points for training and therefore CPD can only be counted as part of the 75 hours if these points have been applied for and awarded.

I, therefore, chose to interview four each of non-accredited, accredited and consultant practitioners, although only those with accreditation are specifically required to complete CPD. I chose to conduct individual interviews. In retrospect, focus groups could also have been useful as in such groups, interactions between participants can be used as additional data to determine why people believe what they do (King & Horrocks, 2010). I also chose face-to-face interviews as opposed to virtual ones as I believed that this created a more authentic interaction with the participant. I was fortunate that my interviews were conducted well before the pandemic lockdown, so face-to-face interviews were possible.

The following themes were explored in these interviews:

- What was your original orientation?
- Why did you choose to train in EMDR?
- Could you tell me about your current sense of your EMDR training?
- What are your current feelings around practising a manualised therapy?
- How did you experience the accreditation process? (if applicable)
- What CPD have you completed since your EMDR training?
- Can you tell me about this CPD?
- How did you choose it?
- What impressions do you have of EMDR CPD courses on offer?
- What do you think is essential for an EMDR practitioner to know?
- Do you have any sense of setting out a CPD plan for yourself? If so, what? If not, how would you feel about doing this?

- How would you feel about a structured EMDR plan of CPD?
- Are you aware of the EMDR personal development plan? (Farrell et al., 2013).

  If so, do you use it?

  If not, would you be willing to look at it and give your impressions?
- How have you used your CPD experiences in your practice?
- How has it been for you to discuss these issues with me?

It has been interesting for me to reflect on the decisions made in the framing of the research question and the interview schedule. Willig (2008) discusses how the framing of the research question influences the understanding of the issues under investigation and whether framing it differently would change the outcome. I now wonder if the research question could have been framed more openly and whether this would have changed the responses I received.

Patton (1990) argues that six types of question can be asked in a qualitative research interview: demographic, experience, opinion/values, feeling, knowledge and sensory. My questions focussed on the categories of experience, opinion and values, and knowledge. Probes and prompts also brought in feeling questions. Largely my questions were about the experience of CPD, the nature of knowledge and views about the acquisition of knowledge.

# Chapter 2. Background Information Concerning EMDR

As some technical terms are used in EMDR, I am including a glossary.

**TABLE 1**

*GLOSSARY OF MAIN TERMS*

| Term | Definition |
|---|---|
| Adaptive Information Processing (AIP) | The main theory underpinning EMDR. It suggests that optimally the brain processes experiences, but in trauma memories become dysfunctionally stored. |
| Bilateral stimulation (BLS) | This is eye movements, or alternate tapping, or the use of pulsers which, it is believed, cause the brain to make associations. |
| Subjective Units of Disturbance or Distress Scale (SUD) | Developed by Wolpe (1990), this indicates the level of distress to be processed. |
| Validity of Cognition (VOC) | This is used to test how true the positive or preferred cognition is in Standard Protocol. |
| Standard Protocol (SP) | An eight-phase protocol developed by Francine Shapiro working normally past – present – future (referred to as the three prongs.) |
| Inverted Protocol (IP) | Standard Protocol but working from the future back or working on unwanted positive affect to be reduced (e.g. unrequited love). |
| Modified Protocol (MP) | A protocol developed by Parnell (2011) which deletes the Positive Cognition and VOC scale and changes the order of the other elements in the protocol. |
| CPD points | One point equates to an hour of CPD. |
| Negative Cognition (NC) | This is what the client believes about themselves *now* when they think about the target issue. |
| Positive Cognition (PC) | This is what the client would prefer to believe about themselves *now*. Sometimes called the Preferred Cognition. |
| EMDRIA | EMDR International Association |

As some understanding of EMDR is required to appreciate my research question and the responses given by my participants, I am including some background on EMDR. The purpose of doing so is to provide a sense of the field including its history and the central debates and protocols. This will provide some context for the research, the participants who work in the field, and their CPD.

EMDR is a NICE recommended treatment of choice for PTSD. It is currently used for many different presentations and was recently endorsed by the World Health Organisation (2013). It was a difficulty for the EMDR Association that, in November 2019, NICE "downgraded" EMDR in the sense that now it is only recommended if Cognitive Behavioural Therapy (CBT) appears not to work for an individual patient. Bizarrely this appears to reflect a view that EMDR is both "better" and "worse" than CBT in outcomes. The difficulty for EMDR appears to be the paucity of randomised control trials (RCTs) to demonstrate efficacy, as compared to CBT. Currently, the EMDR Association has set up committees and sub-groups to make recommendations to NICE about the efficacy of EMDR for a number of other presentations such as depression, psychosis, pain and eating disorders.

It is interesting that in a recent study by Mavranezouli et al., (2020), EMDR was identified as the most cost-effective treatment for PTSD in adults.

EMDR was originally introduced by Francine Shapiro in 1987 and Carrere (2013) contends that 150,000 clinicians have been trained worldwide. There are 10,000 trained practitioners in the UK (EMDR Association Board Minutes November 2019). EMDR has since progressed from being seen as a simple technique, to being considered a distinct psychotherapeutic method with its own theoretical underpinning: The Adaptive Information Processing model (AIP). The issue of whether practitioners still see it as simply a technique is one that arose in analysing the themes from the interviews. This issue is significant to my study in the sense that if EMDR is simply a technique then provision of CPD could be considerably simplified.

The proliferation of CPD on offer suggests that many practitioners do not see it as a technique but as a psychotherapy in its own right. My participants' ideas on this would influence their approach to EMDR and to CPD.

Leeds (2016) suggests that EMDR has evolved through four main periods from a simple technique (eye movements) to an initial procedure (eye movement desensitisation), to a protocol (eye movement desensitisation and reprocessing) for the treatment of a single condition (PTSD), to an overall approach to psychotherapy.

EMDR is a therapeutic model which consists of eight phases: history taking, preparation, assessment, desensitisation, installation, body scan, closure and re-evaluation. It is consistent with a three-phase model of working with trauma comprising stabilisation, traumatic memories, and reconsolidation (Janet 1898; Herman 1992).

Phase three of the EMDR model is assessment, a word that is used in a very specific context in EMDR. In this phase, a target is identified for processing, which typically will be a specific image or worst part of a memory. The client is then asked to identify a negative cognition (NC). This is their current negative belief about themselves when they think of the target. They are then asked what they would prefer to believe, and their answer is known as the positive cognition (PC). They are asked on a scale of 1 to 7 how much they currently believe this (known as the validity of cognition scale or VOC). They are then asked to identify emotion(s) connected to the target, the severity of the experience on a standard scale of subjective units of distress or disturbance (SUDS) and the body sensation connected with this.

This process is intended to lock in the trauma network. The client is instructed to "just notice" whatever happens and not to try to change or control anything. Bilateral stimulation is

applied. Bilateral stimulation can be eye movements, tapping, pulsers held in the hands or tones in the ears played through headphones.

The AIP process is hopefully utilised and this challenges dysfunctionally stored material causing it to be re-stored and consequently to become less upsetting. As a result, the SUDS score should come down. Once a score of 0 or possibly 1 has been reached, the positive cognition can be installed using the same method of (fast) bilateral stimulation. Once the VOC scale reaches 7, a body scan is conducted to pick up any remaining tension or discomfort. Finally, the work is closed down. The following week the target is reassessed to check that that the processing is complete, this would be Phase 8 of the protocol.

This process comprises what is known as the Standard Protocol. There are also a number of recognised variations of the Standard Protocol, to work with depression, bereavement, OCD, pain, dissociation, fear and anxiety, recent events, complex trauma and an increasing number of other presentations.

From the beginning, Shapiro recognised the need to standardise training for EMDR to ensure treatment fidelity, reliability, and validity. Current training is relatively short (lasting between 6 and 12 days, most typically 7 in the UK) and provides a certificate of attendance rather than competence. Practitioners can only be accepted for EMDR training if they have an existing orientation as a mental health practitioner. This involves being a clinical psychologist, psychiatrist, mental health nurse, psychotherapist or counsellor. Psychotherapists need to be registered by UKCP and counsellors accredited by BACP. The integration between theory and practice is therefore largely conducted through EMDR supervision/consultation and CPD training.

The change in EMDR from convergent to divergent (Shapiro 1995; Maxfield 2009) has been an interesting movement in the UK. Originally Shapiro saw EMDR as a convergent paradigm

that was consistent with being integrated into other therapeutic modalities. Increasingly it is now seen as a distinctive modality with its own theoretical underpinning (Farrell & Keenan 2013). At the 2014 EMDRIA Conference in Colorado, Shapiro encouraged clinicians to refer to EMDR as “EMDR therapy” to clarify that it was a therapy and not a technique. When I first trained in EMDR in 2002 it was very strongly taught as an addition to one’s own orientation to be integrated into work. Increasingly, practitioners now define themselves as EMDR practitioners, practising it almost exclusively. I was interested in where my participants would fit in this paradigm.

All EMDR accredited practitioners are required to complete CPD, but often there is little sense of a plan for this and practitioners simply complete available courses. Currently, CPD training often consists of workshops run by charismatic individuals, commonly from the USA, presenting their own “brands” and interpretations of the work. Sometimes these therapists and their trainings are either overtly or covertly disapproved of by the EMDR Association.

EMDR accredited practitioners are required to acquire 75 CPD points in 5 years (1 CPD point equates to 1 hour of CPD). In contrast to this BACP requires 30 hours a year of CPD for its accredited members, whereas UKCP requires 250 hours of CPD over 5 years.

The tradition of requiring CPD courses to apply for CPD points has enabled the EMDR Association to control what courses are recognised as CPD. In the UK this is achieved through courses needing to apply to the Accreditation Committee of the Board of the EMDR Association UK to obtain CPD points.

I decided to investigate the experiences of EMDR practitioners as they are individuals who come from a wide variety of other therapeutic disciplines and also have other obligations for CPD from their main professional bodies. They are also a relatively small group of

practitioners (4,000 members of EMDR UK) and are therefore a group that have some cultural homogeneity as well as considerable diversity. I anticipated that studying the beliefs about CPD of this small group could give some insights into the behaviour of other groups of psychotherapy professionals. It was, and is, also culturally interesting to me that proponents of EMDR refer to it as psychotherapy, despite many of its practitioners being psychologists, psychiatrists, counsellors or nurses.

Since I began my research the founder of EMDR, Francine Shapiro, sadly died in June 2019 at the age of only 71. It is as yet too early to assess what the impact of her death will be on the ongoing progress of EMDR. It is interesting, however, to speculate about the idea that previously, when powerful founders of therapies, for example, Carl Rogers, have died, followers have then found it easier to change and expand on their theories. The theory of the self, for example, had been very fixed in the person-centred approach, but 13 years after his death Mearns and Thorne (2000) felt it possible to expand this to the idea of Configurations of Self. I think that the comparison with the person-centred approach is useful as many practitioners suggest that the theoretical underpinning of the Adaptive Information Processing Model in EMDR is similar to the Actualising Tendency.

During Shapiro’s lifetime, there were challenges to the orthodoxy of EMDR which were largely seen as unacceptable, this will be expanded on in my themes below.

The primary theoretical underpinning of EMDR is the Adaptive Information Processing Model (Shapiro 1995, 2001, 2018). This model is made up of three principles (Leeds 2016). First, that there is an intrinsic information processing system that has evolved to enable the recognition of responses to disturbing events. These responses range from an initial dysfunctional state to a state of adaptive resolution.

Second, a traumatic experience or persistent stress can disrupt the information processing system. This results in the information becoming stored in a maladaptive state-specific form (Bower 1981) and failing to reach an adaptive resolution.

Third, the combination of standard EMDR therapy procedural steps and bilateral stimulation restores balance to the AIP system. The result is a resumption of information processing, which is then able to proceed until an adaptive resolution can be obtained for the individual.

Shapiro (1995, 2001, 2018) described a model of memory networks that has five elements: image, thoughts and sounds, physical sensation, emotion, and belief. These elements are all reorganised during EMDR processing.

The principle of dual attention is also central to EMDR therapy. The client is required to hold dual attention to both selected target memory for the past and the sensory stimulation provided in the present by bilateral stimulation. Leeds (2016) referred to dual attention as the "teeter- totter model of consciousness".

The general plan for organising treatment in standard EMDR therapy is referred to as the three-pronged protocol (Shapiro, 1995, 2001, 2018). The three prongs are the past, present and future and are generally addressed in that order in the Standard Protocol. Sometimes the order can be reversed, and this is referred to as the Inverted Protocol (Hofmann 2009).

This information about EMDR is necessary to understand the basis of my research question and why I think that this question is significant in EMDR and important to pursue.

# Chapter 3. Literature Review

To underpin my research question, it was important to search for literature that involved both CPD and EMDR.

I searched the Cochrane Library, Medline, Pubmed, the British Library, Google Scholar, ERIC, the Francine Shapiro Library and twelve years of editions of the Journal of EMDR Practice and Research 2006-2019.

Keywords used were "EMDR", Eye Movement Desensitisation, and Eye Movement Desensitization and Reprocessing. I discovered that all three entries produced slightly different results, particularly as a distinction between American and British writing. I also used "CPD", "Continual Professional Development", "Continuing Professional Development", "Ongoing Professional Development" and "Ongoing training".

On the databases typically "EMDR and CPD" and variations of this produced nothing, EMDR alone produced between 170-300 entries. CPD initially produced over 2000 but when refined to "CPD and Psychotherapy" results went down to 70. Even then, almost all the entries were about CPD in medicine, nursing or psychiatry.

As I found no direct references to EMDR and CPD on the databases or in Journals, I searched the indexes of twenty-seven published books on EMDR practice for references to CPD and found only two direct references to CPD (Leeds, 2018, Royle & Kerr, 2010.) Leeds refers in a brief paragraph to advanced workshops, Conferences and using the Francine Shapiro library as CPD activities. Royle and Kerr mention CPD equally briefly as helping to build up knowledge but also to build up social support.

As I found no literature on EMDR and CPD I looked at EMDR literature in general. There is a good deal of research regarding the efficacy of EMDR. For example, several meta-analyses exist which compare EMDR to exposure therapy protocols, with and without CT techniques.

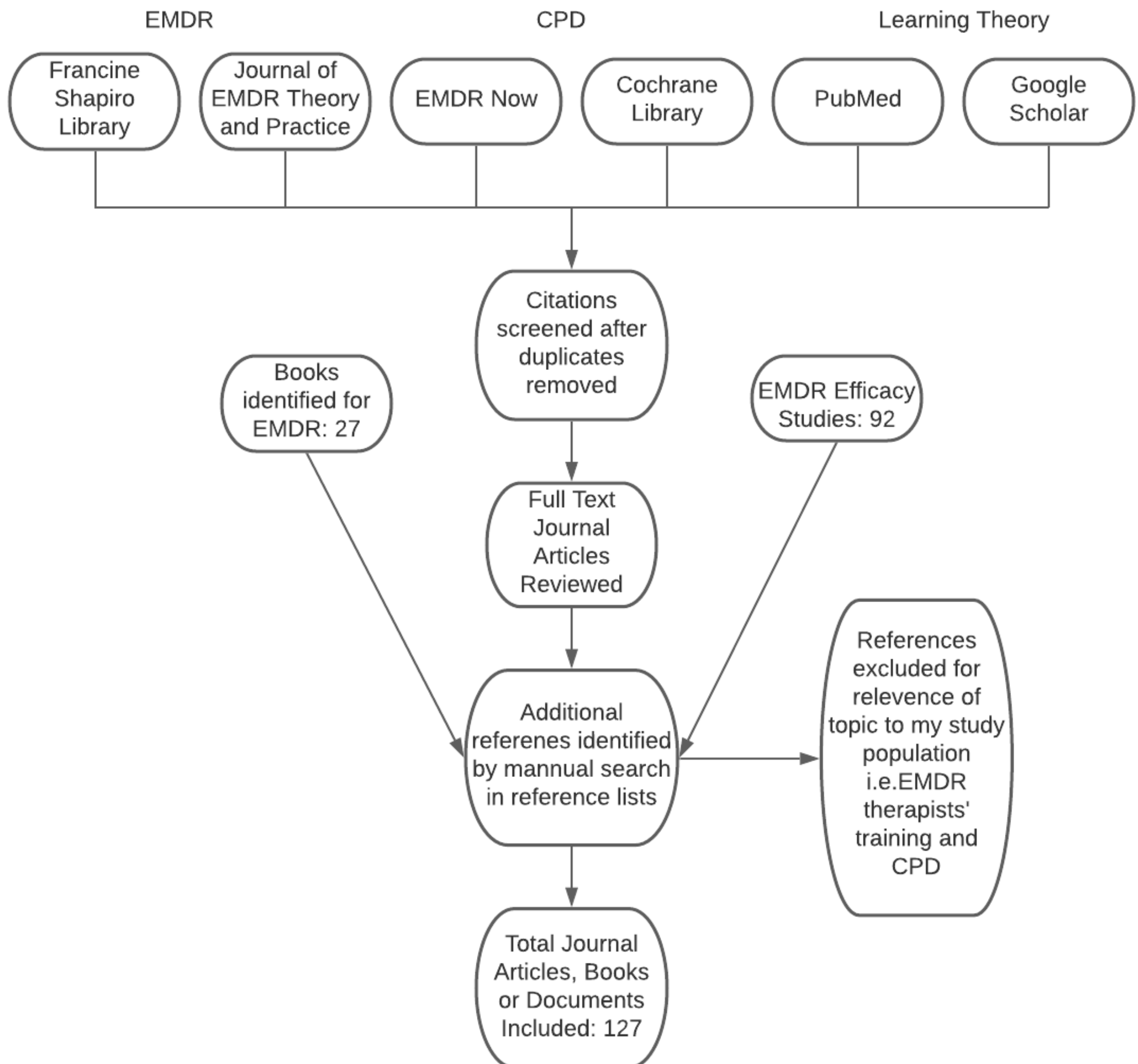
I have included a summary of some of the literature on the efficacy of EMDR as this lays the foundation for my research question and I believe increases the need for research into the experience of EMDR practitioners, as although there is considerable research on efficacy in the approach there is none on pedagogy. The fact that the research on efficacy exists strengthens the need to research further the experience of practitioners in an approach that has established itself as effective.

In searching for EMDR literature I also looked at training in EMDR and found some relevant studies on training and supervision which will be explored below.

Figure 1 illustrates the process of literature selection.

**FIGURE 1**

*LITERATURE SELECTION PROCESS*



The review followed a three-stage process which was iterative, so no formal exclusion criteria were applied.

Stage 1 sought all studies and information about EMDR and CPD as well as learning in CPD. I initially searched for "EMDR and CPD" and when this produced no response entered "EMDR" and "CPD" separately. I obtained 300 entries on EMDR and chose to read in detail some studies on EMDR efficacy. I identified 10 meta-analyses, 39 randomised controlled trials (RCTs), 22 non-randomised studies and 20 evaluations of treatment. 15 studies were selected for mention here as representative studies.

On extending the search, particularly in the Francine Shapiro Library, to "EMDR training" I obtained eight studies that researched participants' understanding of training and were therefore relevant to my study of learning in EMDR, all of these are included in this review.

Stage 2 extended the search to CPD where I obtained 70 references which were screened. I searched the indexes of 15 books on CPD or professional development and obtained some references, including information from the books themselves.

Stage 3 deepened the search concerning professional development. I extended the search to learning theory in general as this seemed relevant to my research question on what EMDR therapists believe they need to know. I also concurred with Vetere and Stratton (2016) who state that "all forms of training and personal and professional development are fundamentally learning" (p. 7).

I used snowballing by searching the indexes of books for references and then searching those books, and citation tracking to track articles from other articles. I also consulted senior figures in EMDR for references and ideas.

I have also been through 15 years of editions of *EMDR Now*, a newsletter with articles on prominent themes in EMDR. This publication was relaunched in 2019 as *EMDR Therapy Quarterly* and I also searched all editions of this.

**EMDR Literature**

I have highlighted some general studies on EMDR as they underpin the learning and knowledge required in EMDR therapy and thus relate to my research question.

The first study on EMDR was published in the *Journal of Traumatic Stress* in 1989 (Shapiro, 1989). It was conducted by Shapiro and comprised 22 subjects aged between 11 and 53 years. They were recruited through clinicians who were treating the individuals for PTSD symptoms related to rape, sexual abuse or Vietnam combat trauma. Five years later a follow-up study (Wilson et al., 1997) indicated that three sessions of EMDR processing produced a clinically significant change in traumatised civilians on multiple measures.

Bisson et al. (2013) found that both CBT and EMDR are superior to all other treatments. Bradley et al. (2005) found that EMDR was equivalent to exposure and other CBT treatments and that all “are highly efficacious in reducing PTSD symptoms”.

Chen et al. (2014) found that “EMDR therapy significantly reduces the symptoms of PTSD, depression, anxiety and subjective distress in PTSD patients”.

Lee and Cuijpers (2013) found that the effect size for the contribution of eye movements in processing emotional memories was large and significant.

These studies help to make the case for the importance of my research as they begin to establish EMDR and its main mechanism, bilateral stimulation, as an important therapy, particularly for PTSD. They also establish EMDR as a highly efficacious therapy. I think this creates the background for researching the experiences of EMDR practitioners.

There are also Randomised Controlled Trials (RCTs) on specific populations. Abbasnejad et al. (2007, p. 16) said "EMDR is effective in reducing earthquake anxiety and negative emotions (e.g., PTSD, grief, fear, intrusive thoughts, depression etc) resulting from earthquake experience." Furthermore, results show that improvement due to EMDR was maintained at a one-month follow-up.

Arabia et al., (2011) reported on a pilot study for survivors of life-threatening cardiac events which showed that EMDR performed significantly better than imaginal exposure for all variables. Capezzani et al. (2013) compared EMDR and CBT for cancer patients and reported that "after eight sessions of treatment, EMDR therapy was superior to a variety of CBT techniques. Almost all the patients (20 out of 21, 95.2%) did not have PTSD after the EMDR treatment".

De Bont et al. (2013) showed effectiveness in patients with psychosis and Diehle et al. (2014) showed that TF-CBT and EMDR were equally effective in working with children with PTSD. Ostacoli et al. (2018) compared CBT and EMDR as treatments for recurrent depression and showed that there were no significant differences between the two groups.

There are also many non-randomised studies. These include Hofmann et al. (2014) who studied EMDR as a treatment for depression, Jarero and Uribe (2012) who investigated recent critical incidents, and Wadaa et al. (2010) who considered EMDR as a treatment for traumatised Iraqi children.

These studies are examples of the many pieces of research on EMDR and its efficacy with various populations and I have included them to introduce the literature on EMDR and also to underline the fact that there is almost no research on pedagogy in EMDR.

There are also many randomised studies testing hypotheses of how EMDR works (including studies on eye movements). These include Engelhard et al. (2010) who studied the effects of

both eye movements and Tetris on memories. The authors concluded that the results were the same, though Tetris taxed working memory to a greater extent than eye movements did. Nieuenhuis et al. (2013) found that eye movements enhanced memory retrieval.

**Research into EMDR Training and Therapists' Experiences.**

Farrell and Keenan (2013) published a study of participants' experiences of EMDR training. This was a mixed-methods study with 485 participants conducted between 2005 and 2011. The rationale was to explore potential differences between EMDR accredited and nonaccredited clinicians concerning retrospective reports of treatment. The results indicated that EMDR accredited clinicians reported better treatment outcomes. The authors argued that EMDR had progressed from a convergent technique to a divergent psychotherapeutic approach. Consequently, they explored whether current EMDR training was "fit for purpose". They outlined a new model for EMDR training, proposing the importance of developing more EMDR training in academic institutions. Although this research has not changed the overall model of training in EMDR, Farrell has established an MSc in EMDR at the University of Worcester.

A central argument in this research is that, whilst individuals are required to have a core mental health profession, EMDR will always be considered a secondary therapeutic approach. Shapiro (2007) stated that the goals of therapy are greatly influenced by the clinicians' original therapeutic paradigm and personal worldview. Farrell and Keenan (2013) enquired as to their participants' original training and found that the two most prominent groups were psychotherapists and clinical psychologists. They further found that 30% of psychotherapists who participated were nonaccredited compared to 65% of the psychologists. Suggested reasons for not seeking accreditation were that clinicians (particularly

psychologists) felt that their existing training and status were enough, that there was a shortage of EMDR consultant supervisors, and that CPD and supervision were expensive.

Farrell and Keenan (2013) suggested that current EMDR training focused on PTSD too much at the expense of other approaches. They presented an outline for training in EMDR. This outline is similar to the one for CPD that I will later explore. Interestingly, in this study, they describe current training as inadequate and suggest a very comprehensive training model. This model comprises the following components:

EMDR as a psychotherapy approach that comprises definitions of EMDR, the AIP model, the three-pronged protocol (past, present and future), the eight phases, managing processing and treatment planning, resourcing, methods of bilateral stimulation and cognitive interweaves.

Background information including psychotraumatology, PTSD, research evidence base, psychometrics, wider applications of EMDR.

General Information including vicarious trauma, clinical supervision, international perspectives of EMDR, Humanitarian Assistance Programmes, EMDR Association and regional networks, EMDR and the law.

Scripted Protocols including recent traumatic events, dissociation, somatic disorders, phobias, children and adolescents, bereavement loss and grief, pain, addictions, OCD, eating disorders, phantom limb pain, medical or health-related conditions.

EMDR and other client groups including EMDR and ego states, depression, highly disturbed clients, forensic settings, military populations, refugees, oncology, cultural aspects of trauma, couples and families.

On examination of the current EMDR training manuals, many of these elements are already included in the seven-day training. However, many issues under the heading of EMDR as a psychotherapy approach are touched on only briefly. Others, such as the eight-phase protocol,

are heavily emphasised. Many of the scripted protocols and most topics under other client groups are not taught.

Dunne and Farrell (2011) published a study concerning how practitioners integrated EMDR into their practice. This work also reflected the debate between divergence and convergence. The study was conducted in the UK at two major conferences and aimed to examine how therapists integrated EMDR into their practice. The authors established that up to 40% of the sample (of 83) had experienced difficulties post-EMDR training. Results indicated that analytically trained and humanistic therapists experienced significantly more difficulty in integrating EMDR than integrative or CBT clinicians. This is an interesting finding which illustrates Shapiro's (2007) assertion that the therapist's original therapeutic paradigm influences their application of EMDR therapy.

DiGiorgio et al. (2004) conducted a small-scale study of three therapists trained in EMDR to investigate how therapists integrate EMDR into their current practice. They found that all three therapists deviated from the Standard Protocol to some degree and that their decision to change the protocol was influenced by their theoretical orientation. The humanistic therapist omitted the positive cognition because of a belief that it was artificial. The psychodynamic therapist admitted using interpretations and reflections on what happened for the client during the session. This represented a very interesting understanding of how EMDR therapists integrate EMDR into their current practice.

I have found very few doctoral theses on the experiences of EMDR practitioners. Harbert (2004) completed a thesis on "EMDR: client and therapist perspectives". Dunne (2010) wrote about EMDR therapists' understanding of how the therapy works, which resulted in the Dunne and Farrell (2011) article quoted above. Smith-Lee Chong (2016) wrote about the experiences of EMDR therapists when working with PTSD. I could not find anyone who had written about EMDR therapists' experiences of CPD or their sense of their learning. Derek

Farrell confirms that there is a complete lack of research on pedagogical processes in EMDR. The literature I have found on EMDR is almost exclusively from the EMDR journals.

Farrell et al. (2013) published a study on enhancing EMDR supervision. The authors also introduced an extremely technical EMDR personal development action plan. This plan asked therapists to rate their sense of ability and knowledge in a large number of operations involved in the EMDR process. These ranged from awareness of the Standard Protocol to quite advanced operations. This reflected the curriculum outlined in the Farrell and Keenan (2013) study on training.

The above paper utilised the Dreyfus (2004) model of skill acquisition which comprises five levels: novice, advanced beginner, competent, proficient and expertise. Farrell et al. (2013) discussed the application of this model to EMDR training and experience suggesting that the stages of novice and advanced beginner comprise the EMDR training. The competency stage involves the trained practitioner undertaking supervision. The stage of proficiency characterises the accredited practitioner and the expert stage describes the EMDR Europe accredited consultant. The studies conducted by Farrell et al. (2013) seem particularly significant as they examine practitioners' progress and development in EMDR. The Personal Development Plan published in this article was important to my research as I used it to show to my participants to elicit their responses. Over time I also assisted in developing a second edition of this plan.

Marich (2012) published a study named: *What makes a good EMDR therapist: Exploratory findings from client-centered enquiry*. The study was based on women in continuing addiction care and it emphasised client-centred factors in the training and formation of EMDR therapists.

Marich (2012) concluded the qualities of a good EMDR therapist are to be caring, trustworthy, intuitive, connected, comfortable with trauma work, skilled, accommodating, have good common sense, smart, consoling, validating, gentle, nurturing and facilitative. The qualities of an ineffective EMDR therapist were seen as being rigid, scripted, detached, anxious, unclear and uncomfortable with trauma.

The qualities of a good EMDR therapist here appear to be exclusively general therapeutic qualities. Issues that could be seen as applying more specifically to EMDR e.g. scripted, are seen as ineffective. I saw this study as applicable to my research in that these qualities are seen as being developed in EMDR therapists and therefore will affect issues of CPD and learning.

**CPD Literature**

As stated above I searched the Cochrane Library, Medline and Pubmed for studies on CPD.

I also found 15 books on CPD or personal and professional development.

Some definitions of CPD may be useful here. The NHS defines CPD as: "The systematic maintenance, improvement and broadening of knowledge and skill, and the development of personal qualities necessary for the execution of professional and technical duties throughout the practitioner's working life" (Department of Health, 1999, p. 84 as cited in Alsop 2000, p. 2).

The Institute of Professional Development defines it as: "A process by which a professional person maintains the quality and relevance of professional services throughout his /her working life." (Alsop, 2000, p. 2).

Alsop (2000, p. 3) described CPD as:

- A process

- Lifelong
- Systematic
- Embracing formal education and informal learning
- Something to assure competence
- Development of personal qualities
- Enhancing professional and technical skills
- Maintaining, enhancing and broadening professional knowledge
- Expanding and helping to fulfil potential
- Maintaining quality and relevance of professional services
- Developing and enhancing practice.

The BACP Directory (British Association for Counselling and Psychotherapy, n.d.) defines CPD as:

> Any learning experience that can be used for the systematic maintenance, improvement and broadening of competence, knowledge and skills to ensure that the practitioner can practice safely, effectively and legally within their evolving scope of practice. It may include both personal and professional development.

These definitions of CPD are relevant to my study in that they outline the expectations of bodies that practitioners will improve and broaden their competence. This seems to me to be very important in EMDR as therapists undertake a very short (7 day) standard training.

In 1953 Joan Fleming proposed three different methods that characterised the learning process of students at different experience levels. These were:

- Imitative learning
- Corrective learning
- Creative learning.

In the first level, learning occurs through imitating the supervisor. In corrective learning, the supervisor assumes the role of the potter. In creative learning, the supervisor assumes the role of the gardener.

In thinking about the EMDR learning process the initial standard training is very much based on imitative learning, as are the first stages of EMDR supervision. At later stages, practitioners seem to very much value the creative aspects of learning.

Csikszentmihalyi (2013) distinguished between what he defined as "small-c" and big-C" creativity in describing how creative individuals influence their domains of knowledge. He stated that small-c creativity was subjective but big-C was the kind of creativity that drives culture forward. Hensley (2021) referred to Shapiro as a "big-C creator" as she created a profound change in how therapy can be seen.

Generally, when searching for literature on CPD, some models which describe the process of CPD were identified. Goldberg (1988) described therapist development as being a journey or a quest. Skovholt and Ronnestat (1995) published a model of therapists' growth and development through CPD. They suggested that therapists pass through eight stages of development: the conventional stage, the transition to professional training, the imitation of experts stage, conditional autonomy stage, exploration, integration, individuation and integrity. I find this description helpful but, as the authors are very biased to the American experience, think it is difficult to apply these stages to the CPD experiences of UK therapists. However, the 20 themes which formulate the essence of their findings are interesting and are as follows:

1. Professional development is growth towards professional integration.
2. An external and rigid orientation in role, working style and conceptualising issues increases throughout training then declines continuously.

3. As the professional matures, continuous professional reflection becomes the central developmental process.
4. Beginning practitioners rely on external expertise, senior practitioners rely on internal expertise.
5. Conceptual system and role-working style become increasingly congruent with one's personality and cognitive schema.
6. There is a movement from received knowledge towards constructed knowledge.
7. Development is impacted by multiple sources which are experienced in both common and unique ways.
8. Optimal professional development is a long, slow and erratic process.
9. Post training years are critical for optimal development.
10. As the professional develops, there is a decline in pervasive anxiety.
11. Interpersonal encounters are more influential than impersonal data.
12. Personal life is a central component of professional functioning.
13. Clients are a continuous major source of influence and serve as primary teachers.
14. Newer members of the field view professional elders and graduate training with strong affective reactions.
15. External support is most important at the beginning of one's career and at transition points.
16. Professional isolation becomes an important issue with increased experience and age.
17. Modelling and imitation is a powerful and preferred early – but not later – learning method.

18. There is a movement towards increased boundary clarity and responsibility differentiation.
19. For the practitioner there is a realignment from a narcissistic position to a therapeutic position.
20. Extensive experience with suffering produces heightened tolerance and acceptance of human variability.

My experience of working with supervisees during and after training (both original training and EMDR), as well as my own experience, suggests that some of these findings are also true in the UK experience. “An external and rigidity orientation” (point two) does appear to increase for people during training and then decline. I have certainly found that continuous professional reflection has been an important developmental process, and I think this has been the experience for the majority of my supervisees.

The points I am less sure of are point eight (Optimal professional development is a long, slow and erratic process) and point ten (As the professional develops, there is a decline of pervasive anxiety). My experience as an EMDR supervisor would suggest that in EMDR, development is often rather a quick process, but that this does not necessarily result in a decline in anxiety. I felt that it would be interesting to see if my interviewees would give any insight into this.

Skovholt and Starkey (2010) also discussed what they referred to as the three legs of the practitioner’s learning stool: practice, research/theory, and personal life. This seems to reflect the experience of the acquisition of knowledge in EMDR, which is largely based on experience.

Alsop (2000) produced a model of planning CPD and the process of achieving a personal development plan. This is helpful, I think, and the idea has been espoused by BACP in their

documentation for registration (2014). However, many practitioners do not seem to use this. I base my belief of this on the reports of my supervisees and also on the fifteen practitioners who attended a CPD course I delivered in 2017, only one of whom was filling in the recommended BACP documentation.

Shuler et al. (2017) conducted a study of 24 counsellors' experiences of personal and professional development, but the study resulted in them talking about their transformational experiences rather than specific learning.

There is some general literature on personal and professional development (Wilkins, 1997; Bager-Charleson, 2012; McLeod & McLeod, 2014) but it seems to focus on personal development rather than on professional issues. I found very little literature based on what therapists think they need to know, which was part of my research question. Wilkins (1997) does discuss the development of a personal programme of professional development which involves further training, keeping up to date and professional recognition. He suggested that practitioners need to develop a personal programme of development and continually evaluate this. Both Wilkins (1997) and Bager-Charleson (2012) refer to research as a component of CPD.

The general CPD literature is important for me as it sets a scene for expectations of therapists in general and the stages that they might expect to go through.

**Adult Learning Literature**

As I was unable to find any other literature on learning in EMDR, and the processes of learning appeared relevant to the ability to benefit from CPD, I looked at the literature on adult learning. The processes of adult learning are highly relevant to my research question as the ways that people learn may influence what they think they need to know.

Theories of adult learning seem to suggest that learning is an active process. Bateson (1972) discussed deutero-learning which is effectively learning how to learn. These ideas are often reflected in supervision trainings which use the learning styles model of Honey and Mumford (1982). Bateson (1972) also proposed that advances come from a combination of loose and strict thinking. This seems to apply to EMDR which has this combination. I am very interested in exploring how people learn and how they integrate the knowledge that they acquire. Bateson (1972) also suggested that training can overemphasise strict thinking because of the requirement to demonstrate competence.

Schon (1990), Kolb (1983) and Gibbs (1994) considered the processes that create learning for adults. Their concepts of reflective practice, however, do not always take into account the ideas of co-creation of the relationship in therapeutic practice and Bradbury et al. (2010) discuss this.

Vetere and Stratton (2016) wrote about personal and professional development. They discussed learning as finding connections between the therapist's professional and private lives and the narrative of therapy that they create. They considered the concept of the hermeneutic circle as a way of thinking about how "information is processed through the therapist's existing structures of meaning and will then be subjected to dialogue either with others or within the self" (p. 18). This process was considered to lead to "a deep learning of theory" (p. 19). They went on to discuss creativity in learning and suggested that: "Creativity is about finding ways to insist on continuity of the exploration by using curiosity to find unanswered questions" (p. 27).

I think this is useful to me in my understanding of how manualisation and creativity can work together. This has been an ongoing debate. EMDR is a fundamentally manualised approach, but creativity is also often discussed as an important element of the work. "Structure versus creativity" later became one of my themes. McCaffrey (2012) suggested that the main

obstacle to creativity is functional fixedness, referring to the way that people readily perceive the function of anything they encounter which tends to prevent exploration of its potential.

Jenson (2016) discussed the gap between what therapists learn and what they bring into therapy from their personal experiences.

Allan et al. (2018) interviewed 14 couple and family therapists about their experiences of learning an evidence-based approach. The main themes they identified were challenges in learning, the embodiment of practice and the experience of shame while learning. This experience of shame is an issue picked up in my overarching themes. Watkins and Scaturo (2013) discussed the shame arising from a therapist's fear of not being approved of by a supervisor. I think this fear is very palpable in EMDR consultancy where the practitioner is dependent on the consultant's approval for their accreditation.

I have included learning theory in this review as I think the literature around this is important for my study which is very involved with learning. In the future, I hope to pursue this area more fully.

In addition to this literature, I also read one book and 15 full-text articles on Interpretive Phenomenological Analysis (IPA) to immerse myself in an understanding of IPA. This reading is discussed further in Chapter Four.

This literature review has included studies on the effectiveness of EMDR, on CPD, on learning theory and on EMDR training. The study by Farrell and Keenan (2013) has been the main focus, as an understanding of the training in EMDR contributes greatly to the need for ongoing professional development. Their finding that the EMDR standard training is not "fit for purpose" underlines the need to consider CPD and what therapists believe they need to know.

# Chapter 4. Methodology

I chose to use IPA (Smith et al., 2009) for this work because IPA concerns a focus on how people make sense of their experiences. This in itself is a complex concept. Smith et al. (2009) say that IPA researchers are particularly interested in what happens when the everyday flow of lived experience takes on a particular significance for people. For EMDR practitioners who are engaging in CPD and ongoing learning, these experiences do take on particular significance.

My Practice Evaluation Project (PEP) was essentially a pilot for this study. I used Thematic Analysis (Braun & Clarke 2013) and found that although this produced relevant themes it did not seem to go to the heart of people's experience. I believed that IPA would be more able to do this. Barton (2021) state:

> IPA is well suited to the study of the idiographic experiences of a homogenous group of people with a shared circumstance, for understanding how people perceive the particular situations they are facing and how they are making sense of their personal and social world (Cited in Bager-Charleson & McBeath (eds), 2021, p. 54).

My group of EMDR practitioners are certainly a homogenous group of people with a shared circumstance, but they also had very individual understandings which I have attempted to express.

Larkin et al. (2006) speak of IPA as a research perspective rather than as a discrete research method. As Barton (2021) suggested, "I offer my interpretation of IPA" (p. 54). Over the course of conducting this study, I have questioned whether IPA was, in fact, the best method of enquiry for this subject. I am very aware of my own position in this research as an EMDR therapist and at one point wondered if the work would have been conducted better using autoethnography (Denzin 2013). However, consideration of the multiple perspectives of

others was important to me in deciding how to do this work. Equally, I believe it is important that EMDR clinicians' experiences and beliefs are considered in thinking about EMDR knowledge.

In EMDR there is already a considerable body of knowledge and the EMDR Association has a view on what people need to know and understand. Individual practitioners also have very specific views and I considered that, therefore, my interpretation of IPA could bring individual insights to existing understanding and possibly change that understanding.

IPA, according to Smith et al. (2009), is phenomenological, hermeneutic and idiographic. It is phenomenological in that it seeks to examine experience in its own terms and to go, as Husserl encouraged, "back to the things themselves" (p. 12). It is hermeneutic in that the researcher needs to interpret the participant's words in order to make sense of their experience. It is idiographic in that IPA involves a commitment to the examination of the particular case.

It felt important for me to understand the underpinnings of IPA and there has been debate between academics such as Jonathan Smith (e.g. Smith, 2018), Amedeo Giorgi (e.g. Giorgi, 2010), and Max van Manen (e.g. van Manen, 2017), as to what extent IPA is phenomenological. Both Giorgi and van Manen adopt a narrower definition of phenomenology than Smith. van Manen (2017) concluded that IPA was not proper phenomenology. He also constructed a contradiction between phenomenology and psychology, leading to the suggestion that IPA should be renamed "Interpretive Psychological Analysis." van Manen argued that phenomenology should not include the use of interpretation of text, but Smith (2019) cited Heidegger to justify this.

van Manen (2017) said that looking at the meaning of the experience was not phenomenological as the researcher should be bracketing their experience following Husserl.

In this research, the experience of bracketing would simply not be possible for me regarding my pre-existing knowledge. I concur with Adams (2014, p. 2) who stated: “I am now convinced that this wonderful term “bracketing” is simply an illusion, a comforting idea that bears no relation to reality”.

I think the counterargument would be Heidegger’s formulation of phenomenology as interpretive. His idea of fore understanding suggests bracketing can only be partially achieved (Finlay & Gough, 2003). Heidegger (1927, p. 141) also stated that we are never free from assumptions and that “an interpretation is never a pre-suppositionless apprehending of something to us” and that we exist in a conditioned environment from which we cannot easily step outside. We cannot be divorced from our *Befindlichkeit* – our subjective felt sense of ourselves in the world (Heidegger, 1927).

Smith (2018) argued that any psychological analysis involves interpretation. The proposed renaming as “Interpretive Psychological Analysis” appears to me to make little sense, as Smith always presented IPA as a psychological method. What makes it different from other psychological methods is the focus on subjective lived experience. IPA, therefore, makes sense to me as a methodology for my research as the subjective lived experience of my participants is important in understanding my research question about CPD and peoples’ beliefs about what they need to know.

My view of bracketing (or epoché) is that it is desirable to attempt to come to each interview without assumptions about the participant and to be open to the participant’s experience. However, by definition, I am also involved in the activity that I am asking about and my fore-understanding will be part of the process. This later created tensions in my understandings of my participants’ comments and my existing knowledge of EMDR.

van Manen (2017, p. 824) criticised IPA for "offering the illusion of an off-the-shelf set of methods to do phenomenological work" but at the same time seemed to criticise it for not being "off-the-shelf" enough in its interpretation of what was considered phenomenological. Smith (2019) presented IPA as a flexible and changeable set of principles rather than a prescriptive template. However, the book (Smith et al., 2009) may give the impression of going in this direction. This is justified by Smith (2019) as being necessary to help beginners.

I have found the clear description of the IPA process in Smith et al. (2009) very helpful but have added elements of my own, such as including my own interview. I was impacted by Glaser (1998) who suggested that interviewing oneself before doing interviews with participants could ground the researcher in the work. I decided to do this, understanding that Glaser comes from Grounded Theory (Glaser & Strauss, 1967) and not IPA, but feeling that conducting my own interview would begin to immerse me in the issues.

Giorgi (2011) suggested that the methods associated with IPA are not fixed enough to be replicable and scientific. I think that as Smith et al. (2009) do give a clear philosophical underpinning and a clear methodology, this does make it replicable.

Zahavi (2018, p. 2) concluded that "IPA clearly stresses the link between its own endeavour and the phenomenological research tradition. But that link does not amount to much.".

Smith (2018) robustly refuted the idea that IPA is not phenomenological and referred to Heidegger: "there is no such thing as the one phenomenology" (1998, p. 328).

Moran (2000, p. 229) wrote:

> Phenomenology is seeking after a meaning which is perhaps hidden by the entity's mode of appearing. In that case, the proper model for seeking meaning is the interpretation of a text, and for this reason, Heidegger links phenomenology with hermeneutics. How things appear or are covered up must be explicitly studied. The

> things themselves always present themselves in a manner which is at the same time self-concealing.

Smith (2011) replied suggesting that Moran interpreted Heidegger as saying that to do phenomenology, you have to engage in hermeneutics.

IPA is therefore also hermeneutic. Heidegger's thinking links the phenomenological and hermeneutic aspects of IPA. Heidegger acknowledged the presence of the "fore-structure" but said that this made sense in terms of the things themselves. Smith et al. (2009) suggested that engaging with the text puts us in a position to know of our preconditions:

> IPA requires a combination of phenomenological and hermeneutic insights. It is phenomenological in attempting to get as close as possible to the personal experience of the participant, but recognises that this inevitably becomes an interpretive endeavour for both participant and researcher. Without the phenomenology, there would be nothing to interpret; without the hermeneutics the phenomenon would not be seen (p. 37).

This makes sense to me in relation to my research, as although I conducted my own interview with myself before conducting the other interviews, I found that sometimes my answers were quite different to the perceptions of the interviewees. I think that engaging with the interviews and allowing me to "dwell in the data" (Eatough, 2019) cast light on my assumptions.

It has also become clear to me that I am researching an area that has a clear theoretical underpinning and a set of structural steps which in themselves create preconditions.

Smith et al. (2009) also considered the importance of the hermeneutic circle. The authors described the double hermeneutic that occurs in IPA i.e., the researcher making sense of the co-researcher making sense of his/her experience.

Therefore, being aware of my insider position in this research necessitated becoming more aware of my own beliefs and assumptions in order to make them a central part of the interpretive process.

Ricoeur (1985) suggested that there is no self without a world in which that self can recognise and know itself, and no world without a self to know that world. He argued that “self” and “world” are interdependent concepts that describe different aspects of experience and so need to be seen together. I would argue, therefore, that in terms of my research the EMDR practitioners I was interviewing could only be understood in the context of the EMDR world which they inhabit, and that “world”, the EMDR community, makes no sense without the individual practitioners to understand it.

Finally, idiography is important in IPA. Eatough and Shaw (2019, p. 61) wrote that: “IPA seeks to retain the rich and personal detail of the particular whilst pointing to ways in which the particular illuminates (and is illuminated by) characteristics of the lifeworld that are common to us all.”

Goldspring and Engward (2018) also interestingly considered the mixture of the participant’s and researcher’s words and experiences. They referred to the phenomena of these resonating with each other during the research process as *echoes* and suggested that “explicitly recognising echoes gives a heightened sensitivity to both the researcher’s own place and being in the research, and to the *other* in relation to the researcher” (p. 291).

I have also been impacted by Smith’s (2011) thinking about gems in the interviews. This paper with its evocative title “We could be diving for pearls” discussed “shining, secret and suggestive” (p. 12) gems. Smith said: “I have found a single extract to have a significance completely disproportionate to its size, and this is what I mean by a gem” (p. 6).

He suggested that the gem was the thing that stood out when reading a manuscript and that it was one illustration of Husserl's call to "go back to the things themselves" (Smith et al., 2009, p. 12). Whilst other research methods might also allow such gems to be discovered I think that Smith's (2011) emphasis on this caused me to be more aware of and look for these echoes or gems.

Smith suggested that the *shining gem* is clearly apparent in the text. The researcher does not need to peer, and the participant is aware of the meaning. The *suggestive gem* indicates that something needs attention, but the researcher needs to peer to find it, although the participant has some awareness of its meaning. The *secret gem* may need much peering to reveal it, and the participant may not even be aware that they have said it.

When I introduce my participants in a section below, I have gone through their transcripts in an attempt to identify gems.

# Chapter 5. Method

I largely followed the steps explained in Smith et al. (2009). Table 2 details the actions taken, which will then be explained below.

**TABLE 2**

*EXPLANATION OF ACTIONS TAKEN*

| Action Taken and Time Frame for Completion |
|---|
| Metanoia approval of research May 2018 |
| Ethical Agreement July 2018 |
| Made Jiscmail appeal for participants July 2018 |
| Made announcement asking for participants at EMDR Conference September 2018 |
| Contact with each person and arrangement of interviews October – November 2018 |
| Interviews conducted November 2018 – May 2019 |
| Interviews transcribed November 2018 – July 2019 |
| Transcripts read and recordings listened to again three times November 2018 – September 2019 |
| Initial descriptive comments made in right-hand margin for each interview |
| Initial linguistic comments made in right-hand margin. |
| Initial interpretive comments made in right-hand margin |
| All comments summarised into emergent themes in the left-hand margin for each interview |
| Initial emergent themes for each interview grouped and identified to create overarching themes for each case January – November 2019 |
| Overarching themes for each case written on post-it notes and compared across cases November 2019- March 2020 |
| A set of overarching themes across cases identified and developed into ten themes March-April 2020 |
| Overarching themes revisited and quotes identified May – June 2020 |
| Writing up June 2020 – March 2021. |

I had identified the research question and methodology, and this was agreed by Metanoia in May 2018. Ethical approval was then received in July of that year.

**Participant Inclusion/Exclusion Criteria**

In my original proposal for this research, I had suggested interviewing 18 participants. The panel suggested that this was too many and that I should reduce the number. I agreed to reduce the number to 12. In retrospect, I am grateful for this intervention as I think interviewing 18 participants would have produced much too much data.

I proposed to interview four non-accredited EMDR therapists, four accredited practitioners, and four consultants. The reason for this was that accreditation, or the lack of it, influences the CPD requirements EMDR therapists are required to undergo. These three categories represent the three categories of therapists to which the vast majority of EMDR trained therapists belong. The only other category is trainer, and in the UK there are only eight current trainers (although there are a number of trainers in training). I, therefore, decided not to interview any trainers as they represented a very small percentage of EMDR practitioners.

**Recruitment**

I asked for participants at an EMDR Conference in September 2018. I made a brief presentation of the proposed research with a request for participation. I also made a request on the EMDR "Jiscmail" which is an email facility with about 2500 members who are trained in EMDR.

I received 23 offers of participation and selected volunteers on the basis of needing four each of non-accredited, accredited and consultants. I then further selected on the grounds of trying to get as wide a geographical area as possible. My pilot research, which will be discussed below, had participants mainly from East Kent. I felt it would be interesting to gain a wider geographical spread as CPD events in EMDR are held in many different places across the

country, and many are delivered by regional groups. Having a wider geographical spread of participants, therefore, seemed desirable.

I conducted all of the interviews in person, spending two separate weeks travelling around the country to participants' locations. One interview took place in May 2019 sometime after the others. Two of the interviews took place in my own office, the rest in the participants' offices. I gave participants the choice of travelling to me or me travelling to them. The two people who were located in Kent chose to travel to Canterbury, I visited everybody else.

**Interview Schedule**

The interviews took place from October 2018 to May 2019. All interviews lasted between an hour and an hour and a half and were recorded. Participants were sent a participant information sheet in advance, together with a copy of the Personal Development Plan which was the subject of one of my questions.

Participants were informed that the themes of the interview would be:

- Your therapeutic background before training in EMDR
- What made you train in EMDR
- Your impressions of EMDR training
- Your impressions of obtaining accreditation /consultant status (if appropriate).
- The manualised nature of EMDR
- Your experience of EMDR CPD to date, and your impressions of this.
- How you plan your CPD and how you think others do this.
- How you use your CPD.
- What do you think an EMDR practitioner needs to know?
- What is your sense of the EMDR Personal Development Plan? (Farrell & Keenan 2011).

Participants were informed that their participation would be anonymous and that they would be asked to sign a consent form which I would hold securely. If Metanoia or Middlesex University wanted to audit my work an assessor might see the consent forms, but this would simply be to check the validity of my work.

Participants were also informed that, if within three weeks of the interview they felt that they would prefer not to be included, their recording would be deleted and none of their comments used.

I informed participants that I did not think that there were significant risks in taking part, although sometimes discussing practice might leave people feeling deskilled. They were informed that I would check their experience with them at the end of the interview and that if they felt in need of further support, I would help them to find this.

All of the participants said they were happy with the information provided and signed the consent form.

**Transcription**

After conducting the interviews, I listened to the recordings. I noted my reactions and the points that held my interest. I then transcribed the interviews myself and typed them up with wide margins on each side. The transcription was time-consuming, but I think it did have the effect of really immersing me in the material. Etherington (2004), suggested that only by transcribing recordings personally do we remain close to the speakers' meanings.

Eatough (2019), discussed the need to "dwell in your data" and I think the transcription and then listening again to each recording twice with the transcription to hand helped me to do this. I then read through each interview several times, finding as Smith et al. (2009, p 82) suggested, that "imagining the voice of the participant during subsequent readings of the transcript assists with a more complete analysis."

**Analysis**

I then went through each interview making notes in the right-hand column. I used different coloured pens to distinguish descriptive, linguistic and interpretive comments.

I found this a fascinating process and began to understand the comment of Smith et al. (2009) that: “It is important to engage in analytic dialogue with each line of transcript, asking questions of what the word, phrase, sentence means to you, and attempting to check what it means for the participant.”

I began to appreciate why IPA normally works with small sample sizes, as going through this process with even 12 participants began to feel like a very overwhelming exercise.

I then went to the left-hand margin and developed emergent themes for each participant. Each theme was then written on a post-it note and the notes were displayed on a long wall in an additional office space adjacent to my therapy office.

Each interview was put up on the wall in this way, and I spent time moving the themes around into clusters, to create overarching themes for each participant. Some interviews had large numbers of emergent themes, typically between 100 and 250, so in each case, these were grouped again to find connections between themes and to create a set of overarching themes. In some interviews, there were up to 27 overarching themes. Once I had done this with one case I then moved on to the next.

When all of the interviews had been analysed in this way I wrote all the overarching themes from each interview on another set of post-it notes. I again displayed them on the wall and regrouped them in clusters to develop my working set of ten themes, so creating patterns across cases.

**TABLE 3**

*STEPS IN IPA (SMITH ET AL. 2009)*

| Steps of Interpretative Phenomenological Analysis |
|---|
| Read and re-read transcript to get to know data |
| Make initial notes to systemically capture observations. |
| Develop emerging (prototype) themes for each case |
| Search for connections across emergent themes for each case |
| Move to the next case |
| Look for patterns across cases |

Table 3 sets out the steps of analysis in IPA as per Smith et al. (2009), which I endeavoured to follow. However, Engward and Goldspink (2020, p.7) state:

> Reading Smith et al. (2009) is not enough to do an IPA study. Attentiveness and knowledge are required to work with, and sometimes wrestle with, the peripatetic nature of IPA analysis, which can get lost in the quest to fast track hermeneutic data analysis.

I think I have a clear position in this research. I would see myself as a “critical realist” (Maxwell, 2012). Etherington (2004, p. 71) sums up my sense of this: “The world exists independently of our being conscious of its’ existence, but it becomes a world of meaning only when meaning-making individuals make sense of it”.

Also, in terms of critical realism:

> The critical realist is a critic, intentionally political, believing that a discernible reality exists, but that this reality reflects the oppressive influence of social, political and historical factors. The researcher’s role is both interactive and proactive, with the

> explicit goal of facilitating change and emancipation from restrictive social conditions (Havercamp & Young, 2007, p. 268).

Whilst my research is not involved with restrictive social conditions, it does engage with what my participants have perceived as restrictive therapeutic conditions and I see my role as both interactive and proactive.

Proponents of IPA assume that there is a reality (as we are attempting to know about a thing or phenomenon that exists) but the true nature of that reality can never be known as it is interpreted differently by each individual.

Epistemologically, proponents of IPA would hold that there are many different kinds of knowledge that are valid depending on the validity of the research and that knowledge is influenced by hermeneutics and reflexivity.

I recognise that in my research, as it has progressed, some of the questions being asked may have seemed more as though they were testing a hypothesis than looking for meaning-making from the participants. For example, in retrospect now, I would have changed my questions about the planning of CPD and made this more open. Nevertheless, I believe that I have been able to identify aspects of my participants' meaning-making and have used these in developing the products which have been required for this project, perhaps thus challenging restrictive conditions.

## Chapter 6. Reflections on my Practice Evaluation Project (PEP).

My Practice Evaluation Project (PEP) was an optional component of Part One of the DPsych course at Metanoia. The other option was to write a piece (RAL) on research that had already been conducted. As my MSc at Metanoia was not very research-based, I decided to do the PEP and start with a small piece of research. The themes developed during this project, on EMDR CPD and what therapists think they need to know, were similar themes to the final project.

I was very pleased to have done this as it alerted me to some of the difficulties and issues that could arise. I decided that having participants who knew me through other means was unhelpful and that, therefore, the close geographical concentration of the selection of volunteers for my PEP should be extended. For the PEP, the participants were all situated in Kent and Sussex (I am based in Kent). I concluded that, as a lot of EMDR CPD is regionally based, it would be more helpful to have a wider geographical spread.

The PEP also allowed me to think about the best methodology for my research. I had originally used Thematic Analysis (TA). I subsequently decided that a different method was required as I felt that TA did not allow me to go sufficiently deeply into the meanings of the participants.

The themes identified in the PEP had some resonance with the results of the final project. However, the current findings are much more detailed and have a different emphasis. When I read the PEP themes now, I see them as much more directive and rather judgemental. For example: “Rebellion and Conformity” perhaps is rather pejorative. There are topics and themes in the PEP which very much became part of the current study, for example, the fact that most of the participants referred to the trainer Laurel Parnell.

As expected, all of the participants had attended several CPD activities. All had attended the EMDR Annual Conference, some regularly for a number of years. All had attended other Regional Conferences or training events with well-known speakers. They had all been present at the September 2017 conference where they heard me speak. I appreciate that I was selecting participants from a very small group and that there was, therefore, a potential for selection effects.

Mostly the participants spoke of choosing CPD in terms of responding to what was being offered and what they could use with their client groups. None of them had made a particular CPD plan and responses to the idea of this were mixed. However, in four cases the response to the Personal Development Plan I showed them, which none had ever seen, was positive, with people feeling they could use this.

The themes identified in the PEP were *structure and manualisation, the relationship, rebellion and conformity, integration and learning and divergence/convergence.* All of these themes have some reflection in my current work, and therefore the PEP was very useful as a pilot study. It alerted me to some of the difficulties that would arise in the larger study.

I have a bias in this research in that I am also an EMDR practitioner with specific views of my own. I am a provider of CPD courses. I appreciate however that "the research relationship involves an interactional encounter in which both parties are actively involved". (Finlay & Evans, 2009, p. 9)

I was very aware of this process as I talked to my participants. All of them had been present at the conference which I had helped to organise. Three participants had some existing awareness of me as a provider of training. I wonder now how much this influenced the way they answered my questions. There was a sense of deference in some of the interviews. For Participant 04, when I asked what made him train in EMDR he replied:

*"You might not want this on the record, but I noticed that you'd done it ...and that made me interested."*

There was a sense here that this participant knew of me and was attracted to EMDR training because he became aware that I had undertaken it. He clearly also felt that I might not want this apparent deference known.

Another participant said she was glad that so much EMDR CPD existed because it took a lot of organising:

*"You know that – you organised the one in Kent" (05)*

All of the participants, including the two who had no prior knowledge of me beyond the conference, asked me questions during the interview. They perhaps assumed that, as a consultant, I would have more knowledge than them. Some of the questions were straightforward:

"*There was a presentation by the one who wrote – the yellow book up there – who is it?*

*Me. Robin Shapiro?" (01)*

*"Is it phases or stages? Me: Phases." (005)*

I was aware that in all cases I straightforwardly answered these questions (except once when I could not remember, but in that instance, I went back to it in the end when I had remembered).

The three people who came to my office for their interview all commented on the books on display, often casually, but perhaps with a different meaning as well:

"*I see you've got the book up there. It's bloody expensive" (004).*

On reading and listening to the interviews I was aware that with some of the participants, I occasionally went into a teaching role, and was alerted to the need to refrain from this in my current study.

**Learning from the PEP**

On reading through this work now, I am very aware of the bias that was created by asking for participants at a conference where I had given a workshop on EMDR and Dissociation. The slight deference that I noticed in the paper for the PEP was, I think, created by this.

Therefore, although I also asked for participants for my Final Project at the Conference the following year, I had not spoken on that occasion, except for five minutes of briefly introducing my topic and asking for recruits.

I was also aware that some of the participants for the PEP, all living in Kent or Sussex, had some prior awareness of me as a psychotherapist. This led to 04's comment above that he had become interested in EMDR because he had seen that I had done it. There was also some sense that he felt this comment might be indiscreet as he said:

> "*You may not want this on the record.*"

I learned from this that participants having some knowledge of me was not helpful to the research. I, therefore, resolved for my final project to work with a much wider geographical spread of participants, so the final group of participants were not otherwise known to me.

I also learned that I needed to be much less willing to step in to teach or give missing information in the interviews for my final project, but instead to try to understand what my participants were experiencing at that point.

One practice that I adopted in the PEP and continued in the final project, was that of numbering participants rather than giving them names. I recognise that this practice could be

seen as dehumanising, and this is not my intention, but I felt that giving numbers decreased the possibility of unconsciously assigning pseudonyms that had some connection to the participants' original names.

The PEP, therefore, gave me a learning opportunity to consider how I wanted to conduct my research for the final project.

# Chapter 7. Participant Biographies

Idiography is one of the central tenets underlying IPA (Smith et al., 2009). I am therefore introducing each participant to give a sense of their individual contribution. I have also considered the presence of "gems" in the interviews, as described by Smith (2011).

In order to make sense of some of the comments here, I need to briefly introduce the concept of "schism" which forms one of my later themes. About two years before the dates of my interviews there had been a difficulty in the organisation based around the trainer Laurel Parnell. The EMDR Association had expressed some disagreement with this trainer, and there was some considerable difficulty in the EMDR Association, with some practitioners being excluded from the UK Association for a period of time.

I realise that choosing to give participants numbers instead of names could be seen as rather depersonalising. I have done this because I think giving pseudonyms can create an unconscious parallel to the correct name. I have changed details of ages and locations although the overall range is correct.

**TABLE 4**

*DETAILS OF PARTICIPANTS*

| Code | Gender | Age | Location |
|---|---|---|---|
| 01 | Female | 40s. | West country |
| 02 | Female | 50s. | South East |
| 03 | Female | 60s. | Home counties |
| 04 | Female | 60s. | South-East |
| 05 | Female. | 40s. | Wales |
| 06 | Female | 60s. | South |
| 07 | Female | 40s. | South |
| 08 | Female | 40s. | London |
| 09 | Female | 60s. | North West |
| 10 | Male | 50s. | Scotland |
| 11 | Male | 50s. | Midlands |
| 12 | Female | 60s. | South |

Each participant contributed something unique to my research which I will now outline. They all contributed to the overall themes but I was concerned with losing the unique voice of each person, so I have attempted to identify these here.

Participant 01

She was based in the West country and ran a small women's charity. She was not accredited at the time of the interview, but I discovered that she was working towards this and had already applied for accreditation but not been successful. She was very focused on the needs of her organisation and talked about themes of magic, intuition and spirituality. She did not mention themes of right and wrong or conflict in the Association. She did talk about the conflict of doing versus being. There was sometimes a sense of vagueness in her answers and

I was reminded of Main's quoting of Grice (in Wallin, 2007, p. 208) about quality, quantity, relation and manner. Sometimes her answers were so brief that it was difficult to have a sense of her meaning-making. She was most comfortable when discussing her organisation and how she worked within it. She discussed the fact that her organisation had managed to get a number of counsellors trained in EMDR and that sometimes, as largely person-centred counsellors, they were surprised by the results:

> *"At the meeting, someone said "my EMDR is coming along very well, and that confuses me!".*

We both laughed as she said this, and I felt with this participant a sense of collusion: we were the ones who understood about EMDR. The responses of her team were also interesting in terms of the research of Farrell and Dunne (2011) discussed in the Literature Review. This research highlighted that humanistic practitioners found it more difficult to integrate EMDR than integrative or CBT practitioners.

Participant 01 stated that she was very committed to EMDR and felt that it offered a choice for women in her charity. She said that she enjoyed CPD, but when asked, could not remember all of the courses she had done. She had a slight sense of grievance that she had applied for accreditation but not succeeded because she did not have enough cases. She then surprised me by saying that although she loved EMDR she was only working with one client at a time. She had believed that doing resource installation (phase two) with a person would count as a client for accreditation and was upset that it did not. She also highlighted a theme of slight dissatisfaction that EMDR consultants did not always give correct advice.

In scanning this transcript for "gems" I felt I had found some examples of "shining gems." The first example was:

> *"Standard protocol is really, really important, but so is your intuition"*

She then went on to say:

> *"I actually think there is something more profound that happens in addition to that trauma reaction, it's much more profound, spiritual stuff with people who have been carrying something heavy with them, and the magic is, the magic is on every level…but there's a spiritual component to it."*

For me, here the gem is the use of the word magic. This is a shining gem in the sense that its meaning is relatively clear, but it may still need some unpacking. Magic, for me, is by definition unreal. People who do stage magic are illusionists who give the impression that something can happen without intervention, where in reality it cannot. A handkerchief cannot actually turn into a dove, the dove has to be concealed in some way. So, I find the use of the word magic for EMDR interesting. I can appreciate that when a person's Subjective Units of Disturbance for a very traumatic event go from 10 to 0 in half an hour, this can feel like magic. But in reality, it is because of very precise therapeutic steps that are being taken and changes that are happening in the brain. The use of this word however reveals some sense of how this participant saw EMDR. I was also aware of the necessity of entering her world and appreciating her understandings.

The word spiritual was also interesting here. It implied that there was a higher force at work in the changes that happened. She also seemed to have a sense that in practising EMDR it was not her actions or the participation of the client that produced change, but some outside activity.

Another shining gem later in the interview was this:

> *"I want to give women their lives back. Sounds a bit bloody pompous doesn't it? EMDR is a very good tool for giving people their lives back."*

My interpretation here involved the question that if she wanted to give women their lives back, who had taken them and where did they go? How had they managed without their lives? As I unpacked this metaphor it felt very powerful as of course, if someone's life had actually gone, they would be dead. The participant was referring to an idea that it may have felt to her clients as though their abusers had stolen their lives and that the therapeutic process could restore this. She was largely working with women who had experienced rape or sexual abuse and the idea was therefore that trauma had "stolen" the lives of the women.

The meanings here appeared to be quite intricate as this statement indicated that this participant felt that she had some part to play in changing things for her clients. "giving women their lives back" could almost seem grandiose, although the participant herself labelled it as "pompous". Here she seemed to be taking some agency in the "magic", which appeared to slightly change this concept.

Participant 02

This participant was a woman who lived in the South East of England. She was not accredited and was not a member of the EMDR Association. She surprised me by saying that she did not conduct EMDR according to the Standard Protocol very often and tended to use continuous bilateral stimulation. She said that she was essentially a gestaltist and used EMDR as a technique where appropriate. She accessed CPD through the internet and said that she did not wish to be a member of the EMDR Association as she did not wish to follow any rules.

This was a fascinating insight into the possible thinking of people who were trained in EMDR but were not members of the Association. It is estimated (EMDR Association 2019) that there are 10,000 people in the UK trained in EMDR, but only 4,000 members of the

Association. It is therefore likely that there are a large number of practitioners who are conducting EMDR in a way that does not follow the Standard Protocol.

This participant was very clear about this:

> *"I will do standard protocol if a person comes with a clear trauma, but most people don't do that. To do standard protocol, you have to have a memory, and if it's pre-verbal you may not have that*."

I suggested to her in the interview that she was perhaps doing the Developmental Needs Meeting Strategy (Schmidt, 2009) rather than EMDR itself. She was open to this idea and had clearly heard of the DNMS but said that she was conducting EMDR in her own, gestalt way. This participant felt that if she were to become accredited, she would have to conform to the Association. She would also have to do CPD in a way that accrued CPD points, rather than online, and she was not prepared to do this as it involved considerable expense.

This participant also used a striking metaphor when she referred to herself as "*a boutique not a department store"* stating that she worked with specific clients and "*I question that you could use it for anything."*

Looking for gems, I found a suggestive gem:

> *"One of the advantages of not being accredited is that I don't have to worry about CPD not being approved, in the sense that you get brownie points or CPD points."*

The use of the term "brownie points" here seemed to refer to the notion that in the Brownies, young girls are given badges or points for doing good deeds or acquiring skills. This participant appeared to be very clearly suggesting that she did not want "brownie points" or to be approved of by the Association. I wondered if this term implied a deskilling or a sense of being infantilised in some way.

She continued:

*"To do standard protocol with everybody, I would feel like I'd been handcuffed."*

This suggested a very strong sense of being restrained or being hampered by what she was trying to do.

The feelings and opinions of people who do not want to be members, and the sense that this would be restrictive in some way, are interesting considerations for the EMDR Association. I think it is interesting from the perspective of the EMDR Association, to consider the motivations for people becoming accredited, and also what stops them from doing so. This participant's ideas on CPD are therefore valuable as they may represent a group of people whose thinking is not readily accessible to the EMDR Association Board.

Participant 03

This participant was also very positive about EMDR but very specific about how she used it:

> "*I adore EMDR, I think it's sensational, but I think I like to think I don't do what I'm told."*

This participant was very opposed to the idea of accreditation. She said, "*It would kill my creativity"*. My response to this participant brought me a little too much into the conversation. I said that many members who are accredited would see themselves as creative. She agreed but said that it was the process of becoming accredited that would kill her creativity.

> "*I have problems with paperwork, protocols, organising, being observed."*

She had some similarities with Participant 02 in her views about accreditation, but she was a member of the Association. She also expressed some fear:

> "*I think one of the arguments (for accreditation) is fear, as in what if something happens, like there is a serious complaint, you know, and would I, would I be dropped*

*like a hot potato if I didn't make the effort to be accredited?... but I really think it would kill my spirit."*

This participant had strong views about the creative use of the protocol and did not want to be hampered in her use of this by going through the process of accreditation.

She had attended a lot of CPD (more than would have been necessary had she been accredited) but still had strong criticism of CPD points and felt that the Association required people to collect too many.

She said that she had enjoyed the CPD she had undertaken most of the time but felt that courses were too expensive and became more so because they often involved travel and an overnight stay. She felt it was incomprehensible that the Association did not support online training.

She was very clear about her identity as a Psychotherapist and mentioned this several times:

> "*I am a psychotherapist, I really see that as my identity, but sometimes I think it would be simpler to do what the psychologists do."*

She had very strong views about the schism in the EMDR community and felt that certain people had been demonised by the Association.

> "*It was terrible, what happened, it was like Captain Dreyfus – do you know about this, in France, it was "J'accuse" and I tell you, I was on the side of the accused. There was an abuse of power, and there are scars…but people are now talking."*

My sense of the mention of Dreyfus was that it was a "shining gem". Although it required some knowledge of French history to understand the allusion, it was a very clear comparison to Dreyfus who had been wrongfully accused. This showed her feelings about a person who was dismissed from the Association. It is perhaps important to be aware that Participant 003 was, in fact, French and operating in her second language.

In her comments about accreditation she referred to the Association:

> *"wanting me to be a member of the Party"*

I saw this as a suggestive gem based on the assumption that she was referring to a political party and saw the EMDR Association as a restrictive political system requiring her conformity. She used a similar analogy in talking about her original training:

> *"the training, with the Americans, there were about a hundred people and it was almost like mass conversion."*

Here the analogy seemed to be about religion, again suggesting that the participant believed that she was being enticed to join something. These suggestions about politics and religion were also shared by Participant 12, and Participant 10, who had also trained with "the Americans" similarly referred to the concept of conversion.

Participant 04

This participant was very impacted personally by trauma work and how she dealt with this. She was also very focused on "getting it right" and was working towards accreditation but very nervous about this process. She too referred to EMDR as "magic" which interestingly was a concept only used by practitioners who were not accredited.

She was the only participant who talked about a concern with standard training and shock that videos were shown of actual sessions with clients.

> "*And I thought: "is this right? Should I be seeing this? Is it ethical?" and it impacted me, because I am so sensitive, and I thought "Oh gosh, Can I really do this. Can I handle doing this work because I might be exposed to levels of trauma that I find incredibly difficult to handle."*

She discussed the possibility of vicarious trauma for practitioners and her concern that she might be susceptible to this. She mentioned her natural tendency to be very cautious and suggested that this had meant that her progress in EMDR had been very slow. She had also attended a lot of CPD but had sometimes struggled to implement it in her practice.

> "*I'm a very cautious person, and it was such an unusual… well, I couldn't trust myself in it. I was feeling I wasn't experienced enough and there was this thing about getting it right, you've got to do it right."*

This participant, though she had been a therapist for a long time, seemed to struggle with the sense of herself as a knowledgeable therapist. She said three times that she was not academic:

> "*You know, when I trained thirty years ago, it seemed to be enough to be sort of compassionate, but now you have to be academic, and I'm not academic."*

In terms of gems, I was interested in this participant's use of the word "epiphany" which occurred on two occasions:

> *"I had an epiphany when I thought "this is so interesting."*

The participant referred to her sense of surprise at feeling so comfortable with EMDR from her person-centred perspective although epiphany felt like a strong term to use here.

She later said:

> *"It's like being a midwife to rebirthing trauma and reprocessing it".*

I saw this as a suggestive gem and again saw this as a rather extreme analogy. If the participant was a midwife and the trauma was being reborn, what then happened to it? I wondered if she meant that the client was being reborn rather than the trauma. Or she may have meant that the trauma was being reexperienced in a different way thus transforming it. The analogy of herself as a midwife was again interesting as it placed her as doing something

specific in the therapeutic relationship, which in her direct speech about the relationship, she denied.

Participant 05

This was a woman who had been fairly recently accredited. She had a strong bias towards practicality and she gave a lot of client examples when she was talking about her experience. She was very positive about EMDR:

> "*It sounded amazing. It allows you to treat people that really I wouldn't be able to treat…so now most of my work is EMDR."*

She had enjoyed the experience of accreditation and had found it validating that someone else had seen her practice. She related this to having been a teacher in the past and so used to being observed.

> "*I liked the idea of somebody seeing what I was doing and saying "yeah, that's alright." Everything you do is evidence-based and related to the person in front of you."*

Her experience of CPD was more limited than most other participants but she said that she always used the CPD she had attended. She stated that she would not attend something unless she thought she could immediately use this in her practice. She also said that there were some issues which she would not go into because she would have no intention of working with them:

> *"I will only do what I am competent at. You can't be good at everything, you should have your own area of expertise. So, I don't work with the pain protocol – if someone has a lot of pain there is a woman up the road who is very good with pain – I just refer them to her."*

She was critical of CPD points in a very pragmatic way:

> "*People could just go to things to get the CPD points and never actually use the information. I don't see the point of that."*

I was particularly struck by her casually revealing that she normally did EMDR in six sessions (a very small number). She also reflected on clients being "sent":

> *"A lot of my clients are sent through work. Even in private practice when they ring up to say: 'Can I have a session?' they're sent by their partners, their friends, their work. They're sent. But they all feel a bit 'sent'".*

As a suggestive gem, I wondered to what extent she was talking about clients lacking agency in attending therapy and to what extent she meant that they were "sent" to her. Was this almost an alchemical process? This was a difficult thing to consider as, in all other respects, this participant was extremely practical and down to earth.

I was also interested in her use of the term "treat" to talk about her work with her clients:

> "*It (EMDR) allows you to treat people that really I wouldn't be able to treat."*

I wondered what this meant in terms of how she saw EMDR and its mechanisms, as it appeared to me to be a rather clinical term.

<u>Participant 06</u>

This was a woman who had been accredited for some time but had no intention of going forward to become a consultant. She had done a lot of CPD but said her accreditation was:

> "*painful, I felt talked-over and deskilled. I was really cross, he (the Consultant) was very unprofessional. I avoid him now at Conferences."*

She had also done a great deal of CPD but was a bit vague in remembering what it was about. She had an interesting insight into CPD:

"*I have noticed that in EMDR there is a tendency to call something a workshop, and actually it is a lecture.*"

She had a strong bias towards practicality and a concern about "*getting it right.*" In addition, she discussed schism in the EMDR community but with a sense of resignation:

"*Twas ever thus in therapy, you know, think of Freud and Jung.*"

The only gem I was able to identify in her transcript was, I think, a suggestive gem when she commented on the Personal Development Plan:

*"It could help with structure, you don't want to get yourself into a corner"*

It seemed a little unclear what exactly the "corner" referred to here was. I speculated that getting into a corner meant a place that it would be difficult to manoeuvre out of. However, I was unsure why structure helped with this, as it might conversely box one further in? From a sense of the rest of her interview, it was possible that this participant felt that her accreditation was deskilling and unstructured and so could lead to her interpreting it in this way.

Participant 07

This participant was a woman from the South of England who was almost at the point of applying for consultancy. She was very clear about her identity as a therapist:

"*I'm an EMDR therapist, you know, but I don't think of myself as just an EMDR therapist…I'm a therapist who just uses EMDR.*"

She had strong views about the schism in the EMDR community but there was no sense of right and wrong in this interview.

*"I'm aware that there's been a recent schism in the EMDR community about the Parnell stuff, and between everyone else and the main committee. But I'm not into tribalism, I don't like that."*

This participant had very positive experiences of CPD and had undertaken a large amount:

*"I really enjoy it. It's a treat for me."*

In terms of gems there was a suggestive gem when she said:

*"I'm not into tribalism."*

This was a comment on the disagreements within the EMDR community. It was a little unclear what tribes were being referred to, although she had been discussing the issues between what she saw as the Parnell group and the EMDR Board. I was not altogether sure who was being tribal, as there seemed to be some dismissal of the Board. However, she also stated that she was not happy with the separate email group for "Attachment Focussed EMDR" as she said that:

*"Sometimes people advertise for AF-EMDR practitioners, and I think "It could just be EMDR" "*

I wondered, therefore, if this participant saw herself as being part of a tribe although she stated that she was "not into" this.

<u>Participant 08</u>

This was an accredited therapist from London who identified strongly as a systemic therapist. She had undertaken the least amount of CPD amongst my 12 participants despite being an accredited EMDR therapist. She asked me a question about the use of the positive cognition. This led me to ask her about her knowledge of Laurel Parnell, whom she said she had never

heard of. This astonished me. She seemed to have no sense at all of any disagreements in the EMDR world. This will be discussed later.

She discussed one of the two CPD events she had attended as follows:

> *"I didn't learn a lot. People asked very basic questions that I could answer myself, basically. They lack systemic thinking. And anyway, when you are accredited, you basically know what you are doing."*

She also criticised the fact that CPD points were not awarded for online training and said that she would prefer to do CPD training online as it would be less expensive. She said:

> *"The thing is, some people will do nothing and will try to get away with doing the minimum."*

In my interpretation of this participant's words, I had to work hard at being aware of my bias. My sense of her was that she was trying to get away with the minimum and had very little awareness of the issues in EMDR. It was interesting to speculate that, whether or not this was true, she represented a swathe of opinion in the EMDR community. I was very conscious, in this interview, of my need to be aware of my own reactions to this therapist, as I felt that she was criticising others for something she appeared to me to be doing herself.

I identified what I saw as a suggestive gem when she responded to my query about what she thought an EMDR therapist needed to know:

> *"I would say, the therapeutic relationship, because some people say it's almost like going to the dentist for a root canal, so just come to EMDR and we will wave our arms a little bit and it's going to be fine – and it needs to be seen as a technique within the therapeutic relationship."*

The reference here to the dentist and the root canal seemed to me to be reminiscent of Freud's analogy of the therapist being like a surgeon. However, this extract does seem to suggest that

the participant saw EMDR as a technique and that the technical aspects of EMDR were akin to going to the dentist. This aspect will be discussed further under the theme of "Doing versus Being". However, I was interested that this participant seemed to feel that the therapeutic relationship was somehow separate from EMDR and that EMDR was simply added into an existing relationship as a technique.

I was also interested that, thinking of her words experientially, a root canal would be associated with a painful experience, so I wondered what the participant was unconsciously associating here with the experience of EMDR?

<u>Participant 09</u>

This was a very experienced consultant from the North West who had undertaken a huge amount of CPD. She used a lot of metaphors and had a strong sense of what was right and wrong:

> "*When I became a consultant I wasn't ready for it … there were still a lot of things I was doing wrong… do you know, I was already a Consultant but when I was going back to the safe place at the end of processing I was using bilateral stimulation! Can you imagine? No need for it at all."*

This comment impacted me as I, also a Consultant, was also using bilateral stimulation in this situation! During the interview, I felt myself being impacted by shame and needed to consciously bring myself back into the interviewer role.

This participant was very clear about the need for the Standard Protocol but also championed creativity:

> *"When you really understand what we think is going on, when you've got your head around it, it enables you to be – er – a little creative with, er, with the protocol…Sometimes you just have to go by the seat of your pants."*

She discussed the issue of division and Laurel Parnell:

> *"I went to hear Laurel Parnell and she was good, I just don't like the way she is behaving. She is naughty…I don't approve of people who are junking massive parts of the protocol willy-nilly."*

She was also strong on her role as a consultant:

> *"I will not accredit somebody who I don't think properly understands what they are doing."*

In scanning the transcript for potential gems, the one I came up with was in her reference to her early experience as an EMDR therapist before she joined the Association:

> *"My group was a bit anti-establishment. What do you do? What do we get for our money? I don't see any advantage in being a member of the Association."*

She said that she did join the Association soon after this. The term "anti-establishment" was, for me, almost a secret gem here. I was not sure that the participant entirely appreciated what she was saying. The rest of her interview suggested heavily conformist views, but I wondered if this "anti-establishment" referred to a hidden, idealised view of herself. Would she, in a way, have liked to have seen herself as part of a group that was anti-establishment? The rest of the interview belied this.

I was also interested in her statement that "*sometimes you just have to go by the seat of your pants"*. On reflection I wondered exactly what this meant and if it was also some reference to the idea of being rather anti-establishment.

<u>Participant 10</u>

This was my first male participant. He was also a very experienced consultant and had been around when the Personal Development Plan, which was the subject of one of my questions,

was produced. This participant had a very long history in EMDR and he spoke a lot about experiences then and now. My linguistic comments during the analysis were the strongest with this participant. He made considerable use of humour and used words like "brutal" several times to describe the Consultants' training in the past. He also several times said:

> "*Delete that" … "obviously don't quote those names" … "You've got me going now but don't quote me"*

He gave the impression that he thought he was being indiscreet, but again there was no sense of right and wrong in this interview. My sense, in fact, was that he was indiscreet only to the extent that he discussed the role of the Accreditation Committee. Otherwise, the indiscretion was really around the fact that he mentioned quite a lot of names of people in the Association. He also referred to himself rather disparagingly as a "*northern working class oik*".

He had again completed a lot of CPD but said:

> *"I don't know how to say this without sounding cocky but they don't tell me anything really, not a great deal, so I just go to get the points basically."*

He described how, as a Northerner, he had initially felt excluded by "*the North London psychologists*" who at that time ran EMDR in the UK. He described how, as he had been facilitating trainings, he felt that one of the trainers was following him around and checking on him:

> "*He was making sure the working-class oik wouldn't upset the apple-cart. But he found out that I have a reputation to keep, rather than break."*

I found these reflections interesting, as this participant had been describing some aspects of divisions within the EMDR community which had occurred at a much earlier time than the more current issues.

He had an interesting take on the accreditation process:

> *"I think the accreditation committee has become very hawkish. It's like they think: "Oh God, we could accredit someone and then they might kill their client!"*

His point was that the practitioners' original accreditation was more significant than the EMDR accreditation:

> *"If you said to me now: "You can either give up your accreditation with BABCP or with EMDR, but you have to give up one, I'd give up EMDR. It would be like ripping my arm off, and I'd still do EMDR, but BABCP pays my bills. EMDR accreditation isn't as important as they think it is."*

There were two suggestive gems in this interview. The quote above with its reference to "*ripping my arm off*" could be seen as a shining gem. The participant explained very graphically what it would be like for him to be unable to do EMDR; he would feel disabled. There was also an interesting possible reference to the fact that traditionally EMDR was delivered by the therapist moving their arm for the client to follow their fingers.

The first suggestive gem was when Participant 10 described his original training which was in America, and early in the history of EMDR.

> *"It was very charismatic, the way it was taught, and almost like Bible-belt, and when we used to facilitate for the Americans coming over, we had to stand on the stage and say how EMDR had changed our lives…it was really, really weird."*

The gem here, for me, was the reference to the "*Bible-belt*". The participant was suggesting that EMDR had been established like an aggressive evangelical religion typified by the term "*Bible-belt*". The reference to the practice of standing on the stage and saying how EMDR had changed one's life sounded rather like the evangelical practice of giving testimony. He was not suggesting that he saw it this way, but that this was the original presentation.

Later in the interview, the participant referred to the Personal Development Plan as a "*damp squib*". I thought this was rather a harsh judgement but it was an interesting analogy. In thinking about the meaning of this phrase, a "squib" refers to a firework. Additionally, seemingly in the 16th century, a "squib" was also a short literary composition with a satirical character. Both references were interesting. I imagined the participant to be thinking of the firework. The PDP was intended to be impressive, to make a mark and be noticeable, but had simply fizzled out. The second meaning seemed to have some relevance as it did refer to literature, but the PDP is very plainly not of a satirical nature!

Participant 11

Participant 11 was a male Consultant from the Midlands. The thing that most impacted me about this interview was that although like most people, he talked about disagreement and schism in the EMDR community, he did so in a very pragmatic way:

> *"Well, it (schism) happens all the time in CBT, doesn't it? People are always splitting off and forming their own variations. I think EMDR could split, that's just what happens. I think you have to tolerant on that, we have to be philosophical."*

He referred to Laurel Parnell as "*a maverick*" but said:

> *"I'm not a stickler. If it works, then I'm in support of that."*

He was also very positive about EMDR:

> *"I threw myself into doing EMDR…I could see the results that I was not getting in any other modality, and I just fell in love with it."*

Of accreditation he said

> "*I was surprised at the level of competency needed. I thought it was really quite tough, compared to CBT.*

This participant had needed to apply for concessions for his CPD for re-accreditation. He had experienced a close bereavement and had been unable to undertake CPD for a while. He then had to undertake some CPD activities in a hurry but felt that this had been useful for him.

Looking for gems, I noticed the following comment when he was talking about the Association's requirements for CPD:

> *"I think EMDR needs to be careful that they don't shoot themselves in the foot with their expectations, which I think are quite high…it's quite a hot potato."*

Interestingly, this participant expressed quite a different view from Participant 10. He thought that the BABCP requirements were much more stringent than those of EMDR. Participant 11 thought the opposite. Both were members of the BABCP as well as being EMDR Consultants.

I was interested here in the phrases "*shoot themselves in the foot*" and "*hot potato*." I thought both were suggestive gems. The first phrase suggested that the organisation would disable itself and do something counter-productive with its requirements. I felt it significant that the participant did not seem to see himself as part of the organisation. He referred to EMDR as "*they*". Then by using the term "*hot potato*" he suggested that this was something which nobody wished to address but was passed along from person to person.

Participant 12

This was a female Consultant. This was my final interview, some time after the others and probably the one that impacted me the most. The Consultant had been expelled from the EMDR Association because (in her perception) of her contact with Laurel Parnell. There was palpably a good deal of pain still present for her and she used very powerful metaphors to describe the EMDR Association:

*"It's like a cult… a Communist Party… a church with high priests. It's like a religion: we have a founder, a founding myth and a devotion to Shapiro. It's like I was a lone wolf shooter and had to be taken out."*

This participant brought up ethical issues for me which will be discussed later. Importantly, towards the end of the interview, I felt the need to tell her that I was now on the EMDR Association Board. She was visibly shaken by this information. We later had an exchange of emails which I think reassured her that I was not going to encourage the Board to exclude her again.

This participant used the word "*transformative*" eight times when discussing EMDR. She had a great deal of enthusiasm for EMDR but was very critical of training and CPD:

*"The EMDR training model is grossly unfit for purpose. My criticism is that it's commercial and delivered by individuals. CPD is too theoretical."*

She clearly saw EMDR as a very powerful therapy:

*"EMDR is such powerful tool and such a brilliant invention, the Heineken of therapies."*

But also saw it as a therapy that has lost its way.

The criticism often levelled at Laurel Parnell in the EMDR community is that she formed a separate "Parnell Institute" breaking away from the main Association. This participant's experience was that this break was necessary for survival, however, she wanted her group to be welcomed back into the mainstream.

This participant's narrative was full of potential gems. She used very rich metaphors (such as those indicated above). She also described the situation within the EMDR Association as like:

*"A Civil War"*

> *"The Thirty Years War"*
>
> *"The Holy Grail"*
>
> *"The Torah"*
>
> *"The Temple"*
>
> *"Like Luther and the Pope"*

Perhaps the most powerful gem for me was when she described herself:

> *"It's like a shooter, a lone wolf shooter, you know, you have to take them out before they do any more damage. Clearly the organisation came to this conclusion about me."*

This analogy felt incredibly powerful. There was also a sense of the participant seeing herself as being very significant to the EMDR Association, which many people would probably agree with. Indeed, there was a sense here of the person being seen as hugely dangerous and having the power to destroy the organisation.

The participant's comparison of the Association to a church or a religion has some resonance with the reference Participant 10 made to the training being like the "*Bible Belt*"

# Chapter 8. Reflexivity

My reflexive comments on my PEP influenced how I would see the final project. I wanted to avoid the participants knowing me and being influenced by this. At the same time, I acknowledged my inevitable influence and my understanding of the research question. I understand reflexivity in qualitative research as being attentive to the influence of the researcher in the process of the research (Engward & Goldspink, 2020). Smith et al. (2009) suggested that the IPA researcher is "the central analytic instrument". The task, therefore, of the researcher is to uncover dual meanings given to the phenomena from both participant and researcher perspectives (Shaw, 2010). Engward and Goldspink (2020) referred to the data (the words of the participants) as "lodgers" because they live with the words of their participants on a daily basis. Eatough (2019) in a Conference Keynote said that all IPA researchers should "dwell in their data" whilst Engward and Goldspink (2020) suggested that the data dwell in us, so is the researcher the inhabiter or the inhabited? If we dwell in the data, our participants' experiences take residence in our interpretations, so perhaps we are able both to dwell in our data and have it dwell in us.

> The researcher invites the data into the home of their lifeworld. Notions of what it means to "live with" may be familiar …but overall, the ideas link somehow with sharing. Through our analytic engagement, the data gains access to our everyday lives, new lodgers who come to dwell in the domains of our cognition, affect and behaviour (Engward & Goldspink, 2020, p. 19).

The role of reflexivity here is in the researcher's active contribution to interpretation. The data may be "lodgers", but I am actively making sense of my interactions with them.

> Whilst an assumption of IPA is for researchers to interpret data through the lens of their own experience, as influenced by their own psycho-social history and their

> comprehension of the extant literature (Smith, 2004), they do so in relation to the lived participant experience. Hence, the researcher and participant are separate, but share a space of enquiry (Engward & Goldspink, 2020, p. 17).

The conflict for me in considering reflexivity in this research is that I am inevitably very much part of the same training and experiencing space as my participants. My own experience, therefore, could significantly intrude on the experiences of my participants, yet my experience is also important and valuable. Finlay (2002) compares reflexivity to a swamp: "a murky and confusing terrain of self-analysis and self-disclosure with endless narcissistic personal emoting or interminable deconstructions of deconstructions" (p. 226).

It seemed, therefore, that reflexivity could lead to confusion and lead away from the emphasis on the data. Finlay makes the point that we can understand and be understood when our horizons overlap with those of another. This resonates for me with Bollas's view of therapy: "It is impossible to find the client unless we search for him within ourselves" (Bollas, 1987, p. 202).

Finlay (2003, p. 108) said:

> Our understanding of "other-ness" arises through a process of making ourselves more transparent. Without examining ourselves we run the risk of letting our unelucidated prejudices dominate our research. New understanding emerges from a complex dialectic between knower and known; between the researcher's past pre-understandings and the present research process, between the self-interpreted co-constructions of both participant and researcher.

Brocki and Wearden (2006) said that substantial difficulties can arise in IPA if the researcher's presence and role are underplayed or lost.

Another significant layer of my involvement began to emerge as I became a trustee of the EMDR Association in March 2019, when my research was already well underway. I had been attending Board meetings since January 2018, so was beginning to learn much about the structure of the Association.

In terms of reflexivity, this gave me a double role in the research. When I started my interviews, I had no intention of becoming a trustee of the EMDR Association. I started attending Board meetings to take minutes but after just over a year was invited to join the Board.

For 11 of the interviews, I was not a Board member, but for the last interview I was, so felt the need to explain this to the interviewee in terms of informed consent.

Finlay's quote above about the dialectic between pre-understandings and the present research process was a very real issue for me. I realised over the course of the research that I was asking people about their understandings of CPD and knowledge in EMDR, an area where there was already a high level of pre-understanding to which I was expected to adhere as an EMDR consultant and (now) Board Member.

I hope that my attempts to understand the perspectives of my participants can ultimately lead to recommendations to the Board of the EMDR Association UK. I also recognise that there is a tension in this, as in undertaking IPA I am trying to appreciate and understand the things themselves, whilst also working towards specific products and understandings of learning.

**My Self-Interview**

In the interests of examining myself and following the recommendation of Glaser (1998), I decided to interview myself. I recognise that Glaser comes from Grounded Theory and not IPA but I felt that to do this would ground me in the work and make me explicitly aware of my approach to the issues. Smith et al. (2009) also discussed the relationship between IPA

and Grounded Theory stating that "Grounded Theory has a strong trans-disciplinary identity. Thus it is not necessarily either experiential or psychological, but it can be used in this way." (p. 201). I, therefore, taped and transcribed my own interview before starting the interviews with my participants.

A considerable time after conducting my own interview I came across Barton's (2021) discussion in Bager-Charleson and McBeath (2021), where he says that (in conducting IPA) "I felt a growing desire to include a chapter on my experience, to tell my story" (p. 57). He felt, however that this was unorthodox and so contacted Jonathan Smith to discuss this with him. Smith understood his concerns but stated:

> "There's a danger that your experience could completely flood this research and drown out your participants, they have to come first. But in principle I have no ideological problem with your approach. If you present your participants' accounts first and this is then followed by what is clearly signalled as your own personal account in a separate chapter, I can see that can offer a useful extra perspective." (Barton 2021, in Bager-Charleson & McBeath, 2021, pp. 57-58.)

I, therefore, felt some vindication in my decision to include some of my own insights in my interview.

My interview threw up a considerable agreement with comments made by my participants, but also some disagreement. I appeared to be the only person who underwent EMDR training from a position of cynicism, stating:

> *"I think I went into the training in order to discredit it, and was surprised that I didn't seem able to do that!"*

I had first heard about EMDR through a Diploma in Posttraumatic Stress counselling that I undertook in the mid-1990s. EMDR was introduced then as a new and experimental way of

working with PTSD. I remember being very sceptical and thinking that there was no way I was going to wave my fingers in front of people's faces!

However, when I finally started training in 2002, I very quickly found, through my own successful EMDR on fear of flying, that it could be very effective indeed. It was interesting that none of my participants discussed early scepticism before their training, as there is still cynicism in general about EMDR so that in June 2019, when Francine Shapiro died, her obituary in the *Daily Telegraph* referred to "snake oil."

Many of the themes identified also showed up in my own interview, predominantly *being versus doing* and *right versus wrong*. I also talked about schism. I alone amongst the consultants expressed concerns about the power given to consultants in EMDR, and this was my concern over the issues of right and wrong. Because in EMDR supervision there is a great deal of emphasis on the formative or teaching element, I was sometimes concerned about whether I was teaching the "right" thing. EMDR accreditation is largely based on the judgement of the individual consultant, and I seemed to feel this responsibility more than the other consultants whom I interviewed. This may have been because they all had more experience as a consultant than I. Participant 12, however, also referred to her concern that consultants were largely unmonitored.

Individuals applying for EMDR accreditation or consultancy need to be in supervision with an EMDR consultant. They must show videos of their work with clients to their consultant, who then prepares a report based on a competency framework. The person is then accredited based on the report given. Reasons for not accrediting individuals given by the accreditation committee are always technical, such as the applicant not submitting enough cases, and the judgement of the consultant is generally accepted.

Looking at the language I used in my interview there were multiple mentions of the term "responsibility" (eight times) and "power" (five times) and I also used nouns such as "worry" and "anxiety." I think this indicated that I had quite a lot of concern about submitting my candidates for accreditation. I had yet to submit anyone for consultancy and I also mentioned this as a concern.

I discussed issues around *being versus doing* in that I spoke about an initial concern that EMDR was "doing something" to clients. My initial counselling and then psychotherapy training emphasised the relational aspect and the importance of presence and "being there" for the client. I expressed my current feeling that relationship is also an important aspect of EMDR.

In my interview, I also stated my positive feelings about the CPD I had undertaken. It was interesting for me to note that I did not participate in very much EMDR CPD until I achieved accreditation and at that point, I became much more involved in the process.

As I have been writing up my research I have also considered the implications for me, of being on the Board of the EMDR Association (first UK and Ireland and now the UK, as All-Ireland became a separate Association on the 1st April 2020.) This seems to create a double immersion and gives me an issue concerning reflexivity and what I do with this extra layer.

I think that most of my participants were unaware that I had any connection with the Board (although I was only a trustee from March 2019, so not a Board member for eleven of the interviews). Participant 07 said:

> *"I am aware that there has been schism…between everyone else and the main committee, who are a small group of people, actually."*

In this instance, I did not feel that I should inform her of my presence at committee meetings. At that point, I was not yet a trustee and I had not been involved during the events she was describing.

I did, however, disclose this in talking to Participant 12 who had been expressing her very palpable pain about her connection and dealings with the Board. I felt that she would feel more betrayed if she discovered later that I was a Board member. She was initially dismayed by this, but we were able to discuss it, and this participant then very actively wanted to be part of the research as she wanted her views to be expressed.

This brought up interesting issues for me about the double layer of my experience. I was talking to people who largely felt that the Board were other to them, and I had the experience of being part of that other. This was interesting but also rather uncomfortable. It caused me to reflect on the experience that members of the Association have of the Board and how this might be worked with. It also created for me a dilemma in my research, in that I wished to present the perspectives of my participants as they were, and yet potentially through my products and my position on the Board, could impart an additional influence.

# Chapter 9. Ethics

I obtained ethical approval for this project on researching EMDR practitioners' experience of CPD and what they think they need to know, in September 2018. At that time, I thought the ethical issues involved in this project would be relatively simple. In experience, I have found them much more complex.

I am mindful here of ethics as a system of moral principles which involves what is good for individuals and society. The word derives from the Greek word "ethos", meaning custom, habit, character or disposition.

In Moral Philosophy, ethics is seen as being concerned with what is good and bad, right and wrong. This is interesting given that this is a strong theme in my study.

Ethics is also seen as being a concern with the interests of other people, which I have tried to be aware of here.

**TABLE 5**

*ETHICS*

| Possible Harm | Mitigating Strategy |
|---|---|
| Complexity of informed consent | I gave participants an information sheet and made it clear that their words would be used in my report. I gave them the opportunity to withdraw their contribution up to three weeks after the interview. |
| Ensuring confidentiality and anonymity | Where interviewees referred to material that could identify them it was redacted, although this was been difficult with the more prominent individuals. I am concerned that in two cases a person who is familiar with EMDR may be able to identify the individual. I will therefore be very careful with material that is written up for the EMDR Community to make sure that people are not identifiable. |
| Recorded voices could be recognised | The recordings were kept securely and no one else had access to them |
| Dual relationships | For this piece I ensured that there were no significant dual relationships and that people had not known me previously. |
| Possibility of participants feeling deskilled by discussing their practice | I was alert to this and prepared to refer for support if needed. |

Informed consent was sought and all findings anonymised. Participants were informed that they could withdraw from the research if they chose, up to three weeks after the interview was conducted. All the participants seemed to be robust about this and they all appeared to enjoy the opportunity to talk about their experiences in this way.

A significant issue that arose for me was that a number of times a participant would say: "*Don't quote me on this*" or "*I can't be identified can I*?" and I assured them that this would not happen. However, on looking at printed final projects in the Metanoia Library I saw that some (though not all) candidates had included full transcripts as an appendix. I had not prepared my participants for this eventuality and I had not considered it. On reflection, I

concluded that it would not be ethical to publish the transcripts as a person aware of EMDR reading this in the future may be able to work out the identity of some people.

One person, in particular, may be readily identifiable. I questioned myself as to whether I should include this person in the findings or simply do another interview, but I felt that a very significant point of view would then be deleted from the findings and make them less relevant to the EMDR Association. Ethically, I think my commitment to this person is to ensure that nothing I report could lead to any repercussions from the EMDR Association. I did double-check afterwards that this individual was happy for her interview to be included. She was in fact very happy for this to happen.

Where people asked not to be quoted, I checked with them exactly what they did not want to be quoted and made sure not to do this. Usually, these were comments that could have been perceived as slightly critical of other therapists.

The last interview was with an EMDR consultant who had in the past been expelled from the EMDR Association and then re-admitted. She spoke to me very freely but was visibly shaken when I told her that, although not at the time of her expulsion, I was on the EMDR Board. I had only recently joined the Board, so when arranging the interview this had not been the case. She was clearly concerned that her words could be used against her. I reassured her that I would not do this and that I, in fact, hoped that over time my research could create more awareness and understanding in the EMDR community.

I am concerned that this individual could possibly be identified by someone who knows about EMDR. My reason for continuing to include this person in my research is that her contribution is highly significant in relation to the issues that have been prominent in the Association in recent years concerning training and the nature of knowledge. I have checked with her that she is happy for her views to be included on the basis that the full transcript will

not be made available. Participant 12 said she was sufficiently eager for her views to be represented that she was OK with the possibility that someone could guess at her identity. It is also important to note that sadly Participant 12 is not the only individual to have been expelled from the Association. This issue brought up for me the importance of recognising that informed consent is an ongoing process.

I think that the ethics of interpretation are also important here. A researcher can tell a different story from that told by their participants (Braun & Clarke, 2013). My analysis involves interpretation which transforms raw data into a story about that data. The ethics of "representing the other" therefore need to be thought about.

I am very aware of feeling anxious about my representation of my participants. Although often they are represented by their own words, the context in which these are presented inevitably involves interpretation. I am also conscious of my role as an insider in the EMDR community and that I have my own opinions about many of the issues raised by my participants.

The interview I found most challenging, with Participant 12, highlighted for me that taking time to understand the perspective of another can illuminate long-held beliefs about things. I hope that my findings can illuminate the issues of this disagreement and contribute toward understanding some of the issues on both sides.

The exercise of coding the transcripts also raised some anxiety for me because of the inevitable interpretation involved. I was concerned that somehow, I might be missing the points the interviewees were making. IPA of course by definition involves interpretation and the idea of the double hermeneutic; me making sense of the participants making sense of their experience. This does put the researcher in a powerful position which perhaps mirrors the position of the Consultant in EMDR.

The discomfort I feel in my representation of my participants is expressed by Josselson:

> "My guilt, I think, comes from knowing that I have taken myself out of relationship with my participants (with whom, during the interview, I was in intimate relationship) to be in relationship with my readers. I have, in a sense, been talking about them behind their backs and doing so publicly…for my own purposes…I am guilty about being an intruder and…betrayer…I suspect this shame is about my exhibitionism, shame that I am using these people's lives to exhibit myself, my analytic prowess, my cleverness. I am using them as extensions of my own narcissism and fear being caught, seen in this process." (Josselson, 1996, p. 70).

This quote captures some of the discomfort I have felt in the possibility of betrayal of my participants. Particularly in the case of Participant 12, I felt an expectation that I could make things better, which I feared not being able to fulfil. This seems to embody the tension between being with my participants in their experience and representing them, which of course involves interpretation. This is the central ethical challenge for me.

# Chapter 10.Results

I will now discuss the results I have drawn from the process of interviewing my 12 participants about their experience of CPD and what they think they need to know.

## An Introduction to My Themes

I began with exploratory notes in the right-hand margin of the transcripts which were descriptive, linguistic and conceptual. I then came up with sub-themes in each interview, which were written in the left margin. The sub-themes were then all written on post-it notes and displayed on a long wall and I worked on each interview to group and cluster the themes into emergent themes. I then listed all of the emergent themes (185) across all 12 interviews and again wrote them on post-it notes and grouped them again, making ten Superordinate themes. These themes are as follows:

1. The exact nature of EMDR
2. The nature of knowledge in EMDR
3. Structure versus creativity/ intuition/ improvising
4. Accreditation and CPD experiences
5. Right versus wrong
6. Love versus fear and shame
7. Being versus Doing
8. Schism
9. Metaphors
10. PDP and planning

I recognise that it may seem a little strange to make CPD a theme as it is so much part of my research question. CPD does feature within many of the other themes as well, but I wanted to

make it a specific theme to give it its own place, and also to recognise the relationship in EMDR between CPD and accreditation.

Themes 5 and 6 are in a strong relationship to each other but seemed to warrant being separated. Most of the themes were present in each interview as demonstrated in Table 6.

**TABLE 6**

*RECURRENT THEMES*

| **Super-ordinate themes** | **01** | **02** | **03** | **04** | **05** | **06** | **07** | **08** | **09** | **10** | **11** | **12** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Nature of EMDR | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |
| Nature of knowledge | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |
| Structure v creativity | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✗ | ✔ | ✔ |
| Accreditation and CPD | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |
| Right v wrong | ✗ | ✔ | ✔ | ✔ | ✗ | ✔ | ✗ | ✔ | ✔ | ✗ | ✔ | ✔ |
| Love v fear | ✔ | ✗ | ✔ | ✔ | ✗ | ✔ | ✗ | ✗ | ✔ | ✔ | ✗ | ✔ |
| Being v doing | ✔ | ✔ | ✔ | ✗ | ✔ | ✗ | ✔ | ✔ | ✔ | ✗ | ✔ | ✗ |
| Schism | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✗ | ✔ | ✔ | ✔ | ✔ |
| Metaphors | ✔ | ✔ | ✗ | ✗ | ✗ | ✔ | ✗ | ✔ | ✔ | ✗ | ✗ | ✔ |
| PDP and planning | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |

The first four themes are present in every interview, and in a sense are reflections on the subject matter in hand, so this would be expected. The views expressed however could be very different and this will be discussed below.

For Theme 5, right versus wrong, eight out of 12 participants expressed issues around this theme. Theme 6, love versus fear, was only strongly considered by five participants. Initially, I had seen this as part of the "Right versus wrong" theme, but as three participants talked about right versus wrong but not love versus fear, I felt that this needed to be a theme on its own, despite not being mentioned by half of the participants.

Being versus Doing was mentioned by eight participants, so two-thirds of the sample. Theme 8, schism, was mentioned by ten of my participants and for some of them, this was a very powerful theme indeed. Theme 9, metaphors, were present in six out of the 12 (therefore half) of the interviews. Some of the metaphors were incredibly powerful and appeared to need a category of their own. The final theme, PDP and planning, was present in all interviews.

The nature of recurrence in IPA appears to be quite fluid. Smith et al. (2009, pp. 106-107) say: "A decision may be made that for an emergent, or super-ordinate theme to be classified as recurrent it must be present in at least a third, or a half, or most stringently, in all of the participant interviews". As all of my themes were present in at least one-third of the interviews I felt that their inclusion was justified here despite this taking me into the least stringent definition of recurrent themes. I am also aware of the idiographic nature of IPA and that if a voice is very powerful it should be recognised.

Some of the themes have a lot of sub-themes. As I created the clusters to make the superordinate themes there were very definite issues that were part of those themes, that felt to me as though they needed to be recognised.

I recognise that ten themes are a lot, but each theme seems to me to have its own "life" and needs to be represented here.

# Chapter 11.Theme 1: The Exact Nature of EMDR

Although my research question was about participants' experience of CPD and what they think they need to know, all of them naturally talked about how they saw EMDR and exactly what it consisted of. This was partly a result of my early questions about their initial training and why they trained in EMDR, together with their impressions of that training. It also seemed, however, that none of the participants could talk about their pedagogical experiences within EMDR without expressing their feelings about it and what exactly it was.

All of my participants had gone through EMDR standard training and there were a number of sub-themes that emerged within this theme:

- The participant's own identity as a therapist
- Is EMDR a Psychotherapy in itself or more of a technique?
- Whether people use EMDR exclusively or as part of a wider practice
- Concepts of EMDR could be the same as the participant's original training
- Pragmatism in training in EMDR
- Very positive impressions of EMDR
- Specific language used
- Is it magic?
- Personal impact of practicing EMDR

I will now discuss each of these sub-themes which contributed to the superordinate theme.

## Identity as a Therapist

Some participants were very insistent on the importance of being a psychotherapist over and above their experience of EMDR. This is significant in EMDR as not all EMDR therapists

are initially psychotherapists. Some people train from a background of being a mental health nurse, a psychiatrist, a mental health social worker or a clinical psychologist. Participant 05 said:

> *"I'm an EMDR therapist, you know, but I don't think of myself as just an EMDR therapist."*

This participant was clear that she was also a relational integrative psychotherapist, as well as an EMDR therapist.

Participant 03 said seven times in her interview "*I am a psychotherapist*", the first time saying:

> "*I am a psychotherapist and I really see that as my identity."*

For this participant, there was a sense that people trained in EMDR who were not psychotherapists (nurses, psychologists, social workers) were not able to work at as high a level. She went on to say:

> *"It would be simpler to do what the psychologists do … it wouldn't ask so much of me."*

My initial interpretative comments on the transcript of this interview were about the feeling that this participant saw psychotherapists who practiced EMDR as superior and that she viewed her own practice as better by definition because she was a psychotherapist. There also seemed to be some assumptions about what psychologists and psychotherapists did differently.

Participant 08 also said four times that she saw herself as a clinician:

> *"I am a clinician: people need to be clinicians.*"

For this participant, there seemed to be an additional idea that being a psychotherapist was essential to practice EMDR. Later in the interview, she indicated that she felt she had a superiority as a clinician:

> *"On the (CPD) training people asked very basic questions that I could answer…When you are accredited you basically know what you are doing."*

Participant 02 was very clear that as a gestaltist:

> *"Even when I do EMDR it's still gestalt…this is gestalt, "let's experiment""*

Participant 10 said:

> *"I am a psychotherapist, I don't want the hassle of being anything else."*

However, this practitioner had been referring to the fact that he did not want to become a trainer. My sense of his statement was that he was clearly placing himself as an EMDR therapist. He thought of himself as a psychotherapist and supervisor, rather than as a consultant, which was a title he did not like.

It was clear that for many of the participants, being a therapist was a prerequisite to being an EMDR therapist. This raised a possible point of conflict in the EMDR Association as mental health nurses and some social workers are also accepted to do the training. The Association has historically seen awareness of mental health as the prerequisite for undertaking EMDR training, whereas, for my participants, the emphasis tended to be on being a psychotherapist. However, my participants were probably not representative of the EMDR membership overall. This is because psychologists, CBT therapists and nurses are a large part of the membership.

This was a bias I spotted in my sample later as I was analysing the transcripts. Three of my participants had, in fact, started life as nurses, but two of them had trained as CBT therapists and one as a drama therapist. One other participant who was an Integrative Psychotherapist

had also trained as a CBT therapist. Therefore, all my participants had an overall therapy background. I am not sure if answers would have been different were this not the case.

**Is EMDR A Psychotherapy or A Technique?**

Initially, it seemed to me that there could be a conflict here. Were the people above who were insisting on being a psychotherapist first perhaps negating claims that EMDR is a psychotherapy in itself? In 2014 Francine Shapiro asked therapists to refer to "EMDR Therapy" rather than just EMDR to reflect its status as a psychotherapy. However, these claims are refuted by some people who would say that as EMDR has such a short training (typically seven days) that it cannot be seen as a standalone psychotherapy.

Mollon (2005, p. 5) stated:

"Shapiro did not design EMDR as an entire psychological therapy…it's effective and safe use depends upon considerable skill and prior clinical experience of the therapist. It would normally be incorporated within another more traditional therapeutic framework."

My participants had very different views here. Some were clear that EMDR is a standalone psychotherapy, others agreed that it is basically a technique to be incorporated into other therapeutic frameworks.

Participant 07 made slightly contradictory statements here, she said:

> "*I'm a therapist who just uses EMDR*," but later, "*Some people treat it as a technique – that's not EMDR therapy.*"

She was clear that her main identity was as a therapist but also seemed to have subsumed EMDR into her practice so that she did not see it as a technique.

Participant 002 on the other hand said that she didn't actually claim to be doing EMDR at all:

> "*I like the freedom to integrate it in my gestalt way and call it BLS … I question that you can use it for anything"*

By taking the central technical aspect of EMDR (bilateral stimulation) and using it independently of other aspects of EMDR this participant did appear to be using a technique. However, by integrating it into gestalt she saw this as an experiment, so part of her gestalt process.

Participant 10 said:

> "*The problem is that CBT is where the evidence is…EMDR is my heart and CBT is my head, but EMDR is a proper psychotherapy."*

This participant seemed to see both CBT and EMDR as different aspects of himself with EMDR perhaps being closer to him "*my heart"*. However, he was clear that EMDR was a psychotherapy.

Participant 11 simply said:

> "*EMDR is a therapy in its own right."*

This issue is currently a huge debate in the EMDR Community. There are criticisms of the commercial training model which provides only a short training as this could therefore imply that EMDR is a technique to be integrated into other therapies. In some circles, there is a wish to take the training to a higher level, expressed by Farrell and Keenan (2011) and discussed in my Literature Search chapter.

Participant 12 said:

> "*I think the model was wrong from the beginning. Beck got it right because he insisted from the start that the training for cognitive therapy needed to be in the universities and he got it in there"*.

In the last few years, Worcester University has offered an innovative MSc in EMDR pioneered by Dr Derek Farrell. This is a four-year course that starts with the standard EMDR training and goes on to a fuller appreciation of using EMDR in many different ways. It uses the curriculum suggested by Farrell and Keenan in 2011. People who are already accredited in EMDR can APL past the initial training. Dr Farrell's critique of the standard training is that it provides only a certificate of attendance rather than an assessment of competence, although peoples' practice is observed on the standard training.

When I completed the standard training some seventeen years ago, it was very much taught as a technique. There is now much more of a sense of EMDR being a therapy in its own right. There is a real issue here of whether a therapy that only provides a short training and a certificate of attendance has the necessary infrastructure to be considered a therapy in its own right.

The EMDR Association has some robust structures but it does not, for example, have a complaints policy that clients can access. When a client does have a complaint about a therapist, they are asked to contact that therapist's main accrediting organisation. This is potentially problematic. I am currently responsible for dealing initially with complaints for the EMDR Association. Although there is a Disciplinary and Complaints Policy it applies only to members of the Association making complaints about other members, which does happen. This is a point that was raised by Participant 12 and is an issue I am currently dealing with on the governance committee of the organisation.

This is one of the issues raised by my research where I am trying to both understand the experiences raised by my participants and see how these issues can be taken forward to change things in the Association.

Only half of my participants actually brought up the issue of EMDR as a psychotherapy in its own right. However, this was brought up spontaneously and not in any way as an answer to a question, so I saw it as a significant sub-theme contributing to the superordinate theme of the exact nature of EMDR.

**Whether People Use EMDR Exclusively or As Part of a Wider Practice**

This was a question that I specifically asked. Six people said that they used EMDR almost all of the time with clients. Five clearly said that it was part of a wider practice, one person (002) said that she did not really call her practice EMDR.

Participant 07 said:

> "*I don't think of myself as just an EMDR therapist"*

This participant was very clear about her status as an integrative psychotherapist but also clear that she would consider using EMDR with every client.

Participant 06 said:

> "*I use it as part of a wider practice"*

This participant felt that EMDR was one of a range of options that she could offer her clients. Participant 05, on the other hand, said:

> "*Now most of my work is EMDR"*

This participant was very enthusiastic about EMDR and had felt that it allowed her to treat clients she would not otherwise have been able to work with.

Participant 02 said:

> "*I just do bilateral stimulation, I don't call it EMDR.*

Participant 02 had been very clear that she integrated EMDR and bilateral stimulation into her gestalt way of working but she also stated that if a client came with a clear past trauma she would use EMDR Standard Protocol. She was, therefore, clearly integrating EMDR into a wider practice.

Participant 10 said:

> "*If you said to me now "you can either give up your accreditation with BABCP or EMDR" I'd give up EMDR. It would be like cutting off my right arm though. If somebody audited my service I would struggle to justify using EMDR for psychological conditions that aren't PTSD"*

This participant was expressing a very strong dilemma that EMDR had to be part of a wider practice because of his core accreditation in CBT. His expression that giving up EMDR would be like cutting off his arm felt very evocative and also expressed how important this therapy was to him.

Participant 11 said:

> *"I threw myself into doing EMDR… I could see the results that I was not getting in any other modality…and I just fell in love with it."*

Participant 11 was an EMDR consultant working in secondary mental health services in the NHS. He clearly felt able to use EMDR with almost all of his clients.

The quotes above show a mixed response to this issue. This is connected to the previous sub-theme (Is EMDR a psychotherapy or a technique?) as if people are using EMDR as part of a wider practice, then there is an increased possibility that they see it as a technique to be incorporated. Some people, however, used EMDR most of the time. Participant 10 was also in this category. He raised the very interesting issue that if he were forced to give up one of

his accreditations, it would have to be EMDR. This was because he was required to have a core profession, and this was CBT.

If a therapist does not have a core registration then they lose their accreditation in EMDR, which is an anomaly for those who desire it to be seen as a standalone therapy.

He also raised the issue that because of NICE guidelines and paucity of research evidence, he would struggle to justify using EMDR for issues other than PTSD, although he did do this on a regular basis. This participant was the only one to raise this issue and this perhaps reflects his background in the NHS, though he was at that time working in private practice.

Again, this is a very interesting issue for a therapy prided by proponents for being evidence-based. Proponents of EMDR have been very dependent on validation by NICE. The devaluation which happened in 2019 was a blow to many therapists. It also had a very significant effect on military populations who have stopped training in EMDR and in many cases stopped their personnel receiving EMDR. This seems a great pity as much of the original research evidence for EMDR was with military populations.

Proponents of EMDR are therefore currently facing a difficult situation as there is a clear need for commissioning RCTs to get a higher profile. The understanding of many members is that EMDR is losing out to CBT.

### Concepts of EMDR Are the Same as The Participant's Original Training

This sub-theme was mainly contributed to by four participants. The main theoretical concept behind EMDR is the Adaptive Information Processing model (AIP). Interestingly, it was only the consultants who discussed AIP.

Participant 09 said:

*"I didn't really know what AIP was – well I did know what AIP was but I didn't call it that, it's like that…Rogerian thing, you know…the actualising tendency?"*

This comparison with Rogers' theory was an interesting one which I will discuss below.

Participant 10 said:

*"By the time I'm supervising practitioners I expect them to have a massive understanding of AIP."*

As a consultant, this practitioner was clearly stating that he expected his supervisees who were accredited ("Practitioner" is a technical term in EMDR for a person accredited in EMDR) to clearly understand the theoretical underpinning.

Participant 02 said:

*"It's still gestalt."*

Participant 02 was very clear throughout that EMDR was absolutely consistent with gestalt, despite the structure and free-flowing nature of EMDR. She saw EMDR as an "*experiment*" within gestalt.

Participant 12 said:

*"We should just call it CBT and be a branch of BABCP."*

This participant startled me by suggesting that EMDR should simply become part of BABCP. Interestingly 12 was not originally a CBT therapist. I had never heard anybody else say this, and usually, EMDR therapists seem to see themselves as being in competition with CBT therapists, so this seemed a very new angle to me. It was interesting that she seemed to see EMDR theory as being compatible with CBT.

Some of my participants trained in EMDR at a time when Francine Shapiro had not fully formulated the underlying theory (the Adaptive Information Processing model). Initially,

Shapiro referred to this as the Accelerated Information Processing Model (Shapiro 1995). Farrell (2011) suggested that a failure to understand the underpinning model contributed to people treating EMDR simply as a technique and not as a therapy in its own right.

My initial interpretive comments on the transcript focussed on the seeming understanding that if the AIP model was the same as the actualising tendency or physis, this then challenged the idea that AIP characterised EMDR. This would mean that everything we did with the client was EMDR. Some participants seemed to be suggesting that the EMDR was only the actual processing (phases 3-6).

Participant 09 said that when she trained AIP was not really taught. My recollection of training was that AIP may have been mentioned but it did not seem to be a large part of the training. My understanding of AIP was only established through the accreditation process and through ongoing training.

It is interesting to speculate whether, in fact, AIP is the same as theories such as the actualising tendency. My sense would be that, although both do posit that a movement in a positive direction is the normal tendency, AIP has a much more technical understanding of dysfunction and so this does make it a different model. Interestingly, Mollon (2005) equates EMDR with free association and credits Shapiro with “something new and astonishing – that given a little help, the mind has its own natural healing process.” (pp. 47-48).

There was an early criticism of EMDR from proponents of CBT, that what works about EMDR is not different and what is different (Bilateral Stimulation) is not what makes it work (Maxfield, 2009). I think that AIP represents a theoretical understanding that it is the different aspects of EMDR that make it so effective. It is interesting though that people do not always perceive this.

**Pragmatism in Training in EMDR**

One of the questions in my interview schedule concerned the reasons people trained in EMDR. Seven of my participants gave clear pragmatic reasons for doing so.

Participant 01 said:

> *"My training was a direct response to the women who are referring themselves or being referred, with a degree of PTSD or clear PTSD symptoms. People like that can't just come in a counselling room, open it all up and go away again. It just didn't feel doable. We felt, you know, some people needed something else, some people don't like the talking bit."*

This participant clearly saw training in EMDR as a practical means to fill the needs of her client group. She saw it as an alternative to traditional talking therapy, arguably, therefore, suggesting that she saw it as a technique. She clearly indicated that talking therapies were not always suitable for traumatised people and that, because in EMDR clients do not have to talk about the trauma, this was much more suitable for her client group.

Participant 06 said:

> "*I could see it was going to be the trend*."

For this participant, the choice to train in EMDR appeared to be pragmatic. The indication was that in the future this would be where work would be available.

Participant 05 said:

> "*It sounded amazing. It allowed you to treat people that normally I wouldn't be able to treat."*

Equally, for this participant, EMDR widened her ability to work with people and therefore she saw the training as a sensible and pragmatic choice. Both previous participants commented on the popularity as well as the efficacy of EMDR.

Participant 10 said:

> *"I was interested in EMDR because my supervisor at the time was interested in EMDR. If he had pooh-poohed it I think I would have as well."*

This participant had trained in EMDR at a very early stage (in the early 1990s). He acknowledged that if his CBT supervisor at the time had not been positive about EMDR he may not have pursued it. He also talked about his knowledge that some people were bullied within organisations having undertaken EMDR training. This perhaps indicated that in the early stages, training in EMDR was not such a pragmatic choice.

Participant 08 said:

> *"the other techniques I knew felt like doing things to people…they felt wacky and quirky."*

This participant referred to "*other techniques*" such as Thought Field Therapy (TFT) and the rewind technique. She clearly felt that EMDR gave her scope not just to do things to people. This was interesting given some concerns around doing and being that I discuss later.

Participant 11 said:

> "*I will support anything that gets good trauma work out there."*

This participant was a consultant working in secondary mental health in the NHS. For him, there was clearly a pragmatism involved in trying to make sure that clients got good access to trauma work. Initially, therefore, training in EMDR appeared to do this.

Participant 03 said:

"*It was the idea that it was happening in real time in the session. That you could actually see the impact of what you were doing.*"

My initial interpretive comment on the transcript here concerned the idea of this being unusual in therapy. Changes are usually slow and the fact that in EMDR sometimes change is very dramatic increases peoples' pragmatic wish to use it more.

Again, these participants were impacted by the clear efficacy of EMDR and the sense that this was a therapy that clearly worked for people.

Two participants were simply given the opportunity to train by their employers at the time so initially just went along with this.

**Very Positive Impressions of EMDR**

All of my participants expressed very positive feelings about EMDR.

Participant 01 said:

"*I was sold on it, hook, line and sinker. And they're kind of: "It does great work, but I don't quite trust it.*"

This participant referred to her enthusiasm for EMDR and her wish to communicate this to her team. She felt that the team, mostly person-centred counsellors, were very sceptical, and this she found difficult, although slightly amusing. She went on to say:

"*In the meeting someone said: "I'm having great results with the EMDR, and that confuses me.*""

In the interview, both of us laughed at this. For me, there was a sense of us colluding as the people who understood EMDR whereas there were people in her team who were confused as to why it worked.

Participant 04 said:

*"It feels like "east meets west" …it feels like a tuning-in."*

This participant identified herself as being spiritual and creative and so for her this sense of EMDR as a tuning-in was a very positive experience, although she also sometimes struggled with the technical aspect. I found it interesting that each participant found their own unique reason to be positive about EMDR.

Participant 05 simply said:

"*It sounded amazing."*

and this impression caused her to train in EMDR.

Participant 12 said:

"*EMDR is such a wonderful tool and such a brilliant innovation…the Heineken of therapies."*

All of my participants expressed some enthusiasm about their use of EMDR. This included Participant 02 who did not claim to be practicing EMDR as such, but rather bilateral stimulation. It was notable that there was no criticism at all of the efficacy of EMDR. All the participants seemed to be clear that, as a therapy, it worked very well. Where criticisms were made, they were of the training or the structure of the Association rather than the therapy itself.

Going back to Bateson's (1972) view that advances come from a combination of loose and strict thinking, I think it was interesting that all of my participants were absolutely convinced of the effectiveness of EMDR, but they had varying views about how to administer this therapy and how it worked.

## Specific Language Used

For some participants the language used was very striking. Participant 12 used the term "transformative" eight times when referring to EMDR. She used very striking metaphors which will be referred to below. This participant was interesting in that she was probably the most enthusiastic about EMDR whilst being the most critical of its current structure.

Participant 10 used the term "brutal" four times. First, to describe the Consultant training:

> "*When (name redacted) was doing it, it was brutal. It was terrible… these hard-nosed therapists being brutalised*."

Second, to compare CBT requirements to EMDR:

> "*CBT is much more brutal than EMDR."*

Generally, the language used was very positive although there were also images of battle and disagreement within the Association. These came largely from Participant 12 but were echoed by other participants. This will be discussed further in the theme concerning schism.

## Is it Magic?

Interestingly this concept was referred to by just two participants. Both were unaccredited therapists.

Participant 01 said:

> "*You go with your intuition, your professional intuition, but it's like it's spiritual, it's kind of like magic"*

Participant 04 echoed:

> "*there's something more esoteric about it: It's magic."*

People with more experience tended to ascribe this to AIP, but I had some sympathy with the experience of these participants. It can indeed feel like magic to work with a client whose level of distress is a 10, to have it reduced to 0 in under 20 minutes. This does not of course occur with all clients, but it happens enough to make EMDR feel like a magical solution. It is interesting that at a later stage, when I presented my findings at the EMDR UK Virtual Conference in June 2020 Participant 12 emailed me to say: *"I was delighted that you got the magic in so elegantly"*

Those with more training and experience tend to accept this more and attribute it to the efficacy of the model, but it is interesting that the idea of magic clearly resonates with other practitioners.

**Personal Impact of Practicing EMDR**

Only one participant mentioned this strongly, but in the interests of idiography, it seemed important to emphasise it. Smith et al. (2009) suggested that if something is very powerful for just one person, it may be significant enough to include. Participant 04 discussed attending training and being impacted and worried by the fact that the trainer showed videos of real clients undertaking EMDR:

> "*I worried, is this OK? And I suppose I'm quite sensitive so I was quite moved by it. It made me feel that I don't know if I can handle doing this work, because I might be exposed to levels of trauma that I find it incredibly difficult to handle"*

She went on to discuss issues that had recently arisen with a client that had impacted her a great deal. This interested me as most therapists find EMDR easier in this regard as normally clients do not give a narrative of their experience. Where the content is very difficult or shaming for the client, it is possible to work in a way that is referred to as "Blind to Therapist". This means that the client does not tell the therapist any of the content of the

memory at all. This participant, however, seemed to be very exercised by the impact of doing the work and saw herself as reacting in a different way to others. It seemed important, therefore, to honour this understanding that dealing with trauma on a regular basis could lead to vicarious traumatisation.

This overall theme with its' nine sub-themes is the foundation for my findings on EMDR therapists' experiences of CPD and what they think they need to know. This is because it seemed to me that my participants' understanding of the exact nature of EMDR would very strongly influence what they thought that they needed to learn and what they thought that they needed to know. The extent to which they used EMDR exclusively or as part of a wider practice also seemed very relevant to my enquiry. Each participant's understanding of the theory, and how they defined themselves as a practitioner, would seem to influence how they approached their CPD.

# Chapter 12.Theme 2: The Nature of Knowledge in EMDR

Knowledge is from the outset part of my research question in that I was asking people what they thought an EMDR practitioner needed to know.

Eraut (1994) described the complexity of defining professional knowledge. He suggested that knowledge is competence, involving procedural, prepositional, practical and tacit knowledge and skills. He stated:

> Professional knowledge cannot be characterised in a manner that is independent of how it is learned and how it is used. It is through looking at the contexts of its acquisition and its use that its essential nature is revealed. Although many areas of professional knowledge are dependent on some understanding of relevant public codified knowledge found in books and journals, professional knowledge is constructed through experience and its nature depends on the cumulative acquisition, selection and interpretation of that experience (Eraut, 1994, pp. 19-20).

Ryle (1949) made a distinction between "knowing how" and "knowing that" which Eraut transformed into a distinction between process knowledge and propositional knowledge. He also stated that "the process of using knowledge transforms that knowledge so that it is no longer the same knowledge" (p. 25).

Braudy (1980, cited as personal communication in Eraut:1994, p. 27) made a distinction between four modes of knowledge use:

- Replication
- Application
- Interpretation
- Association.

Replication and application are clearly utilised in EMDR through the use of the Standard Protocol, but all theory has to be interpreted in order to be used. The associative mode of knowledge is discussed by my participants in their insistence on the importance of creativity in EMDR. This discussed below in a separate theme.

Farrell (2011) drew on Aristotle to describe knowledge in EMDR as either "techne" or "phronesis". Techne is scientific and technical knowledge, whereas phronesis refers to practical reasoning engaged by experts in the field, and the relationship itself is used to gain knowledge.

Farrell (2011) also drew on Dreyfus (2004) who described stages of skills acquisition as novice, advanced beginner, competent, proficient and expert. Farrell suggested that the person in EMDR training starts as a novice and moves to being an advanced beginner. They are seen as competent once they are trained, are in EMDR supervision and are experiencing CPD. Accreditation makes them proficient and becoming a consultant makes them expert. My own experience and that of the consultants in my research would indicate that consultants do not tend to see themselves as experts.

In Table 7 and Table 8 I have summarised the responses of my twelve practitioners. In Table 9, I have provided further answers that were given when I presented some of this material at a networking morning of the Kent EMDR Regional Group. I have attempted to divide the responses into techne and phronesis but I recognise that there would be other ways of doing this.

I appreciate that in approaching the material in this way I risk doing the opposite of what IPA aims to do as I may be shaping my findings using existing theory. I am also mindful of the suggestion in Smith et al. (2009) that IPA can be adapted. In this particular theme, it felt

useful to go back to Farrell's (2011) thinking, whilst still paying attention to the individual understandings of my participants.

**TABLE 7**

*RESPONSES OF MY INTERVIEW PARTICIPANTS*

| Techne? | Phronesis? |
|---|---|
| You need the basic protocol drilled into you.<br>Standard Protocol | That we are not "Doing things" to people. Relationship building. It's an art not a science.<br>That it's profound, spiritual, creative. There's magic. |
| About Janet – the three stages. Bilateral Stimulation. Resourcing. Dissociation. The Window of Tolerance. Structural Dissociation. Interweaves. Neurobiology. The Absorption Technique. | The trauma processing isn't the work. Containment and stabilisation.<br>Eight phases are unnecessary |
| Neurobiology, Child development | Need to know how to be a therapist. To know about people.<br>Need to believe people can change. Intuition. |
| Standard Protocol. Dissociation. Attachment. Knowing how to do thorough assessments. Neurobiology. Resourcing. Safe place. Targets. Three prongs | The client is in charge of the process. It's magic. |
| Standard Protocol. History and main names. How it works. Blocking beliefs. Stuck clients.<br>Knowing that the different protocols aren't different. Resourcing. Who not to use it with. | What are you doing? Why are you doing it? |
| | They need to know their client<br>It's not a tick-box exercise |
| Assessment. Dissociation. Neuro-science. Affect tolerance. Stabilisation. Window of Tolerance. The body. Attachment. Standard Protocol. BLS.<br>Trauma-informed practice. Psycho-education.<br>Readiness for work. | Being a therapist, The therapeutic relationship.<br>What might go wrong. |

| Techne? | Phronesis? |
|---|---|
| How to do Standard Protocol, and when not to do it. | The therapeutic relationship. Don't get too hung up on the protocol. See your client in context, know that they are ok to go home. |
| How to deliver EMDR by the book. Why they do what they do. AIP. Standard Protocol. The mechanics of the brain. Know when people are processing and when they're not. | You need to understand why you are doing what you're doing.<br>How to adjust to complex cases. |
| AIP. Psychological trauma. Neurobiology. Attachment. They need to know that they need clinical supervision and they need to read and keep up with their CPD. It's a proper psychotherapy, not a technique. | They need to know it's not a manualised process. They need to know why it works – and that's also because of the therapeutic relationship. They need to have faith in the protocol. |
| Neurobiology, Window of Tolerance, Safety | It's a passion. They have to follow it whole-heartedly. They have to know how to attune. |
| Neurobiology. Attachment. AIP, 8 phase protocol, 3 prongs. Case conceptualisation, target identification, structure. | Creativity. They need to know why they are doing what they are doing. Imagination. No ideology. |
| My own answers to this question in my interview:<br>AIP, 3-pronged approach, Standard Protocol, that everything they do is EMDR, dissociation. | They need to know why they are doing what they are doing, need awareness of the relationship. |

I found it interesting that some of the responses above did not neatly separate into techne and phronesis and that some participants really only focussed on one area.

Participant 01 was clear that people needed to know the basic protocol, but then that the relationship was important and that EMDR was not "*doing things*" to people. She described it as:

> *"an art not a science…it's profound, spiritual, creative."*

Therefore, my understanding was that for this participant knowledge needed to be underpinned by information and theory, but it is very much more than this.

Participant 02 had already made it clear that she did not entirely practice EMDR, so some of her answers to this question were interesting to me. I have characterised under "techne" some of her more technical answers to the question, including bilateral stimulation, interweaves and the Absorption Technique which are specific EMDR concepts, together with several other answers such as "The window of tolerance… structural dissociation…neurobiology" which are wider concepts coming from trauma theory.

Participant 02 also acknowledged her gratitude to her initial EMDR training in the mid-2000s that first alerted her to concepts like the Window of Tolerance (2010) and Structural Dissociation (van der Hart et al., 2006). This practitioner clearly stated that she felt that the trauma processing itself was not the work and that the main work was in the containment and stabilisation. She also stated that she believed the eight phases of EMDR therapy to be unnecessary. I think this understanding may not be uncommon amongst practitioners.

Participant 03 expressed a belief that clinicians did not need any technical knowledge about EMDR at all, saying that an EMDR therapist needed to know about:

> "*Neurobiology…child development…you need to know how to be a therapist and to know about people…to believe people can change. You need to have intuition."*

To me, this seemed to be more general knowledge about how to be a therapist as opposed to an EMDR therapist. This fit this participant's emphasis on being a psychotherapist.

Participant 04 was similar to Participant 02 in the sense that many of her answers which I have characterised as "techne" are not EMDR specific. "*Standard protocol…targets…three prongs."* (the three prongs of EMDR processing are seen as past, present and future) being the only ones that are. In terms of relationship, she was very clear that *"the client is in charge of the process…it's magic."* I wondered how the concept of the client being in charge fit with

the idea of magic, as this seems to be a quality that is transcendent of the client's agency. However, Participant 04's experience seemed to be that these went together.

Participant 05 presented a very technical understanding of the knowledge required. She maintained the emphasis on practicality throughout her interview:

> "*standard protocol. History and main names. How it works. Blocking beliefs. Stuck clients. Resourcing…Knowing that the different protocols aren't different…knowing who not to use it with.*"

The content that I categorised as phronesis was simply:

> *"What are you doing? Why are you doing it?"*

It seemed to be important to her that people knew why they were doing what they were doing.

Equally, Participant 06 was very concise in her understanding of the knowledge required:

> "*They need to know their client.*"

She seemed to feel that any discussion of technical knowledge was unnecessary, other than:

> "*it's not a tick-box exercise."*

Again, this participant did not state any EMDR specific knowledge.

By contrast. Participant 07 gave a list of technical requirements, although again these were mostly general therapeutic knowledge. The only EMDR specific knowledge was:

> "*standard protocol…BLS"*

and she emphasised the therapeutic relationship.

Participant 08 stated that it was important that the practitioner knew:

> "*How to do standard protocol…and when not to do it…but don't get too hung up on the protocol. You need to see your client in context and know that they are ok to go home."*

So again, this participant appeared not to privilege the Standard Protocol too highly.

By contrast, Participant 09 said:

> *"They need to know how to deliver EMDR by the book…why they do what they do…AIP…standard protocol…know when people are processing and when they're not."*

This participant seemed to soften her belief that people should go "*by the book*" by emphasising the need to understand what people do and why, this echoed sentiments expressed by Participant 05.

For Participant 10 I found it difficult to divide his response into techne and phronesis, as although there was some technical content, most of it felt less technical:

> *"Er…I think, AIP, psychological trauma, neurobiology…attachment. They need to know that they need clinical supervision and they need to read and keep up with their CPD. It's a proper psychotherapy, not a technique. They need to know it's not a manualised process. They need to know how it works – and that it's also because of the therapeutic relationship. They need to have faith in the protocol."*

I was conscious when listening to the recording of this interview that I had expected Participant 10 to say "faith in the process" so "faith in the protocol" was a slight surprise, but it grounds this response back into EMDR practice.

Participant 11 also talked about general therapeutic principles, then said:

> "*It's a passion. They have to follow it whole-heartedly. They have to know how to attune.*"

This suggested that again he favoured knowledge that was not EMDR specific.

Participant 12, who was the person most critical of EMDR training and structure, was quite clear that AIP, the eight-phase protocol, the three prongs (past, present and future) and target identification were important. She then went on to say:

> "*They need to know why they are doing what they are doing…you need imagination. We need to get rid of ideology.*"

She was, therefore, agreeing with Participant 05 and Participant 09 that awareness of what the therapist was doing and why was crucial for an EMDR therapist. She was suggesting with the word "*ideology*" that sometimes knowledge in EMDR may be too rigid.

It is interesting that in my own interview, which I conducted before any of the other interviews, I said that the technical knowledge required was AIP, the 3 pronged approach, Standard Protocol, that everything that people do is EMDR and dissociation. Under phronesis, I also said that people needed to know why they were doing what they were doing, and they needed awareness of the relationship. I think that, therefore, my answers were more technically based towards EMDR. This may be because I had thought more about the question.

It was interesting that all the Consultants (except Participant 11) but no other participants, referred to AIP. Most respondents, however, referred to the Standard Protocol. It was notable that Participant 02 stated a belief that the eight phases of the protocol were unnecessary.

The number of times each technical concept was referred to is reflected in Table 8:

**TABLE 8**

**TECHNICAL CONCEPTS**

| Technical Concept | Number of references |
|---|---|
| Standard Protocol | 8 |
| Neurobiology | 7 |
| Attachment | 4 |
| Dissociation | 3 |
| Assessments | 3 |
| AIP | 3 |
| BLS | 2 |
| Window of Tolerance | 2 |
| How it works | 2 |
| Blocking beliefs | 1 |
| Stuck clients | 1 |
| History of EMDR | 1 |
| Affect tolerance | 1 |
| Stabilisation | 1 |
| The body | 1 |
| Clinical supervision | 1 |
| CPD | 1 |

At a networking morning for the Kent Regional group in February 2019, I asked participants to write down what they thought an EMDR Practitioner needed to know. I had twelve further responses expressed in Table 9.

**TABLE 9**

*FURTHER ANSWERS*

| Techne? | Phronesis? |
|---|---|
| Basic counselling skills. Ability to manage abreactions. Standard Protocol. Adaptations to SP. Technically EMDR is very simple. | Therapeutic alliance. Need to know value of supervision and CPD. Expertise comes with practice. |
| Taking a comprehensive history. Dissociation. Complex trauma. Needs to know how to spot looping and when to take the client back to target. Inverted protocol. Float back technique. Research. | How to use EMDR in a flexible way. The magic happens between sessions. Hold faith in EMDR. |
| Rogers – Core Conditions. CBT. Neurobiological understanding. | Systemic understanding. Relational awareness. |
| How to explain EMDR to the client. Resourcing. How to help client manage difficult emotions. Dissociation. | How to give client hope. How to set up the therapeutic relationship. How to listen to the client. How to use the protocol. |
| Theory of trauma and how EMDR works. History-taking. Dissociation. DES. How to work with abreaction. CPD. Interweaves. Other relevant theory. | Creating a “contactful” relationship. To know what you don’t know. |
| Detailed knowledge of 8 phase protocol. Neurobiology. Interweaves. Knowledge of variations to SP. Dissociation. Stabilisation. When not to use EMDR. | |
| Neurobiology. General issues the client might present. Dissociation. Resourcing. | Developing a relationship with the client. EMDR therapists should have their own EMDR outside training. |
| AIP. 8 phase protocol. Grounding. | When to ask for help |
| Affect tolerance. Target identification. What to do if client can’t find a safe place or there are intrusions there. Attachment. | |
| Resourcing. How to work with BPD. Target identification and prioritisation. How to get unstuck. | Trust the process and yourself. Tolerate abreactions. |
| | How to be confident in using protocols. How to adapt to each client. How to be a therapist. How to establish the relationship. Keep the client safe, contained and grounded. |

| Techne? | Phronesis? |
|---|---|
| AIP. History-taking, trauma, self-soothing, time scale, dissociation, interweaves. When not to use EMDR. | |

These twelve practitioners had less preparation for the question than my twelve interviewees. They listened to me giving a 20-minute presentation on my research. They were then asked what they thought an EMDR practitioner needed to know.

It was, therefore, interesting to compare their answers to those of my research participants. For the twelve research participants, I characterised only one with no techne and one with no phronesis. The additional participants had one with no techne and three with no phronesis. It could be seen, therefore, that this group saw EMDR as a more technical endeavour. However, two participants gave technical answers that were general to therapy and not directly connected to EMDR:

> "*Rogers – Core Conditions – CBT. Neurobiological understanding.*"

> *"Neurobiology. General issues client might present. Dissociation. Resourcing."*

However, I think it is important not to extrapolate too much from this difference as the second group had received less preparation. In the content of their replies, there was considerable agreement.

The twelve additional participants were also asked to give informed written consent to their answers being used in my research, three people at the event did not give this so I did not collect their responses.

I realise that there could be ethical and methodological issues around discussing this additional piece of research in my work. However, I saw it as an extension of the discussion and in a sense as a part of my subsequent product which will involve an assessment of the issues an EMDR practitioner needs to know.

**To What Extent is the Knowledge Discussed Generic and to What Extent Specific to EMDR?**

I am interested in practitioners' experience of the knowledge they need to conduct EMDR, but to a large extent, the discussion seems to be around a more general knowledge requirement. If we separate out EMDR knowledge as technical knowledge would this make it seem more like a technique?

There was a very strong emphasis for some participants on the fact that they were therapists and what this meant for them. I wondered to what extent this question was being answered as "What does a therapist need to know" rather than "what does an EMDR therapist need to know"? Can we assume knowledge of being a therapist? Possibly not, as not all EMDR therapists, mental health social workers for example, actually have therapeutic training.

I was, therefore, left with the question of what EMDR therapists might need to know that other therapists did not. Other than the technical aspects, the answer I came up with was the Adapted Information Processing Model. Only three of the Consultants actually mentioned AIP, and nobody else did. Arguably, for some, the AIP was implicit, but it was not specifically mentioned. I was interested, therefore, in the perception of EMDR and what a therapist actually needs to know.

Participant 09 actually discussed her feeling about her previous belief that she did not really understand what AIP was. She said:

> "*I don't think I really understood because when I did my training AIP wasn't mentioned – and I didn't really know what it was, well I did know what AIP was but I didn't call it that, so I had to ask (name redacted) and she told me, and it's like that … Rogerian thing, you know*
>
> *Me: The actualising tendency*

*09 "Yes, the actualising – it's just the same as that, isn't it."*

This was a very interesting idea because, in my view, AIP is not quite the same as the actualising tendency. As discussed above it is about information processing rather than moving in a positive direction. However, I am interested in the beliefs about the AIP model and what makes something EMDR, together with the need to relate it to a theory that the participant understands.

This theme has highlighted some very interesting ideas for me in terms of my participants' views of what an EMDR therapist needs to know and what is important to them. Some participants believed that technical knowledge was not very important, whilst to others, it seemed to be crucial. I continue to be interested in what level of knowledge marks out an EMDR therapist rather than a therapist in general. I will consider this further in the discussion section.

# Chapter 13.Theme 3: Structure versus Creativity

One of the questions in my interview schedule for this study, concerned how participants felt about conducting a manualised therapy. The rationale for this was that the issue of manualisation might affect how people saw CPD and ongoing learning in EMDR. With a highly structured therapy might people see CPD as less important?

EMDR is by definition a structured therapy. It consists of an eight-phase protocol that encompasses the therapy from the very first moment of meeting the client to the last session. The phases of EMDR are:

1. History-taking
2. Preparation
3. Assessment
4. Desensitisation
5. Installation
6. Body Scan
7. Closure
8. Re-evaluation

There are some modifications to the Standard Protocol for particular client populations and these have been published as a series of scripted protocols (Luber, 1993; 2004; 2018). However, the introduction to EMDR processing, in the phase three assessment, is also scripted. The practitioner is instructed to say:

> What is it you would like to work on today? Is there an image that represents that? Or what is the worst part of the incident? When you think about that incident, what words express your negative belief about yourself now? When you think about those words (repeat negative cognition) what would you prefer to believe about yourself now?

> When you think about that incident, how true do those preferred words feel to you now on a scale of 1-7, where 1 feels completely false and 7 feels completely true? (VOC scale). When you think about the incident and those negative words (repeat words) what emotions do you feel now? On a scale of 0-10, where 0 is no particular disturbance or neutral, and 10 is the highest possible disturbance, how disturbing does that incident feel to you now? (SUDS Scale) And where do you feel it in your body? (Shapiro, 2001, pp. 132-140)

There has been a suggested adaptation to the Standard Protocol which is followed by a number of practitioners, most notably in my participants by Participant 12. This is known as Attachment Focussed EMDR and was developed by Parnell (2013). This is still scripted but misses out the positive cognition and the Validity of Cognition scale and changes the order of the questions to issue to be worked on, emotion, body sensation, negative cognition and SUDS.

Both are clearly scripted protocols. It was, therefore, interesting to find that some participants strongly refuted the suggestion that EMDR was manualised. I questioned how they felt about conducting a manualised therapy with varied results:

Participant 07 said:

> "*When I did the training I was quite happy about the structured nature of it, I like that, I think it's really helpful for trauma in its widest possible sense.*"

However, Participant 09 immediately responded:

> "*that is tish-tosh.*"

This participant initially strongly denied the suggestion that EMDR was a manualised therapy. She later conceded that there was a manual, but that it was not intended to be used slavishly. She stated that it was about being clear about direction:

> *"If you go to the station and you want to go to Edinburgh, you don't just go to the ticket office and say "give us a ticket" you say: "I want a ticket for Edinburgh please." And you might end up going via Preston but you end up in Edinburgh".*

This participant, therefore, saw the structure of EMDR as creating direction but not as being manualised as there could be various ways to get to the destination.

Participant 01 said:

> "*I'm alright with it. I really think the reason it's been designed that way is because it works*."

This participant seemed to accept the concept of manualisation more easily than most, despite her humanistic counselling background. I wondered if this worked for her because her major preoccupation concerned how to give a different option to the clients and integrate EMDR into the service? A manualised approach might suit the population of sexual abuse survivors. 01 was clear that EMDR gave a different option and that many of her clients did not want to talk about their trauma.

Participant 03 said:

> "*I do have a problem with manualisation. I do because I'm a psychotherapist, I really see that as my identity.*"

This practitioner felt that being a psychotherapist meant that following a manual was unhelpful. For her, it seemed that if a structured approach was being followed then this detracted in some way from the skill of the therapist.

Participant 06 said:

> "*There is an emphasis on doing it right – the manualised approach, it gets in the way."*

For this participant, the issue seemed to be that having a manual meant that the manual was right and that anything outside the manual was wrong. This will be reflected on further below.

Participant 05 said:

> *"I don't mind practising a therapy that is manualised, but scripted stuff is a bit too far…like an ATM type of therapy."*

The reference here was to "Scripted Protocols" (Luber, 2004). These are several large books that set out very specific scripts for working with specific populations, for example, people with OCD, depression or dissociation. The participant here overlooked the fact that the Standard Protocol is itself scripted, although experienced practitioners tend to internalise it so that it does not feel scripted. This seemed to be what Braudy (1980) referred to as the associative aspect of knowledge and perhaps reflected Eraut (1994, p. 25) who said: "The process of using knowledge transforms that knowledge so it is no longer the same knowledge".

Participant 04 said:

> *"This is a completely clear protocol and I am a bit purist."*

This practitioner conceded later that she was not entirely purist and did allow aspects of creativity. Interestingly she was one of the participants who were most insistent about creativity.

Participant 02 said:

> "*It can hinder me, deskill me, bring up the not good-enough."*

This participant was the one who did not tend to use the protocol at all. She used continuous bilateral stimulation so it was interesting that she felt that using a manualised protocol would

deskill her. However, she also stated that if a client came with a clear single incident trauma she would use Standard Protocol.

Participant 12 was very clear on this issue:

> *"The term manualised is not helpful, I say "clearly-structured." It becomes a tension if the manualised version becomes the new dogma and you just read out the words. I prefer to talk about the structure and the focus rather than the protocol."*

This participant was the one who used what is known as *adapted protocol*. Adapted protocol has been a matter of controversy in the EMDR community. Her response is interesting as the adapted protocol is still basically scripted. Her desire not to "*just read out the words"* did perhaps reflect a difficulty. In EMDR when people do standard training, they are taught to do exactly that, particularly in phase three.

I recently started work with a supervisee who had been practising EMDR for about ten years. She referred to "*reading from the crib sheet*" and it transpired, when I enquired into this, that she was still reading out the script. She was astonished when I said I didn't use the proforma sheet but asked the questions in my own way and wrote the answers on a plain piece of paper.

I have recently (since February 2020) been training to be a facilitator on EMDR trainings and trainees are specifically instructed to read the words. I can see, therefore, why people would feel that they need to continue to do this.

Participant 10 said:

> *"I don't see EMDR as manualised. Well…I read the frigging manual, but I think CBT is far more prescriptive.*"

This practitioner was very clear that in his practice of CBT there was much more manualisation than in EMDR. He then listed the procedures and protocols that had to be used

in CBT with certain presentations. He was implying that EMDR was much less prescriptive than this.

Participant 11 said:

> *"I think you need to cut your teeth on the manualised approach but further down the line you are able to be more intuitive."*

This seemed to be a powerful idea. A therapist's teeth were cut, through training, to become sharper or more effective. This seemed to express a particular view of the process. His reference to "*further down the line*" was also reminiscent of Participant 010's comments about buying the ticket to Edinburgh. For both participants there seemed to be an idea of therapy going in a specific pre-decided direction, but with choice about how the journey was conducted.

All of the participants in some way referred to being creative with the protocol to a greater or lesser extent:

Participant 07 was clear that:

> *"I'm a creative therapist, unashamedly. But you should always know the standard protocol very well. People shouldn't be too creative before they know the basics. Creativity shouldn't be based on just – erm – instinct."*

For this participant, creativity seemed also to be based on the idea of having a very firm direction and structure. She was clear that instinct was not enough. There was a suggestion that instinct was developed by a very firm understanding of the protocol, perhaps rather like the concept of phronesis.

Participant 09 also said:

*"When you really understand what we think is going on, when you've got your head around it, it enables you to be – a little creative, with, erm, with the protocol. Sometimes you just have to go by the seat of your pants."*

For this participant, creativity was totally bound up with understanding and with associative knowledge; when we know what is going on, we can respond creatively. The "*go by the seat of your pants*" comment seemed to go further than Participant 07's ideas, in suggesting that perhaps creativity was more bound up with instinct.

In contrast, Participant 01 said:

*"You go with your intuition, your professional intuition"*

It was unclear to me exactly how this professional intuition was acquired for Participant 01. This statement also seemed to disagree with those of Participant 07 who said that creativity needed to be based on more than instinct.

Participant 03 said:

*"I have problems with paperwork, protocols…I am a psychotherapist, I don't take history, it comes as we talk. But I admire standard protocol, and I'd go even further, I notice that when I stay out of the way, it does work."*

This participant was referring to Shapiro's (2011, p.147) instruction to stay out of the client's way in the Standard Protocol because Standard Protocol will unlock the trauma network and cause the brain to make associations. So, this participant appeared to be saying that although she did not like the idea of manualisation, she noticed that Standard Protocol did work.

Participant 06:

> *"It's a bit like reading a historical novel or a thriller where the novelist knows their stuff really well, and all the historical details, about guns etc, and then they forget about it and put it to one side. It's about the reader's experience, and the story."*

Again, this participant seemed to be referring to associative knowledge meaning once something was known very well it was assimilated and felt part of the person, although it was still the structured version.

Participant 05 seemed to reflect this saying:

> *"I take history creatively…you talk around it. I suppose that's why I don't like the scripted stuff, but I will get answers to all those questions."*

Participant 04 said:

> "*It gives me the freedom to be in my creativity."*

She had also earlier referred to herself as a "*purist*" but here implied that this might not entirely be the case.

Participant 12 was clear that:

> "*if you get the structure right you can then do anything."*

The sense here was that, for Participant 12, the structure was clear but it became a place that people could jump off and do different things.

Participant 08 said:

> "*I keep to the protocol – but then I improvise. It's like a classical musician just keeps to the notes, but a jazz musician adds to the music and improvises. I do all that, but I don't do it necessarily in a very rigid way."*

Participant 08 seemed to be comparing herself to a jazz musician and suggested that although she said she kept to the protocol, she might add or take away from it as she thought

appropriate. Interpreting here, I had a sense that the jazz musician was felt to be somehow cleverer than the musician who just stuck to the notes. That being a classical musician somehow might be experienced as boring and that adding something of one's own was more exciting. I was slightly unclear about what the participant meant when she said: "*I do all that*". Did she mean that she both kept to the notes and added to them?

Participant 11 said:

> "*You need to be intuitive. This is where you can get really skilful, isn't it?"*

Again, this participant came back to the idea of intuition. For him, skill was based on the therapist's ability to be intuitive. It was not entirely clear what intuition was based on for him and again there was a disagreement with Participant 07 who said it was not enough just to be intuitive.

This theme was, therefore, a little confusing in that all the participants (except Participant 02) accepted the nature of the Standard Protocol and stated that they used it. Many of them expressed disquiet with the notion of scripted protocols, although there are several large books of these. Many of them talked about the possibility of creativity but seemed to suggest that it was still important to stay within the structure of the Standard Protocol, there was a belief that at some level the Standard Protocol was in itself creative.

This brought the whole question of what being creative meant up for me. What was the basis of creativity? Participant 07 said that creativity should not be based just on intuition. On what then should it be based? I returned to the quote from Vetere and Stratton (2016, p. 27): "creativity is about finding ways to insist on continuity of the exploration by using curiosity to find unanswered questions".

I wondered if, in a sense, the notion of creativity was actually being used to close down on questions, and whether McCaffrey's (2012) *functional fixedness* was at work here. There has

to be a question about the role of creativity, in a therapy that is evidence-based and backed by research. Was the therapists' apparent belief that EMDR was efficacious in its own right related to why they felt that they had to be creative?

I wondered if they saw creativity as the process wherein the EMDR protocol became so embedded in their own process that it was simply how they operated? I, therefore, wondered how creative people were actually being. Was creativity simply an aspiration, or a sense they had of themselves as a therapist? This was contradicted by the idea of following a manual or a protocol.

My own view is that creativity in EMDR is limited by the extent to which I choose to use a variation on the Standard Protocol for a particular client presentation (such as phobia or OCD). I also believe that the use of the interweave offers a major possibility for creativity. This is part of the Standard Protocol but allows the therapist to decide when simply saying "go with that" at the end of the self-report after a set, is not enough and the client needs some other intervention. I am surprised that no therapists mentioned interweaves as an element of creativity, but they may have simply assumed this.

In EMDR, some individuals, including Shapiro herself, have seen the need to change the protocol to work with particular populations. These include children and adolescents, those who dissociate, people with addiction issues, or problems such as bereavement, OCD or depression. All these adaptations then become scripted protocols. I am unsure, therefore, of where creativity can be used here without changing the nature of these protocols. I wonder if people saw creativity as being in the choice of protocol or issue to work on, or in what order to address issues of the past, present and future?

The metaphors used by some of the participants were interesting. Participant 08 talked about the classical musician and the jazz musician. The classical musician kept to the notes as

written but the jazz musician improvised and added to them. This participant suggested that the practitioner needed to add to, or take away from, the protocol as indicated by the needs of the client.

This suggestion was particularly favoured by those participants who were attracted to the work of Laurel Parnell. Parnell took away the positive cognition and the VOC scale from Standard Protocol and added in some other elements. However, the participant who talked about the jazz musician also said that she had never heard of Laurel Parnell, which was a surprise to me.

Participant 06 talked about the therapist being like a historical novelist who knew the background very well but that it faded away with the story. My interpretation of this comment was that the participant felt that the therapist needed to be very knowledgeable but that the ability to relate to the client was the most important factor.

Participant 12 said:

> "*If you get the structure right, you can then do anything*".

The difficult issue here was that it appeared to be problematic for therapists to agree on exactly what the structure was. Participant 12 was a strong follower of Laurel Parnell, who proposed a different structure to that of the Standard Protocol. She accused the EMDR Association of being too fixed on the Standard Protocol, but what then stops people from becoming fixed on modified protocol? Participant 07 expressed her disquiet that people in EMDR were advertising for Attachment-Focussed EMDR therapists rather than just EMDR therapists. There could be some indication here of a fixation on the Modified Protocol.

In asking this question, I wondered if peoples' attitudes to manualisation or standardisation would affect how they saw CPD. This seemed not to be the case. All practitioners seemed to

accept that it would be necessary to learn how to adapt the Standard Protocol for specific clients or presentations and that this did need to be learned.

My sense of this theme, structure versus creativity, was that my participants, who generally held the therapeutic relationship as being very important, saw the relationship as the creative aspect of the work, which mitigates any aspect of manualisation.

I think these are fascinating issues that need to be discussed more in the EMDR community.

# Chapter 14.Theme 4: Accreditation and CPD

As my research question was about EMDR therapists' experience of CPD and what they thought that they needed to know, I asked about accreditation as this affects the amount of CPD people are required to do.

It may seem strange to isolate CPD within a theme as the whole question involves this. However, although the other themes also reflect what people think is necessary in terms of knowledge and CPD, I felt it was important to isolate the sections on CPD.

## Accreditation

Accreditation in EMDR is undertaken when the practitioner has had at least a year's experience of using EMDR after standard training and when they have undertaken around 20 hours of supervision. It is a significant theme for this study as it is associated with CPD in EMDR. There are some anomalies around the expectations of accreditation. For example, practitioners are required to show evidence of having worked with at least 25 clients over 50 sessions. The session number is an anomaly as no experience of EMDR could be fully completed in two sessions.

People are frequently turned down for accreditation for not showing enough client hours, but the hours may still sit within the requirements. Additionally, accreditation is awarded through a competency-based framework, but frequently practitioners expect that if they have 25 clients and 20 hours of supervision, they should be put through for accreditation. A further requirement is that consultants must see samples of the candidate's work, either in vivo or through recordings.

The decision for putting a practitioner forward for accreditation is made by the supervising consultant. Consultants thus have a great deal of power and authority in this process. Where applications are refused by the Accreditation committee, it is always because of technical

issues, for example, not having enough hours, or cases from a previous supervisor not having been signed off. I have never known a case where a consultant's recommendation was called into question other than on technical issues.

People therefore sometimes experience difficulties in gaining accreditation and may find themselves in conflict with their consultant. The process is not a simple one, it appears in some ways to be quite technical but is also, as a competency framework, dependent on the judgement of the consultant.

Participant 09 said:

> "*It was messy, a rocky road. I wasn't ready to be a consultant. I did the worst consultants training ever. It was a challenge"*.

This participant reflected on her own experience of and the difficulties of putting others through, accreditation:

> "*Some people think they're fantastic when they're not, and some people think they're rubbish and they're great."*

Participant 01 said:

> "*It was a bit faffy. Frustrating because of confusion about standards"*.

This practitioner, although unaccredited at the time of the interview, had actually submitted her accreditation twice. She had been turned down because of not having enough clients who had completed the full eight phases of EMDR. She clearly felt that the process was confusing and that her consultant had not been clear enough about the process.

Participant 03 was opposed to accreditation:

> "*I don't like how it is done. It doesn't guarantee any particular talent… It would kill my creativity. I would worry about saying what is expected and never actually doing what is expected*".

This participant was absolutely adamant that she would never apply for accreditation. She had a clear view that accreditation did not suggest competency and that it would "*kill my creativity*". When I said that many accredited practitioners would see themselves as creative, she conceded this but felt that the process would involve her having to claim that she did things which she did not.

Participant 06 had had a difficult experience of accreditation.

> *"It was painful, I felt talked over and deskilled…I was really cross. It was unprofessional.*"

This practitioner had clearly had a bad experience when the consultant she was seeing had not allowed enough time to view her work. She said:

> "*but he did pass me, he couldn't not, really*."

The same practitioner also felt deskilled with her current consultant and unclear about what was expected.

In contrast, Participant 05 said:

> *"It was really good for someone else to see my practice."*

This practitioner had had a different experience and clearly found it useful for someone to be monitoring what she was doing.

The comments seemed to suggest a certain amount of confusion over accreditation. Participant 10, who had had knowledge of the accreditation process for many years, said:

*"The Accreditation Committee have become very hawkish recently…it's like they are thinking: "Oh my God, what happens if we accredit someone and they kill their patient?"*

He suggested that the committee felt a large degree of responsibility, whereas, in fact, the responsibility appeared to lie with the consultant.

It was interesting that generally, most participants seemed to feel accreditation was useful. However, there were concerns over it and a number of participants who had undertaken accreditation had not enjoyed it.

Participant 12 said:

*"This is the tension. On the one hand I found it an extraordinarily rewarding experience, but the EMDR Association is not an accrediting body, it has no right to be accrediting people, it takes no ethical responsibility for the practice of its members…the tension here is as I went to practitioner and did my consultants' training is that it was one of the most rewarding professional experiences of my life…I came out of the process already a better practitioner, but I think it was a very flawed process. There's a complete absence really of oversight as to how consultants are working, and the Association is not kitted out to do that, really the Association is run by a bunch of well-meaning amateurs – they are professionals, but in running an organisation they serve on the Board in their spare time, and EMDR is far too important to be managed in this way. But getting the Consultant's accreditation was possibly the most rewarding professional experience of my whole life, including getting a double first at university. When I got the Consultant in 2011 it was profoundly rewarding and I felt sort of validated and competent - not necessarily that I was, but it was a watershed."*

This participant had very clear criticisms of the accreditation process but had also found it personally very rewarding. It was at this point of the interview, when she commented on the Board being a bunch of amateurs, that I decided to tell her that I was now on the Board. I thought that she would be embarrassed if she found this out later. I wanted to ensure fully informed consent had been obtained. Participant 12 was my final interview and I had become a trustee on the Board just two months before. During the other interviews, I had not been on the Board.

The comment that there was very little oversight into how consultants worked resonated with my own comments in my recorded interview. I think this is something that the Association needs to look at. I recognise that, in terms of generalisation and validity, I have a small sample and it is difficult to gain concrete ideas of what the Association should look at, but I believe that there are sufficient other views on this to warrant making it a recommendation.

At the time of writing there had been a recent conversation on the EMDR Jiscmail (May 2020) about accreditation, together with a complaint that only accredited practitioners and consultants were listed on the Association's "Find a Therapist" feature. A number of respondents on the Jiscmail felt that all trained EMDR therapists should be listed as fully trained. There was an interesting discussion around this, with some members saying that they felt they were being "disavowed" by the organisation as not competent.

This was clearly interesting as standard training, by definition, does not make people competent in EMDR. People can train and not have supervision and be doing their own version of EMDR which does not match the Standard Protocol, as with Participant 02. I would not question that Participant 02 appeared to be doing good and effective work but would question whether the Association could endorse someone who was not following the Standard Protocol.

This brings up very real issues for the Association and whether it is actually an "accrediting" organisation. Participant 12 questioned this and said that although she supported accreditation, she felt it should be referred to as certification as the EMDR Association was not a fully accrediting body.

The issue of people being accredited is significant because, before accreditation, no specific CPD is required. After this point practitioners are required (from January 2020) to accrue 75 CPD points over five years. Only two-thirds of these are required to be EMDR specific.

**CPD**

Most participants referred to CPD in very positive terms, although there was an interesting degree of vagueness around what they had actually done and learned.

Participant 07 said:

> "*I really enjoy it, it's a treat for me."*

She expanded on the CPD she had actually done:

> *"I've done loads. I like Dolores Mosquera, who I've seen a couple of times, I saw her in Milan and I thought "Now this is amazing." I always go to the Conferences, since I trained I've been to, oh, about three or four I suppose. I like Andrew Leeds, but I saw the thing on positive affect tolerance, it's quite interesting but I haven't really been able to use it successfully – not quite sure why."*
>
> *Me: You haven't been able to use it because you haven't had the clients, or…*
>
> *007: I don't know. No, I've had the clients but I think sometimes I try to use an idea but if it doesn't work very well it kind of puts me off. There's just so much to learn really."*

Participant 07, therefore, thought that it would be useful to be able to use the training she had. However, perhaps her experience was that short trainings were not always enough to give her experience in the various techniques. She went on to say:

> *"Sometimes the workshops are really good value and really interesting and sometimes they're not. I go between trying to do a lot of reading and then going to some workshops."*

My sense then was that Participant 07, having started out talking very enthusiastically about CPD and calling it a treat, then began to reveal some misgivings. She was very enthusiastic about Europe Conferences and particularly keen on the trainer Dolores Mosquera. I pointed out to her that on the day we had the interview, Mosquera was doing a training in the Midlands. Participant 07 responded that she had considered going to this but felt she had seen her doing this training before. She had, however, encouraged her supervisees to attend this training.

Participant 09 said:

> *"I've done loads of CPD and it's really useful but I don't always have the clients and if you don't use it you lose it*."

This person was referring to the fact that a lot of EMDR CPD refers to work with specific client groups such as people with an addiction issue and she did not always work with such clients. She had, however, done a lot of CPD:

> *"I've been to every UK Conference since 2010. Nearly every Europe Conference…because I like it, I like finding out about the things that are presented…I've done a lot of ego-state work, I went to America for it because I didn't want to do it in my own backyard, so I've been to a couple of week-long workshops on ego-state stuff in America. It was really good and incredibly useful."*

This participant also talked about the CPD she had not found so useful:

> *"I wasn't that thrilled with Sandra Paulsen. I did her ego-state stuff and the Sensorimotor thingy, there were a couple of things in it but for a weekend I didn't really take away enough."*

This participant previously referred to not doing things in her own back yard. She later said that she struggled with the idea that some therapists only did CPD in their own small local groups. She thought that this was why the Association had insisted that, for reaccreditation, people must attend a Conference so that they got access to wider thinking.

Participant 01 said:

> *"I probably go to at least two events a year and have done for the last four years. By a longshot they are the best bits of CPD that I do with my job, in fact I probably don't do much other CPD at the moment. They tend to be tangible, they deliver, I tend to learn things, I always appreciate the chance to go back to the basics, why we're doing it, why it works, why we think it works."*

This participant appeared to be very enthusiastic about her CPD. Interestingly, when asked more about what she had actually done she was very vague:

> "*I really can't remember what I did up in Bristol but I was there for two days".*

She was able to name some presenters but was very unsure about what she had actually done. She also talked about doing CPD locally and not going to Conferences because they tended to be a long way away and expensive.

This criticism of CPD as expensive and London centric was a prevalent one.

Participant 03 said:

*"I've been to a lot of conferences, I went to several of the Attachment-Focussed things, or the – what do you call it, interpersonal, because it's quite close to systemic, I think. I've done a lot, I've been to Jamie Marich several times. I just adore training days. I've got the books but I want the training days…the one in Norfolk, that was amazing, it was long, it's always too short for me, and it was not just that, it was the setting, it was in the country and you could really go into serious stuff. Because I am a therapist, and it was in action, and there was a lot of room to talk, to think, and it was three, was it three? Four days? That one stands out, because I came away thinking I've got to do more, I've got to do some for me."*

This therapist also pointed out that training was expensive and that this was compounded by the need to stay somewhere.

Participant 06 was also a little vague about the CPD she had actually done:

*06: "I've done very good training but can't always remember …The most recent was a couple of weeks ago … it was very good"*

*Interviewer (LM): What was it on?*

*06: "Oh gosh, I can't remember."*

She also said:

"*What I have recently noticed is that there is a tendency in EMDR to call something a workshop when it is actually a lecture."*

I found this an interesting comment. The EMDR Virtual Conference in June 2020 indicated that there had been confusion between keynotes and workshops that had very similar content.

Participant 05 looked for training on issues that came up. She was only interested in training if she had a client whom it spoke to. She said she was not interested in doing things she didn't

want to practice. She had a very clear view that people couldn't be good at everything. She felt it outdated that there were no online CPD points. (As of May 2020, this is no longer the case). Her view was that the Board did not really encourage people to present at Conferences or do trainings as they did not get additional CPD points for doing so.

Participant 05 was unique amongst my interviewees in that she mentioned trainings she had done and then told me stories about the clients she had worked with where the training had been helpful.

She was very critical that online training was not, at the time, accepted by the EMDR Association:

> *"I think that's so outdated it's unbelievable, really it is. Having said that the online training I did was absolutely awful, so much so that I complained."*

It was interesting that many people spoke about the prohibition of online training. As of May 2020, this is no longer the case because of Covid-19. The EMDR UK Board decided that this would be reviewed but it is very difficult to imagine that it could now be reversed. At the time of writing, however, the agreement for CPD points for online workshops had been extended only to the end of 2021.

Participant 04 said:

> *"I love it, I've loved the CPD locally, often CPD is a way away, so I think: "Have I done everything that's here?" So I've been loyal to the CPD here, it's interesting, when I learn from a CPD, how I put it into practice, how I develop that muscle."*

This practitioner, in using the metaphor of developing muscles, seemed to be talking about how she actually embodied the CPD that she undertook. She also had some criticisms:

> *"I want to do the Intergenerational training, but I think you have to have done the Laurel Parnell training, so I just think: "Well, why is that a condition?" If I want to*

*do that training, and it sounds like it's quite an open, explorational day, workshop…I'm going to be doing Flash, well I think I am, I haven't quite decided, suddenly it feels like there is so much."*

She also talked about going to CPD when she had not really been emotionally available:

"*I did one working with OCD. It was in Nottingham and my dad died that day in Sheffield, so I was really, I really wasn't there."*

Participant 04 also talked about going to the European Conference in Edinburgh in 2014:

*"I loved Edinburgh, it felt fantastic, I really loved it. The training I really love, that really energises me, is really interactive, so Joany Spierings at Edinburgh was absolutely spectacular and I loved her, you know, so she's the person I remember and I think the Conference is really good and I haven't been to one since."*

I was interested that this participant was so enthusiastic about the Edinburgh Conference but had not then repeated the experience. She did comment about the expense of CPD:

*"It would be easy to spend an awful lot of money on EMDR CPD so I think I kind of prioritise it with whatever emerges."*

This participant also commented that there had been a lot happening in her personal life and she had not been able to focus on CPD. In my initial interpretive comments, I wondered if her experience of being at a CPD event when she heard that her father had died had affected her ability to attend CPD.

Participant 02 reported that she only did CPD online as this was more convenient. The advantage for her in not being accredited was that she did not need CPD points. She could, therefore, do whatever CPD appealed to her without worrying whether or not it had points. She clearly valued CPD but did not want to be constrained in the way that she undertook it. She talked about the online training she had done with Sandra Paulsen:

*02: "I really enjoyed it. I think it's excellent. It's comprehensive, it's accessible, er, you have access for a year so I actually find it better than your normal training because you can go back. Not all the courses do this online. I mean sometimes it's a one-off or you can watch on live webinar, but what I liked about this, and why online training, is I can do it in my own time, I can digest it, I can rewind it, I can back up and watch. It's cheap, much cheaper than going to London. So it's accessible, in terms of time, energy and money, er, so, it's actually…you know, if there was more online training I'd be very happy to do it."*

*Interviewer (LM): "How would you choose if you were to do more?"*

*02: "Purely on what interests, what comes up, what issues come up with clients, so this is client-led. My first port of call would be to see if there is stuff online. I'd consider going and doing a day or two somewhere, but probably no more than that in terms of travelling, but my life and circumstances now, in terms of energy and choices, but I don't feel that I need to add more qualifications."*

This participant also talked about having taken a year out in 2016 for medical treatment. When I first asked her about CPD she said:

*"Previously most of my CPD was through the supervision group that I was part of, but then I took a year out in 2016 and stopped attending. I noticed that in the training in Part three they were the first ones to talk about structural dissociation theories and I mean, I don't know, that's not specifically EMDR but I've done that workshop."*

I was interested here in the participant's sense-making of CPD. She understood supervision to be a part of her CPD experience. There seemed here to be a misunderstanding of EMDR CPD. Supervision is not considered part of CPD.

Participant 10 also referred to this idea when he said a regional group had asked him how to get CPD points for a supervision group. It seemed that this needed to be made clearer by the Association.

In trying to do an IPA study here, however, I am very aware of trying to understand what these experiences were like for the participants, and it seems that a lot of requirements in EMDR are difficult for people to understand.

Participant 10 also said that it was difficult to find stand-out CPD. He felt that CBT CPD was better. He felt that often people attended CPD because of the name of the person, but for him, it was about the topic. He talked about being bored by having seen basically the same training over and over again.

> "*I don't know how to say this without sounding cocky, but they don't tell me anything really, not a great deal, so I just go to get the points basically. I mean, Jim Knipe, if I see "My Toolbox" again I'd run a mile, see him coming a mile. You know, I've seen it fifteen times, the back of the head scale approach."*

He mentioned some particular trainers as doing good workshops:

> *"Complex trauma stuff I find interesting to a degree, but at the end of the day they are all saying the same stuff, but slightly differently really, you know. If we are talking about what I like in CPD – they happen occasionally, is updates on the protocol for newly qualified people, I think they are very useful."*

Here this participant seemed to be reflecting more on the efficacy of CPD for his supervisees than for himself. There was a sense, for him, that he had done it all.

This practitioner was the most experienced therapist I spoke to and he also provided CPD himself. He clearly felt that he had seen most of the training on offer. He listed trainers that he felt were effective, but immediately told me that the names were "off the record". I found

it interesting that the more experienced therapists were worried about mentioning trainers, even in a positive way, where the less experienced therapists did this readily.

Participant 12 had strong views about CPD:

> *"My general experience is that the CPD is too theoretical. It's very good to have presentations on research, but the CPD misses the absence of fundamentals in the early training, which is practice and experience. I think all EMDR practitioners should have their own experience of EMDR. So I think there needs to be a much greater emphasis on essential supervision – CPD if you like, between parts one and two."*

This was interesting in light of the discussion above. Participant 02 considered her supervision group to be CPD, but this was not recognised by the Association. Participant 12 suggested that supervision should definitely be seen as CPD.

> *"So I think there needs to be a much greater emphasis on the requirements for supervision, because coaching and training takes place in supervision and I have to pick up the pieces with my supervisees after basic training, because they've got the basics, about the first 20%, but the 80% they learn in supervision."*

As a consultant, Participant 12, like Participant 10, seemed to be much more concerned about CPD for others than for herself, although she said:

> *"I've got CPD coming out of my ears,"*

It was true that both Participant 12 and Participant 10 provided CPD for others and therefore perhaps felt less in need of it. However, both regularly attended National and European conferences.

Participant 12 was very critical of the brevity of standard training. She felt that practitioners did not know enough after training:

*"I think it's unconscionable that people can do parts one to three without scarcely having done any EMDR on clients or without any supervision and no experience of EMDR themselves yet they can then advertise themselves as EMDR therapists and they basically haven't a clue of what they are doing. You know, it's dangerous, it's unethical and it's dangerous. The EMDR Association needs to take proper ethical responsibility for the practice of its' members, it needs to grow up and become a proper fully-fledged organisation."*

The issue of people needing additional training following standard training was picked up very definitely by this practitioner. She said she thought that 80% of the learning was in supervision and practitioners only got 20% of needed knowledge from standard training. This informed my belief that the Association needed a syllabus of training for people following standard training.

Participant 08 said:

"*I went to Kent but I didn't learn a lot, people asked very basic questions I could answer myself.*"

She also said that CPD cost a lot.

*"I have never been to an annual conference. I mean, I know it sounds awful but they are quite expensive"*

It appeared that she was not aware that as an accredited practitioner she was required by the Association to attend at least one Annual Conference in five years as part of CPD.

She reflected on the EMDR Child and Adolescent training that she had done:

*"I enjoyed it very much, and I was…I think if you are doing CPD and you pay a lot you expect more. And it was fine. But I have got other things. I mean, I have got all*

*my other professional organisations, you know, UKCP, Institute of Family Therapy, so before I start thinking about anything I pay a lot of money."*

She expressed a view that she did not want CPD to become a chore, rather than something she did gladly (taking me back to my original title of "a duty or a joy".)

She also was annoyed there were no CPD points for online training:

"*I don't want to go somewhere because I need CPD points, I want to go somewhere because they are offering something I want."*

Participant 11 felt that EMDR CPD expectations were quite high. He stated that 75 points, a Conference and a Consultants' Day (the requirement for consultants), was quite a lot and considerably more than required by BABCP:

"*CBT doesn't expect this – they have brought expectations down. There are too many hoops to jump through."*

This practitioner had to get an extension for his last re-accreditation because of life events. He found himself doing things he wouldn't otherwise have done but enjoyed them. He stated that he did the training in the Feeling State Addiction Protocol that he never normally would have and that he found it useful. He also talked about conferences:

*"I love the Conferences, I like being absorbed into that sort of environment, and er, the trouble is that there is too much going on in too short a space of time, but er, I enjoyed Michael Patterson, about working with parts and about how one part wanted to be excluded and not to go down that road."*

The issue of CPD points appeared to be very thorny. EMDR therapists who are accredited are required to accrue 75 points over 5 years. CPD points are awarded by the EMDR Association for approved trainings which are exclusively EMDR. Typically, a day's training will be awarded 6 CPD points. The requirement over 5 years, therefore, commits a practitioner to an

average of two and a half days a year. At the same time, as a third of the CPD can be non-specific to EMDR, this reduces the points requirement to 50 over 5 years, which is less than 2 days a year. It is important to note that, unlike other bodies like the BACP or the UKCP, the EMDR Association will not recognise activities such as reading as CPD and will only give points to specific training activities.

In March 2019 there was a great deal of discussion around CPD on the "Jiscmail" which is an online forum intended for the dissemination of research and information, but which is used by some members as a kind of chat forum. There was considerable criticism of what were seen as excessive demands. Also, members were very unhappy about the fact that online CPD was not given CPD points.

Participant 05, for example, felt that this decision was incredibly old fashioned and that the EMDR Association was not operating in the real world.

There was an interesting disagreement between Participant 10 and Participant 11, both consultants and both members of the BABCP. Participant 10 felt that the requirements of the EMDR Association were "easy" and that the BABCP required considerably more from its' members. Participant 11 said the opposite.

I was interested in the perception that many members seemed to have, that the requirements of the EMDR Association were excessive. My CPD requirement for the UKCP is 250 hours over 5 years, as opposed to 75 for EMDR. People do not seem to complain about the UKCP.

Even the BACP requirement is 30 hours per year, which is twice the EMDR requirement. I wonder if people feel this is excessive because they see it as "extra" to their other commitments? It can, of course, be included for the requirements of other organisations, so my sense is that perhaps the Association has not been very good at explaining the requirements to people.

My participants had attended a wide variety of training including many standard courses. Half of my participants mentioned training in Attachment-Focussed EMDR which is the work of Laurel Parnell.

**TABLE 10**

*NUMBERS ATTENDING CPD TRAININGS*

| Presenter | Number mentioning |
|---|---|
| Laurel Parnell | 6 |
| Mark Grant | 3 |
| Philip Manfield | 5 |
| Ana Gomez | 2 |
| Robert Miller | 4 |
| Gus Murray | 1 |
| Derek Farrell | 5 |
| Paul Miller | 1 |
| Dolores Mosquera | 3 |
| Mel Temple | 2 |
| Regional Events | 8 |
| Conferences | 6 |
| Jim Knipe | 2 |
| Andrew Leeds | 1 |
| Jamie Marich | 2 |
| Sandra Paulsen | 2 |
| Robin Shapiro | 1 |
| Justin Havens | 1 |
| Robin Logie | 1 |
| Pam Virdi | 2 |
| Matt Wesson | 2 |

Table 10 is very interesting as although most participants mentioned Laurel Parnell, only half appeared to have actually trained with her or her UK representative. Two-thirds of the participants mentioned regional events, but only half actually mentioned conferences. At least

eight of the participants (those who were accredited) had a requirement to attend at least one Annual Conference every 5 years. However, some of the people who did mention conferences clarified that they had attended several. One person (Participant 09) said she had attended every Annual Conference and almost every Europe Conference in the last 10 years.

Overall, the experience of CPD was perceived as positive, but there were strong aspects of seeing it as a "duty" or as simply a means to obtain necessary points. This seemed to be experienced by some practitioners as a pressure, which lead to people not wanting to be accredited so that they did not have to follow the requirements.

# Chapter 15.Theme 5: Right vs. Wrong

In asking questions from my interview schedule about CPD, accreditation, manualisation and what people thought that they needed to know, a theme emerged around the question of applying the therapy correctly or getting it wrong. This theme seemed to be powerful for many participants.

Participant 07 was one of the four participants who showed no evidence of this theme. She was very clear of her position as an EMDR therapist and did not seem to display concerns about right and wrong, although she did say that confidence could be an issue for her.

Participant 09, however, talked a lot about getting it wrong:

> *"I wasn't ready to be a consultant – I was doing the safe place wrong. When I went back to the safe place at the end I was using bilateral stimulation. No need for it if you have got the trigger word. People need to understand technicalities."*

In the interview, as I was listening to this, I felt a rush of shame. I, similarly a consultant, had also been using BLS in going back to the safe place at the end of a session. I had a very visceral sense that I too was "doing it wrong"

She also discussed times when the Standard Protocol may have needed to be changed, but there seemed to be a contradiction here:

> *"You might abandon it (standard protocol), but I wouldn't because I wouldn't need to."*
>
> *"(Standard Protocol) is like the Highway Code. If the red light's on you stop, and all those things, but when you, when you can drive you stop thinking about the highway code… but you still have to stop at a red light."*

In my interpretation, I wondered if she really did see the Standard Protocol as a specific thing like the highway code. Generally speaking, this is the law, even if you don't think about it. I wondered she did in some way see the Standard Protocol as the law. This would create very powerful themes around right and wrong. This participant was a Consultant, so her belief that the Standard Protocol was "the law" may well have affected her attitude to CPD and what she thought she, and her supervisees, needed to know.

Participant 01 seemed to have no themes around right and wrong. I could have interpreted her sense of not achieving the accreditation to have been about this. In fact, she simply seemed to have a sense of irritation about the requirements and no particular idea of getting things wrong. She interpreted her inability to get accreditation twice as a misunderstanding about the requirements on the part of both herself and her consultant, but with no obvious value judgement.

Participant 03 said:

> *"I think I like to think I don't do what I'm told."*

This therapist didn't talk much about right and wrong because she saw herself as a rebel. She felt that the Association would interpret her as doing things wrong but that she didn't want to face this scrutiny. The interpretation of herself as someone who did not want to be told what to do appeared to be a very strong identity.

Participant 06 said:

> "*There is an emphasis on doing it right. The manualised approach – it gets in the way."*

Participant 05 did not seem to have anything in her interview that related to this theme. She had a very strongly practical approach. She told a lot of stories about how she related the approach to her clients so the whole process seemed to be very pragmatic.

Participant 04 said:

> "*I'm a very cautious person and it was such an unusual …that I couldn't trust myself with it. I was feeling that I wasn't experienced enough."*

She went on to say:

> *"there was this thing about getting it right, you've got to get it right. You shouldn't be doing this if you're doing that. I'm not academic."*

In my linguistic comments on the original transcript, I was interested in this participant's connection between being right and being academic. She seemed to imagine that she had to be academic to get things right. Her definition of what being academic meant was a little unclear, but she referred to her belief that when she trained as a therapist over 25 years ago:

> *"It was enough to be just sort of a compassionate person, but now you have to be academic."*

The sense that there was a connection between getting the protocol right and being academic seemed to be strong here. I found this interesting as actually, the fact that EMDR is highly manualised might suggest it is not academic. There is not a great deal of room for interpretation, except in the areas of case conceptualisation and target prioritising.

Participant 02 said:

> *"I should let go of "I'm not doing this right." It feeds in to my general:*
>
> *"I'm not good enough.""*

This participant clearly had some sense of "doing this right". However, she freely admitted that much of the time she was doing continuous bilateral stimulation, not EMDR. By not following the training she had undertaken, she was setting out to do something that might very well have fed into a propensity to feel not good enough. It seemed though, that this

feeling was not strong enough to stop her working in the way she had clearly decided was best for her.

Participant 12 felt passionately that the EMDR Association had set up a system that defined what was correct and acceptable and cast other ideas out. She referred to the Association as being like "*a church, a cult… a communist party"* and suggested that the EMDR Board had set itself up to protect the "*purity of the protocol*".

She clearly saw herself as being seen by the Association as wrong and had experienced a great deal of hurt about this. At the same time, I sensed a kind of pleasure in being different and being seen as a dissident.

Participant 10 did not have a strong sense of this theme. He did, however, discuss an instance when he was facilitating training in the very early days of EMDR. He described feeling that he was being followed around by a particular trainer to check that he was working correctly. His conclusion was:

> "*they soon realised that I have a reputation to keep and not to lose."*

Participant 08 said:

> "*Do I do it right? I don't know. But when you are accredited you basically know what you are doing"*

This participant strongly discussed the idea that other people didn't do it right or tried to get away with things. The statement suggested that she thought she did "do it right" as, as an accredited practitioner, she must "*know what she is doing*".

Participant 11 said:

> *"In training you're told, "here's the direction you need to go in. This is the direction." But some people do it differently."*

This participant seemed to feel that doing it differently was fine. As a consultant, he appeared to have a rather relaxed attitude towards what should be seen as acceptable within the Association. This participant also felt that breaking away was common in therapy and that in EMDR it was likely that there would be groups separating from the Association.

The lived experience of participants here was varied but there seemed to be a strong sense of needing to conform or of rebelling against this tendency. The very strong language used by Participant 12 when she described herself as a lone wolf shooter who needed to be taken out, accentuated her sense of being seen by the organisation as wrong.

This theme applies to CPD and knowledge in that there was a sense that some CPD was experienced as being “wrong.” Participant 12 in particular had a strong sense of this, and this will be discussed further in Chapter 18 under the theme of Schism.

# Chapter 16.Theme 6: Love versus Fear

> There are two very different ways of journeying through our professional lives. One is with fear; fear of not being in control, of getting hurt or lost and of being wounded or judged. The other is with love, love of our patients and ourselves, love of the uncertainty, opportunity and unknown (Owen, D. 2008, as cited in Shohet, R. 2008 p. 68).

This was a sub-theme from right versus wrong, but it seemed to have some life of its own. My sense of this was that there was a fear of what would happen if a therapist "got it wrong". The quote above put this very eloquently in the sense of people being afraid of being hurt or lost or out of control. Participant 03, who was very insistent that she did not want to be told what to do, said that she feared being unsupported by the Association if she had a complaint made against her and was not accredited.

> *"I think one of the arguments is fear, as in what if something happens? Like there is a serious complaint, you know, and would I, would I be dropped like a hot potato if I didn't make the effort to be accredited? If I become accredited I become part of that community."*

Although Participant 03 did not want to conform to the rules of the Association, she did want to be protected by it, so seemed to have an ambivalent view. She was able to identify fear.

Participant 12 had clearly lived with a great deal of fear. She referred to herself as "*a lone wolf shooter, who the Association had to take out*." Her belief here seemed to be that she was a very dangerous person and the Association was afraid of, and so wanted to remove, her. It could be argued that members of the Association were experiencing the fear that what was being suggested was changing and diluting the Standard Protocol.

Participant 12 retained a lot of fear that she was not part of the prevailing culture, whilst at the same time not wanting to be. She also felt that she had to tread very carefully. She expressed a fear that in the Association people were shamed into using Standard Protocol. She also discussed the idea that Shapiro herself felt under threat from people attacking EMDR from the outside:

> "*Shapiro and those around her have felt the need to hold on to the purity of the model because they felt much more under threat. You could make the argument that there were people who wanted to destroy EMDR."*

Participant 10 also referred to the EMDR Association as being fearful:

> *"I think the Accreditation Committee has become very hawkish…it's like they think: "Oh my God, what if we accredit somebody and they kill their patient!"*

The fear was referred to as a concern from the trustees on the Board; that they could get things wrong and cause a great deal of trouble. My observations from being on the Board were that Trustees rightly took their role very seriously, but this did bring up the fear of legislation or being seen to be negligent.

It was interesting that there seemed to be many different types of fear here. Participant 04 talked about her fear of disturbing images and that the work would be too much for her. She described herself as sensitive, seemed to be afraid of the work itself and feared that exposure to a high degree of trauma would overwhelm her.

Participant 01 talked about the fear of the therapists in her service. Somehow, they might be betraying their original training by doing well at EMDR.

> "*My EMDR is going well …and that confuses me."*

She described these therapists as person-centred therapists who were committed to their own theory and felt that they were going against it by practising EMDR.

These many different types of fear also had the flipside of love. The participants strongly expressed their commitment to EMDR and their clients and the belief that EMDR could be of amazing benefit to their clients. It seemed to me that most EMDR therapists felt this commitment created the fear because they were fearful of letting their clients down, as well as of being hurt or humiliated.

This theme contributes to the work around CPD and knowledge in that if people are experiencing fear, they will be less likely to be able to benefit from learning and to develop their knowledge.

# Chapter 17.Theme 7: Being versus Doing

This theme is important in my analysis of EMDR therapists' experience of CPD and what they think they need to know, as it feeds into the initial theme of the exact nature of EMDR. There was a tension between the wish to be relational and the structured and "doing" nature of the therapy. Eight of my participants (two-thirds of the group) referred directly to this theme.

This was a powerful theme for EMDR therapists as there might be a sense that EMDR was "doing something to people". There is currently a massive debate in the community about whether the therapeutic relationship is necessary or not. Some therapists in the Netherlands are trying to prove that it is not by doing intensive therapy where clients have sessions with a different therapist each time (EMDR International Association, n.d). This seems to me to be establishing EMDR as a technique and not a full-blown therapy. It is interesting that although the therapists advocating this approach are controversial and also do training in this country, nobody mentioned them as having done CPD with them.

There was a strong sense for my participants that the therapeutic relationship was crucial and that it was the presence of the therapist that enabled the therapy to work. This seemed to be the thinking behind the new definition of EMDR (February 2020) which said that EMDR must be administered by a clinician and cannot be self-administered.

Participant 07 said:

> *"Some people treat it as a technique, something that you do, that's not EMDR therapy."*

For this participant, doing equated to seeing EMDR as a technique. She appeared to feel that she contributed much more to the process to make it EMDR Therapy. She also discussed the relationship between structured and exploratory therapy and felt that both were present in

EMDR. This therapist appeared to feel that being and doing could sit alongside each other in the sense that doing is structured but being is exploratory.

Participant 01 said:

> *"It's important that people know that it's not doing things to people. People think "Oh no, that's a bit mechanical, we're doing to people, but actually he (her therapist) was totally relational.*
>
> *"I deliver EMDR in the way which is how I do counselling, it's me doing it."*

This participant's position here was very clear. She recounted her initial response to EMDR, as well as the fears of the therapists working in her organisation, that EMDR could be mechanical. However, her experience with her own EMDR therapist was that he worked in a relational way and she had no sense of him doing things to her. Her own experience of delivering EMDR, therefore, was that she did it in her own unique way. This, for her, seemed to be very much about being and not about doing. There was, however, also a distinction between doing something and doing something to someone, which appeared to be very important for this participant.

However, she also talked about the clients in her service who did not always want to talk about their experiences. Therefore, EMDR was an ideal solution for them. The suggestion seemed to be that this could be encompassed in the relationality and the being of the therapist.

Participant 03 said:

> *"I am not averse to the idea that EMDR could be a therapy in itself…my identity is as a psychotherapist, so I have a relationship – history comes as we talk."*

This practitioner emphasised her identity as a psychotherapist. For her, therapeutic presence and her being as a therapist seemed to be the most important thing.

Participant 02 said:

> *"It's about knowing when you need to be more present as a therapist alongside the stimulation, versus staying out of the way...I do it in a more free-flowing way than the strict protocol."*

When using the expression "*staying out of the way*", this participant seemed to be referring to the instructions originally given by Francine Shapiro. These were that ideally in EMDR, the therapist should step back and allow the processing to happen, generally saying only "go with that" between sets. She directly stated that the therapist should "stay out of the way" (Shapiro 2001).

However, Shapiro also conceded that, with more complex clients and presentations, it was necessary for the therapist to be more present and to use interweaves to help the client process. These interweaves represented an opportunity for the therapist to use clinical intuition and to be more present in the work. Shapiro also referred to the therapeutic relationship as a "dance" between therapist and client (Shapiro 2001).

Participant 02 also talked a lot about the relational aspect, intuition and:

> "*holding people at sensation level."*

Participant 03 also talked about:

> "*staying out of the way*":
>
> *"I'd go even further, I notice that when I stay out of the way it does work."*

Participant 12 said:

> *"the shadow side of EMDR is rigidity and dogma."*

She seemed to be suggesting that the rigidity was about doing. The structure had been held so tightly that there was little room for the individual being of the therapist. She also said that for her, the process of targeting was about making meaning for the client.

Participant 10 said:

> *"it's not a technique, it's a proper psychotherapy."*

He spoke about the need to work in a relational way and again saw himself as working relationally with his clients. I wondered if, for participants, the sense of being relational precluded doing.

Participant 11 said:

> *"I think it's about being intuitive…I have been told to be more directive"*
>
> *"EMDR asks a lot more of you as a person (than CBT). It's a lot more than a protocol."*

He discussed what he saw as the need for the therapist to be immersed in the work and to be safe but to *"work outside the box and just go with it"*. He also discussed the concept of flow which seemed to be very much about being.

However, Participant 08 talked about other therapies that she had learned, such as the rewind technique (Muss, 2013) and the Emotional Freedom Technique (Carrington & Craig, 2000). She said these therapies seemed to be doing things to people, in contrast to EMDR.

Participant 05 had a slightly different view. She talked again about the need to be practical and evidence-based, and to apply what was known, to the individual client. This appeared to emphasise "doing" a little more than most of the other participants.

This theme linked to the idea of whether EMDR is a technique or a psychotherapy in its own right. This becomes complicated as it has changed over the years. I think that initially EMDR

was taught as a technique, and some trainers still perpetuate this idea. If EMDR is taught as a set of steps in the protocol it becomes skills-based. If it is taught as an overall model based on the AIP, this creates a conceptual framework. It may be that over the years EMDR has become over-technical, without enough emphasis on intuition.

Most of my participants were very clear that the relationship with the client was a very important part of the therapy for them and that EMDR was not simply a series of technical steps. At the time of writing, there was clearly an ongoing debate within the EMDR community, with some people claiming that the therapeutic relationship was not necessary (Bongaerts, et al., 2017).

I think there is an interesting comparison to be made here with CBT. Johnsen and Friborg (2015) demonstrated that CBT was only half as effective as it had been 30 years ago. They analysed 70 studies conducted between 1977 and 2014 on the effects of CBT on depression. Perhaps as it became more mechanised it became less effective? Johnsen and Friborg's suggestion was that perhaps present-day CBT therapists were less well trained and less cognisant of the model than those in 1977. I wonder if this might also be true of EMDR therapists?

I also note that as an EMDR Consultant and Supervisor, the questions that beginner therapists ask are usually technical. I wonder if this reflects the more technical nature of the training? Initially, for therapists in EMDR, there does seem to be a heavy emphasis on what they do

Perhaps for a manualised therapy, this is inevitable, but my participants' strong emphasis on the relationship indicated that as therapists become more experienced they are less focussed on what they actually do.

This has interesting implications for the provision of CPD within EMDR and peoples' experience of it. My sense is that most CPD is about "doing" and about the application of the protocol to specific client groups, so perhaps there needs to be more emphasis on being.

Perhaps the fact that CPD in EMDR can only be specific activities to do with learning, as opposed to more fluid personal development such as reading, encourages the idea that the practice is about doing and not being.

# Chapter 18.Theme 8: Schism

There were two sub-themes connected to this theme

- Laurel Parnell
- Other Disagreements

**Laurel Parnell**

This theme is relevant to my research question about CPD and knowledge, because within EMDR certain CPD trainings have been seen to be unacceptable over the years, and strong disagreements have arisen. The major recent disagreement has been over trainings offered by an American trainer, Laurel Parnell (2012).

This was the theme that seemed to bring up the most energy in many of the interviews. Only one participant did not talk about it, and she (Participant 08) talked about omitting the Positive Cognition, which is one of the things Laurel Parnell suggests. However, on enquiry, she had never heard of Laurel Parnell.

Most of the participants brought this issue up very naturally, often towards the start of the interview.

The precipitating event that seemed to exercise many of the participants, was that Parnell, having disagreed with Francine Shapiro some years before, started to offer her own trainings based on attachment-focussed EMDR. She then began to offer these trainings in the UK and formed a separate organisation, the Parnell Institute. She was supported in this endeavour by a small number of prominent EMDR therapists in the UK. I attended Parnell's training in 2015 and found many of her ideas interesting. However, I did not appreciate her constant criticism of Shapiro. Many people in the Association criticised the term *Attachment-Focussed EMDR* as they felt that all EMDR was attachment-focused.

In 2016 in the UK there was a crisis between some of the prominent Parnell followers and the Board of the EMDR Association UK and Ireland. Some people were excluded from the organisation for a while. This caused some consternation in the wider EMDR community and the expulsion was reversed. My participants had a range of things to say about this situation.

Participant 07 said:

> *"I'm aware that there's been a recent schism in the EMDR world about the Parnell stuff ... and between everyone else and the main Committee, who are a small group of people actually…I'm not into tribalism, I don't like that…But I didn't like the separate email group either, and people advertising asking for Attachment-Focussed EMDR therapists, when it could have just been an EMDR therapist."*

This participant was referring to the initial disagreement and the fact that there was a separate email group for Attachment-Focussed EMDR. She was clearly perturbed by the disagreement but also by the fact that the small group seemed to have broken away and were advertising between themselves for "Attachment-Focussed EMDR Therapists". This was part of the behaviour of which members of the EMDR Association disapproved, but Participant 12 said that they needed to do this to survive.

Participant 09 said:

> *"I went to see Laurel Parnell, and it was good, I just don't like the way she is behaving. I don't approve of people who are just junking massive parts of the protocol willy-nilly. She is naughty … this sort of separate Parnell Institute…they are up to mischief."*

This participant was, therefore, referring to the separate group and disapproving of the "*breaking-away*" from the organisation.

Participant 03 said:

> *"there was an abuse of power, and there are scars, but people are now talking…It's like Captain Dreyfus, do you know this – J'accuse? And I was on the side of the accused. I was horrified about what happened. People have a very belittling – they used to – they've shut up now, they used to deal with questioning and controversy with two or three techniques that were on the side of bullying and I really had a problem with that. People have to think for themselves."*

This participant had a very clear view that supporters of the Association were bullying the Attachment-Focussed group. She also seemed to feel that the worst of this was over and there was now little difficulty. She said that previously people had not talked but now they did.

Participant 06 said:

> *"I suppose I get the impression that there's a bit of a schism between Laurel Parnell and Francine Shapiro, when I first trained I was in a peer supervision group and someone there was into Parnell and there was a feeling I would be confused by it…but I read her book and I enjoyed it. And I found Shapiro's book totally turgid. But there you are, there will be disagreement. 'Twas ever thus with therapy. Look at Freud and Jung. I went to a training with (name redacted) and he said he was having to tread very carefully."*

This participant seemed to be holding a balance between Parnell and Shapiro (and, interestingly, she mentioned Parnell first). She did not have the strong sense of schism of some participants (although she used the word) but seemed to have a philosophical view that disagreements happen in therapy.

I thought the comparison to Freud and Jung was interesting. The letters between them spoke of a very anguished, philosophical level of disagreement which was perhaps enhanced by being in letter form (McGuire, 1974). There seemed to be no real open dialogue, and perhaps

the same happened in the disagreement between Shapiro and Parnell. There are doubtless people who remembered this and could catalogue the disagreement but in the wider EMDR community it simply went down as a vague awareness. Participant 06 seemed to voice a vague feeling that she preferred Parnell, finding her book less "*turgid*" than Shapiro's.

Participant 05 said:

> *"A lot of people speak very highly about Laurel Parnell. A woman in my supervision group talks about her all the time. But she goes a bit rogue…she's a bit marmite isn't she?"*

This participant generally had a very pragmatic and practical style and she seemed to have a practical approach here. She stated clearly that she was aware of the issues but also said that she had never read Laurel Parnell, though she had the book there ready to read. Also, she had not attended training so her perception of Parnell as "*marmite*" seemed to be a little disinterested. She understood that people had very polarised opinions but did place herself on any side in the debate, perhaps because she felt she did not know enough. This participant also perhaps placed less importance on the debate than others. She did not seem to have a great sense of schism, simply that Parnell polarised opinions.

Participant 04 said:

> *"I'm aware that there's conflict in the EMDR world … you hear things like: "Who started EMDR first? Was it Francine Shapiro or Laurel Parnell? … I like Parnell though, is the modified protocol better? I use both."*

This comment was rather startling to me. It is absolutely clear in the history of EMDR that the originator was Francine Shapiro (Shapiro, 1996). But here Participant 04 was suggesting that people were actually disputing this and suggesting that it was Parnell. This was not something that I had ever heard anyone say but was clearly something that the participant had

experienced. This was fascinating in terms of her experience and interpretation of it. She seemed to lean a little towards Parnell and suggested that she liked the modified protocol. It was interesting that she seemed to see the debate between them as an equal one, rather than as about Parnell being cast out. This was a different perception of the issue.

Participant 02 said:

> *"People always experiment. People go off on a tangent all the time and call it a new protocol…I don't sign up to a set of rules."*

This participant was clearly saying that there were always adaptations to the protocol and that this was a healthy process.

Participant 12 said:

> *"Standard protocol is brilliant as far as it goes. But a revolutionary psychotherapy then becomes the establishment … the shadow of EMDR is rigidity and dogma. Shapiro was a revolutionary with feet of clay. I think the modified protocol is more efficient and can be used by anybody. Laurel Parnell fell out with Shapiro and was punished for it. It has not been possible to be open and honest. People will not credit Laurel Parnell with the Attachment focus and that makes me very sore. I am standing up to the system – not to destroy it but because it is in need of reform. Laurel Parnell is a genius just like Shapiro. She has been damaged and cast out…It's like all totalitarian systems – dissidents are cast out."*

This participant used very strong language to express her belief that she and Laurel Parnell were dissidents and that she, therefore, saw the EMDR Association as a totalitarian system. She also seemed here to equate Parnell with Shapiro and called both "geniuses".

There is an opinion amongst some EMDR therapists that all EMDR is Attachment-focussed (Dworkin, 2005). Therefore, referring to a modification of EMDR as Attachment-Focussed is

rather strange. Parnell in fact claimed that this label for her work was suggested by Dan Siegel (Parnell, 2013). It could be seen that people in the community would not credit Parnell with the Attachment focus because it had been there all along. It is also fair to note that this was clearly not the perception of Parnell or Participant 12.

Participant 08 said:

> *"Do you have to use the positive cognition – I don't… No, I've never heard of Laurel Parnell … but I don't get hung up on the protocol."*

This participant was interesting. She asked me about the use of the positive cognition, which she preferred not to use. Because this was one of the identifying characteristics of Parnell's Modified Protocol, I asked her about this and she said that she had not heard of her. I was interested in what, therefore, had led her to omit the Positive Cognition, and it seemed that she just did not feel it was useful.

In terms of schism, it was notable that this participant was an accredited practitioner but had never heard of Parnell. This led me to wonder as to the extent that this concept of "schism" (which had simply gone over the heads of many people in the Association), was only understood by people who had some knowledge of the process?

Participant 11 said:

> *"I'm interested in Laurel Parnell. She's a little maverick, but I'm a little maverick myself. I sometimes use modified protocol. If it works and it's safe it's Ok… Breaking up happens all the time in CBT doesn't it?*
>
> *I think we have to be tolerant of that – this will always happen and we have to be philosophical"*

This participant had a rather philosophical view of possible splits in the EMDR Association and seemed to think it was simply something that might happen. He seemed to have no strong views about the disagreements in the Association.

This debate has, therefore, polarised feeling in the EMDR community. It was very obvious in my interviews that two-thirds of the people referred to this issue very quickly and with no prompting or questioning. Some appeared to be very focused on it and others were rather disinterested saying that disagreements would happen and there was a need to be philosophical about that. Nonetheless, it was a significant topic.

**Other Disagreements**

Most of my participants talked about what they perceived as a disagreement between the UK Association and Laurel Parnell. This dispute seemed to totally dominate the landscape. At the time of conducting the interviews, other figures in EMDR were rather controversial. These included clinicians in the Netherlands who were teaching what they referred to as *EMDR 2.0,* based on the working memory theory. These clinicians suggested that resourcing was unnecessary and promoted *intensive EMDR.* Here clients may have several sessions of EMDR in a day, with different clinicians, interspersed with other activities such as physical activation (Reader 2021). The implication here was that the therapeutic relationship was not a big factor in EMDR and that EMDR was seen more as a technique.

These clinicians were, at the time of writing, teaching in the UK. They also presented at the 2020 EMDR Virtual Conference. What, therefore, made their controversial ideas seem more acceptable? Perhaps, as at the time of writing these people were involved with their own National Association and not attempting to break away from it and form a separate organisation, debate felt more possible?

I found it interesting that none of my participants mentioned training with these clinicians.

There could, therefore, be a suggestion that it was not the actual teaching that caused problems, but the suggestion of breaking away from the EMDR Association and forming a separate group. Participant 12's perspective, however, was that it was necessary to separate to some extent because ideas were not accepted.

One of my participants (Participant 03) who had had strong views about the Parnell issue, asked me if I thought there was also a disagreement between two other prominent American presenters. My view was that there may have been disagreement but not significantly so. Of course, clinicians are always going to disagree, what was interesting was why sometimes this was tolerated and sometimes not.

Participant 10 also recounted a story about being at an EMDR Conference and asking a question of the presenter. He queried the place of bilateral stimulation in the theory being presented, as it had not been mentioned. The speaker said that bilateral stimulation was not required for EMDR. Participant 10 was clearly incensed by this and wanted to pursue the issue. He said he was, however, restrained by a senior figure sitting next to him who told him to leave it.

This incident clearly took place some time ago, but I wondered what stopped this particular variation from becoming more controversial? I suspected that it was because it did not take hold. For some reason, the idea of omitting bilateral stimulation did not seem attractive to most clinicians so the suggestion simply died. Notably, bilateral stimulation was one of the things that made EMDR unique, and other therapies that used it, such as Brainspotting (Grand 2013) or the Developmental Needs Meeting Protocol (Schmidt 2009), came out of EMDR.

Participant 02 raised the issue that people in EMDR were consistently adapting the protocol. Marilyn Luber published four large books of scripted protocols, although she accepted in a

2020 speech (See Spector, 2020) that 92% of her scripts were actually Standard Protocol with a slight tweak. Tweaks to the protocol have, therefore, been accepted by the community since the inception of EMDR. Luber was a friend of Shapiro and her manuals were accepted by Shapiro as reasonable adaptations of EMDR. The manuals included protocols for working with dissociation, depression, unrequited love, pain, addiction, phobias, OCD and many other presentations. Notably, Parnell's Attachment-Focussed approach was not included.

The question then arose as to what it was about Parnell that had so incensed some people within the Association. It was very clear to me that there was very significant hurt on both sides of the debate. The accusation made by Participant 12 was that the Association was more concerned with the purity of the protocol than with supporting its members. The people involved in the 2015/6 serious incidents appeared to be concerned that EMDR was being misrepresented and that senior figures in EMDR Europe were being criticised.

Participant 12, in her interview, indicated feeling that the rancour of earlier times had been ameliorated and that things were better. She stated that she could get CPD points for training, whereas at one point these had been denied. She said that one senior figure in the organisation had apologised to her, although there seemed to be some hurt that others had not.

Participant 03 also said that things were better and people were talking. My sense in talking to people about this issue was that it was still a simmering sore point for many, although some dismissed it as an inevitable disagreement.

I was interested in the difference between something which was simply a disagreement and something which held the threat of splitting an organisation, which the Parnell issue clearly did. This whole issue was highly relevant to my research as it involved areas of continuing professional development and what people thought therapists needed to know. The clear

position of the Parnell Institute was that Attachment-Focussed ideas should be more mainstream in the EMDR community. It was, therefore, a large concession in 2019 that the protocols put forward to the 2019 meeting of scholars in California included the Attachment-Focussed protocol. I am not sure if this has been understood.

There was clearly still pain on both sides and I was unsure about the inevitability of this. It is fascinating that 11 of my 12 participants talked about these areas of disagreement in a very focused way.

Participant 12 was pleased that Laurel Parnell could get CPD points for training when for a period these had been denied. I am not aware that any other trainer had or has been refused CPD points, except for reasons that part of the training did not focus on EMDR. This disagreement appears to have a long shadow on the experience of the EMDR community.

# Chapter 19.Theme 9: Metaphors

Some participants used very rich metaphors to describe their experience, the sense of their learning and what it was to be an EMDR therapist. I identified these as a theme because many of them gave a very strong understanding of the participants' positions and many were relevant to their understanding of CPD and knowledge within EMDR.

Participant 09 said:

> *"Standard protocol is like the Highway code…if the red light's on, you, stop, and all those things, but when you, when you can drive you stop thinking about the Highway Code…but you still know you stop at a red light. It's organic"*

In my initial interpretation of this metaphor in the transcript, I was interested that in fact, the Highway Code is legislation, and people are penalised for not following it. The participant was suggesting that when people learn to drive, they internalise these rules and stop thinking about them although they are still there and still followed. This seemed to reflect how she thought of the Standard Protocol, that it was, in fact, the law and had to be followed, but that people internalised it and could possibly be a little creative with it. Later it was interesting to reflect on this idea in light of other metaphors to do with dogma.

The same participant talked about the direction of the work as being like buying a ticket:

> *"If you want to go to Edinburgh you don't go to the station and say: "Give us a ticket" you say: "can I have a ticket for Edinburgh please?" And you might go via Preston, but you end up in Edinburgh."*

She also discussed people singing from the same hymn sheet, perhaps picking up on the religious themes suggested by other participants such as 10 and 11.

Participant 03's primary metaphor compared a member of the Association to Captain Dreyfus. She also personified the process of accreditation by saying "*It would kill my spirit.*"

Participant 02 referred to the use of metaphor in therapy three times in her interview. She also referred to herself as "*a boutique, not a department store*" in terms of seeing what she did as specialised, that it would not suit everyone, and that not everything possible was available. This person was saying that she did not think that EMDR could deal with all issues, also that she herself did not deal with all issues.

Participant 06 had a similar metaphor to Participant 10 in that she talked about how people operated once they knew the protocol well:

> *"It's a bit like reading a historical novel or a thriller where the novelist knows their stuff really well – and all the historical details, about guns etc. And then they forget about it and put it to one side. It's about the reader's experience, and the story".*

For Participant 12 the metaphors were very rich and sometimes disturbing. She referred to EMDR and the EMDR Association as:

> *"A cult"*
>
> *"A Communist Party"*
>
> *"A Church with High priests"*
>
> *"It's like a religion: we have a founder, a founding myth and a devotion to Shapiro"*
>
> *"Parnell and Shapiro are like Luther and the Pope"*
>
> *"It's like the Lutherans and the Catholics, they're at war with each other, but it's the same God."*
>
> *"It's like we're in a Civil War"*

> *"I sometimes say it's like the Eiffel Tower – it was heavily over-engineered when it was built in the late 19th Century by very competent experts in cast-iron who didn't yet fully understand stresses and strains and the sort of way that if you build a building out of iron – like the one outside this window here – a building with girders on the outside, that's really lightweight. So, I don't remember when it was but it was the 30s or 40s or even the 50s that engineers went into the Eiffel Tower and stripped it out of all the unnecessary weight – and they took thousands of tons of cast-iron off the Eiffel Tower and rendered it therefore more resilient in the longer-term. And for me the standard EMDR protocol is like the original Eiffel Tower. Shapiro put it together – cobbled it together, put it together pulling a bit from here, a bit from there. A bit from hypnotherapy, a bit from CBT, exposure therapy. She created a protocol that was actually brilliant in its essence, but that was years ago."*
>
> *"I compared it all to the Life of Brian, but people didn't like that."*
>
> *"It's like they saw me as the lone wolf shooter – so to protect everyone you have to take her out."*

This participant's metaphors were extremely critical of the EMDR Association and they clearly expressed a lot of hurt and pain. I sensed that, at the time of the extreme difficulties, the Board of the Association were entirely fixated on maintaining the purity of the protocol so that dissent was being punished. My participants were mostly of the view that dissent was healthy and a fact of life that could not be prevented.

I could see that in many ways the Association had behaved like a cult, or the Communist Party, or the Catholic Church. However, I also questioned the payoff for the dissenter. The group of people based around Laurel Parnell saw themselves as being cast into outer darkness, but there could also be an ultimate reward for being seen as a martyr.

Ongoing, I would be interested in the number of people who, upon seeing a dispute, automatically saw the Association as being in the wrong. This is not to say that I think they were in the right, however, the Association seemed to have taken on a naïve view that members would support the Board, whereas of course, the British inclination is to support the underdog.

What was interesting here was that my participant clearly did not see herself as the underdog. The metaphor of the "lone wolf shooter" had, to me, the undertones of someone who saw themselves as dangerous and a force to be reckoned with.

The Eiffel Tower metaphor seemed to apply directly to the fact that the Modified Protocol of Laurel Parnell left out two of the main elements of Phase Three of the Standard Protocol (the Positive Cognition and the Validity of Cognition Scale). She was, therefore, suggesting that time had shown these elements to be unnecessary.

However, many people would agree with Francine Shapiro (2001, p. 141) in saying that the positive cognition was the "light at the end of the tunnel" and could be very useful in processing as it could be used as an interweave. This metaphor seemed to me to be provocative. The participant was saying that she used this in training, so to some people this would be experienced as a very clear criticism of the Standard Protocol.

The metaphor describing EMDR as a religion in that it has a founder, a founding myth (the walk in the park) and a devotion to Shapiro, appeared to me to hold a lot of truth. However, I suggest that this is true of all therapies, from psychoanalysis to the person-centred approach to Cognitive Therapy. If all therapies by definition have these factors, then they could perhaps be compared to religions. This is not a new concept, as referred to by Halmos (1965) in the book entitled *The Faith of the Counsellors*.

The sense of this metaphor, however, for this participant was that by comparing it to a religion she was perhaps suggesting that absolute belief and absolute obedience were being required. The fact that other people questioned aspects of the protocol suggested that total obedience was not being required. However, there was something particular about this situation.

Participant 08 again referred to the ability to use the Standard Protocol creatively and she compared this to music:

> "*It's like in classical music the musician keeps to the notes but in jazz the musician adds to the notes and improvises. I improvise.*"

This metaphor, together with the novelist metaphor from Participant 06 and the Highway Code metaphor from Participant 09, again suggested the possibility that therapists could so thoroughly internalise the principles of EMDR that they became second nature and no longer needed to be thought about. Participant 08, however, seemed to go further in comparing herself to a Jazz musician and stating that "*I improvise*". This metaphor reminded me of Stern's (2010) comparison of dialogue with "jam-sessions". He said that to play jazz the musician has to learn to get differences to function together, even though they are contrasts. This requires modulating with other musicians to create a shared construction. This seems to shed an interesting light on Participant 08's metaphor.

I think these metaphors were very powerful and gave a real insight into how my participants saw the process of acquiring knowledge in EMDR and internalising it.

# Chapter 20.Theme 10: PDP and Planning

This is a very significant theme for my study, as whether or not people plan their CPD is a significant factor in their experience of it.

The Personal Development Plan (Farrell & Keenan 2011) was developed as a tool to assist practitioners in their learning of EMDR and to help them to identify what they needed to develop. Only two of my 12 participants had seen this plan before or had any sense of using it.

Sub-themes under this theme are:

- Do people plan?
- Do participants think a structures plan of CPD would be a good idea?
- The existing Personal Development Plan (PDP)
- Do people want a PDP Plan at all?
- A new plan?
- The Difference Between a PDP plan and a plan for CPD.
- Are there specific protocols of which all EMDR therapists should be aware?

**Do People Plan?**

One of the interesting issues for me was the extent to which individuals planned their CPD. The participants varied in their response to this question. All were members of other organisations which largely required their members to have a sense of forward planning for their personal and professional development.

The EMDR Association requires 75 CPD points over 5 years for those seeking re-accreditation. This is effectively two-and-a-half days of training a year, but it was interesting that for many people this was too much.

Participant 07 said:

> *"I think I half plan it (laughing). I'm more selective about what I choose."*
>
> *"I'm a bit concerned about the level of experience people have before they do the training."*

For me, this was a significant issue and my initial interpretation on the transcript concerned the level to which CPD was depended on to fill the gaps in the original training in EMDR. This participant was also clear that she selected CPD she saw as relevant but did not really plan development in advance.

Participant 09 said:

> *"I don't plan. I see things coming up and I think "Oh, I really want to do that." I get annoyed with people who do things just for the CPD points because they are coming up for re-accreditation. They could have planned better. But I don't think people plan."*

This participant clearly felt that it would be difficult to plan her CPD. She reacted to things that were offered rather than pursuing a plan of learning.

Participant 01 said she didn't really plan but tended to attend local events whatever they were. Conferences and events further away were too expensive.

Participant 03 did not plan but thought some people did. She also said that events were too expensive. She thought that people tended to want to do the minimum, although she believed that this did not apply to her. Although she was not accredited she had actually done much more CPD than would be required for accreditation.

Participant 06 misinterpreted my question about planning and told me a story about a year when she decided that she would not spend money on CPD and would only attend free events. The result of this, she said, was that her experience that year was quite patchy.

This was, of course, a plan, only not in the way that I had anticipated. I wondered if I had misinterpreted her. This was interesting in terms of IPA and going with the person's meaning-making. I was aware that sometimes my more direct questions lead to hypothesis testing rather than to a more inductive experiential meaning-making process. This whole question of planning was rather factual, and although relevant to my research question, it was more difficult to determine individual meaning-making.

Participant 05 said she did not plan but looked for training on issues that had come up with her clients. I queried if this was not a plan. She said maybe, but that it was not possible to do in advance as she couldn't plan for what her clients were going to bring or what she would need. In my interpretation in the margin of the transcript, I wondered if the difficulty with this was that if one suddenly needed training with a particular client, that training may not be immediately available.

Participant 04 said:

> *"I don't plan my development. It would be a chore. I am not academic".*

This was an interesting theme with this participant. She appeared to believe that planning would be hard work and require her in some way to be academic. In my interpretation, I considered that if she did not plan her development, how then did it happen? Did it just evolve? I wondered if there was a lack of agency here.

Participant 02 said she did not really plan. This was the participant who had no requirement for CPD and took up online CPD which seemed attractive to her as it occurred.

Participant 12 said she did not really plan, and that people don't plan. Participant 12 appeared mostly to undertake CPD within her own Attachment-Focussed modality. However, she made it clear that she always attended the Annual Conference and Europe Conferences. This could of course be seen as planning.

Participant 10 said:

> *"People do plan but not as much as they do in their other disciplines. The problem is that EMDR is a secondary therapy"*

This participant had a lot to say about EMDR not being the priority in terms of CPD for most people. He made the point, which initially surprised me, that were he asked to give up either CBT or EMDR he would have to give up EMDR:

> "*Although it would be like cutting off my right arm"*

When I considered this point, I realised that he was of course right. For therapists, EMDR is a secondary therapy as all clinicians already have to be qualified in a mental health practice. He, therefore, felt that it was more difficult for EMDR therapists to plan.

Participant 08 said she didn't plan CPD but did respond to emails sent out from the Association if the topic interested her. She also did things online and was critical of the stance of the Association that online CPD was not acceptable (As of May 2020 this is no longer the case.)

Participant 11 said he would plan now because he got into some difficulty with his recent re-accreditation when he had needed to ask for mitigation. He felt that his CPD needed to get broader and that although people could plan a bit, planning really depended on what things came up and what was available.

He also said that having to hurry in the prior few months to get sufficient CPD meant that he had undertaken training that he would not normally, and this had been beneficial for him.

Going back to my original title of "A duty or a joy" there seemed to be an overall feeling that if people were to plan this would be a chore. Seven of my participants were clear that they did not plan their CPD and were unsure how they could do this. Learning as things became available seemed to be more acceptable to most therapists. It was interesting to me that generally, my participants did not have a sense of assessing things that they needed to know and planning a way to achieve this knowledge.

This brought up the issue of whether there were specific things that people needed to know which were not covered on standard training.

**Do Participants Think a Structured Plan of CPD Would be a Good Idea?**

I had initially wondered whether creating a suggested structure for EMDR CPD would be useful, I was interested in my participants' views.

Participant 09 felt that to structure things was good because:

> "*some people think they're fantastic when they're not, and some people think they're rubbish and they're great. I will not accredit somebody who I don't think properly understands what they're doing."*

Participant 09 seemed to feel that more structure in CPD would help people to understand what they are doing.

Participant 03 said:

> "*I have problems with paperwork, protocols, organising*".

She felt that planning would be difficult as it would feel like she was being organised and

> "*I think I don't like being told what to do."*

My sense here was that this participant would oppose any sense of being given a structured plan.

Participant 06 said:

> "*A structured plan would be useful, because there's nothing clearly required."*

She felt that it would be good to be clear about what is being asked so she could follow it and also create her own plan.

Participant 05 was always very practical in her approach to the issues, so she said:

> *"I think people need a practical plan. What are you going to do, and how are you going to do it?".*

This was therefore pragmatic and clear.

Participant 04 said that following a structured plan "*would be a chore"* and also that "*I am happy with my progress".* This indicated that she felt no need for a structured plan.

Participant 10 said simply that all people needed was a massive understanding of AIP. He seemed to feel that a structured plan was not necessary and would not be followed.

Therefore, only two of my participants were enthusiastic in any way about a structured plan.

**The Existing PDP**

In 2011 a Personal Development Plan was introduced in the organisation. It was developed initially as a Consultant /Supervisor plan by Farrell & Keenan (2011). It was a technical instrument consisting of four sections with 62 individual items in Section One.

Farrell, Keenan, Knibbs and Jones (2013) produced a similar plan for general use in the Association. This had three sections, missing out the specific supervisor material. In essence, this plan outlined the theoretical underpinning of EMDR and then became very technical. It outlined the eight phases, broken down into micro-skills. It then asked people to self-assess and rate themselves on a scale of Strong to Not Strong. This PDP was not disseminated widely and most of my participants had never heard of it. Nine of them queried why they had

not seen this before. I sent it to them in advance, as this was part of my original question schedule. Some of them had clearly studied it and some had simply glanced at it. There were a number of interesting reactions to it.

Participant 06 was one of the therapists who had seen the form before. She said that her supervisor had used it with her in supervision:

> *"We went through the form, you know, what do I know, what don't I know, am I ready? But I could get into thinking I have to know everything"*

She went on to discuss the idea that the PDP might be off-putting to people. She felt this was because they might feel that they had to know everything and that all the micro-skills listed were a requirement.

Participant 09 had not seen the PDP before although initially she thought she had. She asked questions about how it had been disseminated and how I got hold of it. Her main criticism of the form was not its technicality but that for her:

> *"Strong and not strong is silly"*

She felt that a full Likert scale would have been better and that self-assessment was not always helpful because:

> *"some people think they're fantastic when they're not, and some people think they're rubbish and they're great."*

She did, however, think that some kind of PDP could be useful in working through issues with supervisees.

Participant 01, when discussing the PDP, said that she found it intimidating and clinical, but that it would also give areas to work on.

Participant 03 was very vocal in her opposition to the PDP:

*"It kills my spirit completely – I really think it would break my spirit – or I would have to take drugs!"*

This was tongue in cheek, but she clearly felt that using the PDP would overwhelm her. She also talked about the self-assessment aspect and said that generally, people over-rated themselves. There was a sense that this did not describe her and that she did not over-rate herself.

This brought up for me the Dunning-Kruger Effect (1999), a cognitive bias where people with low ability tend to overestimate their ability. The authors refer to a "dual burden". Not only are people incompetent, but their incompetence robs them of the ability to recognise how incompetent they are. Also, to a lesser extent, high performers tend to underestimate their performance. This is the effect that Participant 09 above was discussing.

Participant 06 was very admiring of the PDP and said she would definitely use it. She felt that it would make things clearer in her supervision.

*"this could be really useful to me."*

Participant 05 was very practical in her appraisal of the PDP:

*"I like the idea of it …but it would be better if it wasn't a tick-box exercise. There seems to be an idea here that you have to be good at everything, but people want to have an area of expertise if you see what I mean. I think you need to make it more practical…more boxes… "What are you going to do? How are you going to do it."*

She then discussed thinking that the PDP was too theoretical, and that self-report was not always helpful. She said she would like the plan to exist but would like it to be different with more boxes to write in. She also felt that the plan did not take proper account of her expertise in working with young people.

Participant 04 reported that the plan made her feel fearful:

*"It's a bit overwhelming, I feel intimidated by it, it would be a chore for me to do this. I am not academic. Also is this personal or professional?...it's called a personal development plan but there is not much here that seems personal to me."*

The point made here concerning the difference between a personal and professional development plan was an interesting one. The term personal suggests that people assess their own abilities and come up with a personal plan of learning and development. This participant had a different understanding of "personal" and seemed to feel that the plan was trying to force her into a mould. It was clearly true that the plan largely referred to development that was professional rather than personal. Participant 04 continued by saying:

*"Why is it important for me to know all these things?"*

In my original interpretative comments, I noted that seemingly the rationale as to why EMDR therapists needed to know certain things according to the Association, was not being made sufficiently clear to them.

Participant 02 had a very strong visceral reaction to the PDP:

*"It makes me want to pull back. I really felt myself recoil away from it. It's really deskilling for me. I would feel handcuffed if I had to do this. It's the worst part of manualisation."*

This participant felt that she did not want to follow the rules and did not want to sign up to the EMDR Association for that reason. Her very strong reaction of wanting to pull back and recoil seemed to reflect her feeling that having to follow this PDP would restrict her and hamper her in her work. This participant had the strongest visceral reaction, although Participant 03 also had a strong negative reaction to the PDP. This will be an ongoing project for me: how to present elements that people need to know in a way that does not seem too technical and overwhelming.

Participant 12 had a very different reaction, the PDP seemed in some way to validate her.

> *"I think this is really useful and I would endorse every single piece of this. The only one I would not endorse is "applies duration of set at approximately 25-35 seconds" The set sometimes needs to be a bit longer, usually not a great deal shorter…this is what's extraordinary, this is what's so tragic actually about the divisions in the community, that we really are all on the same page."*

This participant had seen herself as a rebel, and that she had been "*cast out*" by the EMDR Association. To feel that she agreed with most of the plan seemed important to her. She also said that she was not entirely happy with the scale used and thought that the points should be weighted more thoroughly. She also thought that the plan should be used more widely.

For Participant 12, there seemed to be some excitement that there was something produced by the Association that she would more or less endorse. It was interesting to me that this participant was the most enthusiastic about the PDP, although she was the person who was most critical of the Association.

It was notable that apparently, she felt able to almost endorse everything in the PDP, despite having serious disagreements with the strict application of the Standard Protocol.

Participant 10 had initially contributed to the development of the PDP, but he expressed surprise that I had brought it up:

> "*I haven't looked at it for years. I know it's very long"*

I then asked him how he thought people might use the PDP:

> "*I -er- as a planner. Basically. That's what we thought. It can be used in a variety of ways. It could be used as a proforma at a workshop, it could be used before and after at a training. But we expected people to be honest with it, to highlight their strengths and weaknesses. But I've noticed that people are far more honest with their*

*weaknesses than they are with their strengths. I think they will quite happily tell you how crap they are at things but being British struggle to tell you how good they are at things."*

It was interesting that Participant 10 discussed something that seemed to accentuate the aforementioned issue of the Dunning-Kruger Effect. However, he made this into much more of a general issue. He had not seemingly had the experiences discussed by Participant 09, for example, that some people were not very good and thought that they were. He went on to say:

*10*: "*And so, it was to plan their accreditation almost based around this. And to use it as a baseline. So I would highlight the terms planning, baseline and honesty. Erm, that's the way it was planned to be used. I, in the early days, used to give it to all my supervisees. But I don't think I've got it electronically now. I don't really use it."*

*Interviewer (LM): Why do you think you don't use it anymore?*

*10: "I think I don't use it … bear with me, I also send my supervisees this, this supervision document, and they were completing this, and forgetting about that. Let me think, I think its' main strength is that it allows people to reflect on their practice and what they need to do. I think where it falls down, possibly falls down, is that the intention in the planning stage was that this would be an ongoing thing people would do. People would take this to their supervision. I don't think any of my supervisees have got one now, and I certainly haven't pushed it."*

I then asked him how he thought the PDP could be improved:

*"I'm thinking about this for the first time, and I think it's about the answer to your question, what do they need to know? Erm, as a therapist. What do they need to know as a practitioner and what do they need to know as a consultant.? And how the levels will be the same and some of them will be different. And I would have CPD etc etc*

*like a tick box, and then it would be a five or a four, or go to accreditation, filed away and it would start again. That's how I think I would make it slightly different. I'm a behaviourist at heart, and I think people do things if they are rewarded, if they are reinforced."*

I found this an interesting comment. This participant clearly felt that people would not use the PDP because there was no real reinforcement for them. However, he also said that there was no reinforcement for the people who produced it, because, were that the case they would be standing up at every consultant's day promoting it.

The three words he wanted to highlight: planning, baseline and honesty, brought me to think about the concept of baseline and how therapists reacted to this. As many participants reported feeling intimidated by it, seemingly if the PDP was being presented as a baseline, then that baseline was too high.

There were also comments that the PDP made them feel required to know everything. My sense, then, was that the original concept of baseline was too high.

There were two lines in the above quote from Participant 09 that, on reflection, I did not really understand:

*"I would have CPD etc etc like a tick box, then it would be a five or a four, or go to accreditation, filed away and then start again.. That's how I think I would make it slightly different"*

I think here, that Participant 10 was suggesting making the exercise more of a tick box exercise, which most participants were not happy with.

Participant 08's major comment about the PDP was that self-assessment did not work because people overestimated their competency. Again, perhaps a reference to the Dunning-Kruger Effect:

*"80% of practitioners apparently believe that they are above average – and obviously that isn't possible."*

I sensed that she did not think that this applied to her, and there seemed to be a slight contradiction with her earlier comment that:

*"When you are accredited you basically know what you are doing"*

She felt that the PDP needed to be simplified and that generally things were made to be too complicated:

*"My strength is interpreting complex ideas and simplifying them. People make ideas too complicated."*

Participant 11's comment about the PDP was that it was too long but overall he liked it and found it useful. He saw it as a guide but felt that it could give the impression of being too prescriptive. He believed that the very best way to assess a supervisee was through the video (as required in EMDR for accreditation both as a practitioner and as a consultant). He did feel, however, that the PDP could be helpful for both the supervisor and the supervisee. He also questioned the extent to which self-report was useful and the level at which supervisees were able to assess their own strengths and weaknesses. He felt that a focus on things to *"brush-up on"* was useful.

*"I like the idea of broadening my perspective, I like to be grounded in ideas, new things come up all the time and I try to channel in all I have learned and find new ways of doing things."*

**Do People Want a PDP at All?**

This seemed to be an important element of this theme as three of my participants expressed very negative views about having a plan.

The views on this were quite varied. Participant 07 felt the concept of a plan was useful, but that it was important that the plan did not erode confidence:

> *"Sometimes confidence has been an issue for me, so I work on that really hard."*

Participant 09 did support the idea of a plan but thought that it needed to be changed, with a Likert scale and more openness.

Participant 01 equally liked the idea of a plan that gave things to work on but was not so intimidating and clinical.

Participants 02, 03 and 04 were very much against the idea of a plan feeling that it would inevitably direct them in a way that they did not want to go.

Participant 06 loved the current PDP and had no particular ideas about improvements.

Participant 05 strongly supported the idea of a plan but wanted it to be more self-directed with open boxes allowing the therapist to create their own goals.

Participant 12 was strongly supportive of the idea of a plan. However, she felt that the difficulty with the PDP was that it equally weighted all the components. She also felt that there could be more emphasis on certain things:

> *"I wouldn't massively change it. I think I'd probably emphasise attachment and neuroscience more, and brain, brain function…and soothing behaviour. So in other words I'd emphasise case conceptualisation much, much more. It's, you know, it's number 6 and I'd unpack that…With, with an understanding of neuroscience – if you could weight these things. At the moment there's an awful lot of points and they're not weighted. But actually, the first ones, up to six, one to six, are so much more important than the others. It could restructure it actually, you could take 1-6 as subject headings. I think it would be very useful if this was used much more widely."*

Participant 10, as discussed above, felt that the idea of a PDP was a good one but that it needed to be more directed towards the supervisee's age and stage. In addition, there needed to be some sort of reward or reinforcement for using it.

I reflected on this and it seemed to me that the only way to do this would be to make a PDP part of the accreditation process, both for practitioners and consultants. In this case, consultants would in fact be using it all the time with their supervisees and people would be encouraged to self-evaluate.

I think the issue that people raised about the use of self-evaluation could be dealt with by having a section where the consultant also evaluated the therapist. However, this may raise other issues for therapists.

It was also true at the time of writing that the accreditation process involved the consultant evaluating the supervisee's levels of competency.

Participant 08 felt that a PDP could be useful, but that it needed to be far simpler and the idea of self-evaluation removed:

> *"Some people will do the minimum or think they are practising to a higher level than they are"*

Participant 11 felt that it would be useful to have a plan but that it should not be too prescriptive, and that people should be encouraged to go with what worked for the client.

Therefore, nine of my twelve participants were broadly supportive of the idea of a plan, with eight of them feeling that it needed to be changed in some way and only one totally supportive of the current plan. I found it interesting that the three participants who were strongly opposed to the concept of a plan were all unaccredited. I wonder if the structure of the things people needed to know for accreditation, therefore, put people off from applying for it?

**A New Plan?**

As I reflected on my participants' opinions, I felt that perhaps a new CPD plan was required and that I could begin to develop this. 75% of my participants were basically in favour of a plan, though many wanted it to be different. I sensed that this would be a much more open plan with more boxes and that if a self-assessment scale was needed, it would be a true Likert Scale with five points rather than a simple "Strong – not strong" continuum.

Initially, I developed a completely open plan which I piloted at my first CPD course on "What does an EMDR therapist need to know" in September 2019.

When I discussed this idea with my Academic Consultant, Dr Derek Farrell, who originally developed the PDP, he revealed that he was also working on a new version of the plan. He, therefore, suggested that I should participate in the formulation of this PDP, which I did. I suggested more boxes and more open questioning, with a different scale, developed as a six-point Likert scale.

The new PDP (Farrell et al., 2020) is now being disseminated. It was intended to be launched at the EMDR Annual Conference at Cardiff in March 2020, but sadly this Conference had to be postponed due to Covid-19.

The PDP was, therefore, launched at the EMDR Virtual Conference in June 2020. The new version is in Appendix One.

In the section on my products, I critique the new PDP and suggest how it could be improved.

It is clear to me that it is not really possible to produce a PDP that everybody in the EMDR community will approve of. However, I think something more open can be produced, and consultants could be encouraged to use it more with their supervisees.

**The Difference Between a PDP Plan and a Plan for CPD**

I thought that Participant 04 made an interesting point when she discussed what made the PDP a personal rather than a professional plan. My sense was that both the old and new PDPs focussed on the knowledge that needed to be acquired technically. Perhaps therapists needed to be more aware of how to apply the knowledge they had to work with the client?

This takes us back to the debate about EMDR being a psychotherapy or a technique and also to my question: “What does an EMDR therapist need to know?”.

Some participants made the point that the PDP seemed to imply that people needed to know everything and that all of the knowledge available to a therapist should be acquired by them. This was clearly impossible, so how did people decide how to find their way through the learning and the CPD that was available?

I started this research wondering whether there could be a plan set up of CPD that a person could work through as a sense of the things that an EMDR therapist would be expected to know.

Having spoken to my participants this seemed less possible or desirable. People described very specific needs related to their own client groups.

I, therefore, shaped my ideas for products very much around the ideas generated by participants.

Some people did suggest that a skills framework for EMDR might be useful. I, therefore, adapted the CBT skills framework to suggest skills for EMDR. I introduced this in the first CPD activity I did on “What does an EMDR Therapist need to know?”.

I followed the CBT framework in creating the four columns as general therapeutic competencies: Basic EMDR Competencies, problem-specific competencies and meta-competencies. One of the criticisms of this at the CPD event was that it did not include

PTSD. I may need to think more about this, but my initial view was that PTSD was not a problem specific competency as EMDR Standard Protocol was based around PTSD.

**Necessary Skills for EMDR Therapists**

**TABLE 11**

*INITIAL SKILLS FRAMEWORK*

| General therapeutic competencies | Basic EMDR competencies | Problem Specific Competencies | Meta competencies |
|---|---|---|---|
| Knowledge and understanding of mental health problems | Understanding of AIP model | Phobia | Ability to use clinical judgement |
| Knowledge of, and ability to operate within, professional and ethical guidelines | Understanding of neurobiological underpinnings of EMDR | Panic disorder | Capacity to adapt interventions in response to client |
| Ability to form a therapeutic alliance with the client | Understanding of the three prongs | Depression | Capacity to use and respond to humour |
| Ability to manage emotional content | Ability to undertake Phase One: History-taking | Pain | Capacity to implement EMDR in a way that reflects its underlying philosophy |
| Ability to undertake assessment and history-taking | Ability to create a case formulation | Bereavement | Capacity to apply the EMDR model to the individual client |
| Ability to manage endings | Ability to utilise Phase 2 according to the resourcing needs of the client | Addictions | Capacity to select and use the most appropriate adaptation of the Standard Protocol. |
| Ability to make use of supervision | Understanding of and ability to | Eating Disorders | Capacity to structure sessions with appropriate pacing |

| General therapeutic competencies | Basic EMDR competencies | Problem Specific Competencies | Meta competencies |
|---|---|---|---|
| | undertake Phase 3: Assessment | | |
| Ability to assess for risk | Understanding of how to move through Phase 4: Desensitisation | Dissociation | Capacity to manage resistances to EMDR |
| | Understanding of when to move to Phase 5 | OCD | |
| | Ability to operate Phase 5 and install positive cognition | Personality disorders | |
| | Appropriate use of Phase 6: Body Scan | Autism | |
| | Ability to close down a session in Phase 7, including incomplete session | Psychosis | |
| | Going back to re-evaluate the work | | |
| | Ability to manage blocks and looping | | |

In my CPD training, I asked people to critique this model and received fifteen feedback sheets (Feedback discussed in Appendix Three).

I have adapted this framework further and extended it and this is included in my products.

**Are There Specific Protocols of Which All Therapists Should Be Aware?**

In 2019 Farrell sent out a survey to all UK and Ireland members. This survey outlined an audit to determine which scripted protocols were most frequently used in clinical practice. Clinicians were given a list of 16 protocols and asked to rank them from 1 to 16 in the order

with which they were used in clinical practice. The data were presented to the Council of Scholars forum which took place at the EMDRIA Annual Conference in September 2019. The protocols listed for the survey were as follows:

- Shapiro Standard EMDR Therapy Protocol
- Resource Development and Installation Protocol (RDI)
- Recent Traumatic Episode Protocol (R-TEP)
- Group Traumatic Episode Protocol (G-TEP)
- Integrative Group Treatment Protocol (IGTP) – often referred to as the "Four Field Protocol"
- Flashforward Protocol (FF)
- Blind to Therapist Protocol (B2T)
- Parnell Attachment-Focussed Protocol
- Feeling State Addiction Protocol (FSAP)
- Desensitisation of Triggers and Urge Protocol (DeTUR)
- Constant Installation of Positive Orientation and Safety (CIPOS)
- Eye Movement Desensitisation (EMD)
- Eye Movement Desensitisation and Restricted Reprocessing (EMDr)
- EMDR Recent Traumatic Events Protocol (Shapiro Version)
- EMDR Pain / Phantom Limb Pain Protocol
- Other

There were some interesting omissions from this list. For example, the Tip of the Finger Dissociation Protocol, the Phobia and the OCD protocols. These presumably could be included in the "Other" category. The Flash Technique, which is a new protocol, created by Philip Manfield (Manfield, et al., 2017) was also not included.

It was also interesting to note that all of the protocols, except the Shapiro and Parnell Protocols, were referred to with acronyms. This perhaps gave both special statuses. It was notable, however, that the Parnell Protocol was included in this list, which would have created celebration in some quarters and not others.

I wondered about the possibility of creating a plan of CPD trainings that listed protocols that, ideally, people might have achieved by the time they reached the status of consultant. It is worth noting that I have not received training in all the protocols listed above. Some of them (DeTUR, CIPOS, Pain Protocol, Shapiro Recent Events Protocol) are included in Standard Training, but the rest are not.

Over time I adapted the skills framework I had formulated to include awareness of specific protocols. This is discussed in the Chapter on Products.

# Chapter 21.Validity

Smith et al. (2009) discussed the assessment of validity and quality of qualitative research. They present Yardley's (2000) criteria, which are as follows:

- Sensitivity to context
- Commitment and rigour
- Transparency and Coherence
- Impact and importance

*Sensitivity to context* in IPA terms involves close engagement with the idiographic and with the particular. I believe that my study demonstrates a sensitivity to the data and my participants. I have attempted here to show the lived experience of each of my participants as well as to draw general information from them. I am aware that in my study I am immersed in the context of EMDR and thus sometimes could be too involved in the context.

Yardley suggested that sensitivity to context could be shown by awareness of the socio-cultural context of the study, the existing literature and the material obtained from the participants.

Smith et al. (2009. p. 180) said: "the sensitivity to context continues through the analysis process. Making sense of how the participant makes sense of their experience requires immersive and disciplined attention to the unfolding account of the participant and what can be gleaned from it.".

I believe that my attention to my participants material has been immersive and I have attempted to "dwell in my data" (Eatough, 2019).

I have become increasingly aware that some of the formulations of my research question have made it harder to work using IPA. I am working in an Association that already has a

formulated theoretical position and I am attempting to immerse myself in the individual experiences of practitioners who are sometimes struggling with this position.

I have, however, for example, by immersing myself in the experience of Participant 12, come to understand much more of the experience of being "cast out" and what this must have meant for her.

Yardley's second principle is *commitment and rigour*. Smith et al. (2009) suggested that, in IPA, commitment is shown in the attentiveness to the participant during data collection and the care with which each case is analysed. "For some elements of the research process, a demonstration of commitment can be synonymous with a demonstration of sensitivity to context" (p. 181).

Rigour concerns the thoroughness of the study and the completeness of the analysis. My study is, I believe, reasonably predictive of the views of a group of EMDR practitioners. My findings from my participants are also backed up by participants at networking and training events. I am also informed by the topics discussed through the EMDR Jiscmail which have contributed to my analysis.

Yardley's third principle is *transparency and coherence*. She described transparency as the clarity with which the stages of the research process are described in the study. Smith et al. (2009) suggested that coherence lies in dealing with ambiguities and contradictions in a clear way. I am aware of contradictions in some of my initial questions which involve a possible pre-supposition.

The final principle is *impact and importance*. Yardley says that the test of validity is whether it tells the reader something interesting, important or useful. I think the IPA process helps to do this but that my feelings will hopefully also be useful for the EMDR community in general.

I am aware that my very significant personal experience in this topic could be seen to compromise validity. I was therefore encouraged by Rooney's (2005, p. 5) suggestion that in qualitative insider phenomenological research considering validity and trustworthiness may not be helpful, and more useful terms may be "authenticity, credibility and understanding". Therefore, the suggestion is that very personal involvement in the project does not detract from it but carries "the potential to increase validity due to the added richness, honesty, fidelity and authenticity of the information required." (p. 7).

The products that arise from this work will, I hope, create an impact for EMDR generally, and have already been interesting, important and useful for the EMDR community.

# Chapter 22.Summary of Findings

There are a huge number of findings from my research, already introduced in the themes above, which I will now attempt to discuss.

**A Duty or A Joy?**

This was my original question in terms of practitioners' experience of EMDR CPD and training. Was CPD simply a requirement and a duty, or did they value this and find it a joy?

Generally, I found that practitioners were impacted by their CPD and found it very definitely useful explaining: *"it's a treat for me"* (Participant 07)

All the participants both indicated that CPD had been useful and had criticisms.

There was criticism of people who were perceived to attend CPD solely to obtain CPD points, for example from a very experienced consultant:

> *"They only came because they were up for re-accreditation and hadn't got enough points. I think they're twits."* (Participant 09).

There was also criticism of those perceived to be doing the minimum. Participant 05 suggested that others tried to get away with doing the minimum, although my perception of her was that she had done very little CPD. I was aware of my responses to Participant 05 and that there was a potential for these to be critical.

Generally, most practitioners valued their CPD, although some had rather vague memories of it. This was an interesting phenomenon observed in two participants. Participant 01 and Participant 05 were both rather vague about the topics they had looked at in their CPD, although they appeared to be enthusiastic about the whole experience.

People felt that CPD could not always meet their immediate needs if an issue arose with a client, and so supervision was their preferred learning medium. Equally, some felt that they

would attend a training because they thought it would be a useful thing to do but then had no opportunity to use it with a client. Participant 09 discussed this when she described attending a training in the Feeling State Addiction Protocol and not having an opportunity to use it as she did not have a client with addiction or co-dependency issues. Participant 08 was very strong on this saying that there was no point in doing a training unless one could use it directly with a client.

There seemed, therefore, to be a conflict between the experience as a joy of receiving CPD which directly benefits the client work, and some other experience, particularly involving the accruing of the required CPD points, being seen as a duty. There is a conflict here for EMDR therapists who are also members of organisations like the BACP or the UKCP, where other activities such as reading are permitted to be considered as CPD. The EMDR Association does not accept this as it is based on a points system, so CPD is required to involve specific activities.

There is a further issue here as to whether there were specific things that all EMDR practitioners should have covered in CPD.

At the time of writing, there were several issues and models taught in Standard Training. There were also many things that were not taught in Standard Training and I wondered if there should be a specific curriculum of issues to cover? Most participants had not really considered this idea and I was aware that eight of my 12 participants made comments about CPD being expensive and therefore needing it to be relevant.

My suggestion to the Association for the future would be that areas to be covered should be:

- The Flash Technique
- The Feeling State Addiction Protocol
- Constant Installation of Present Orientation and Safety (CIPOS)

- Loving Eyes Protocol
- The Tip of the Finger
- ARCHITECTS and ACT-AS -IF (A dissociation protocol from Sandra Paulsen)
- R-TEP and G-TEP (Recent Traumatic Events Protocol and Group Traumatic Events Protocol.)
- Attachment-Focussed EMDR.

If these issues were included in a general curriculum to be covered in CPD, people would have more idea of what they needed to learn post Standard Training. This could also be covered in EMDR supervision. I am conscious however that nine of my 12 participants were either uncertain or definitely against a structured programme. It would be important, therefore, that such a programme was simply a suggestion and something that could be discussed in supervision and as an ongoing developmental issue. The new Personal Development Plan also develops these suggestions as things people could be working on.

Most peoples' experience of their initial training was very positive and they felt that it was thorough and good preparation for practice. The consultants were generally also supportive of the training, although Participant 12 was very critical of it:

> "*The training model in EMDR is not fit for purpose…It's very sad and I think actually it's been catastrophic for EMDR's impact that Shapiro set out with a commercial training model that was focussed around individual trainers.*"

This comment, that the training was not fit for purpose, echoed the conclusions of Farrell and Keenan (2011). At the time of writing, this was clearly an ongoing issue for the EMDR Associations worldwide and was being addressed by the EMDR Council of Scholars (Hensley 2018).

Participant 12 agreed with the other consultants that training was only the very beginning and that supervision after training was where practitioners really learnt to be EMDR therapists.

Participant 12 said:

> *"80% of learning is in supervision after training. We churn out basic trainees and there's this great big gap after the initial training where there's this empty space, and that's why most EMDR trainees never go on to actually use it or to accredit, and they might be doing some pretty crappy EMDR but nobody is there to monitor it. So that's why the whole structure needs rethinking."*

It was interesting that this insight seemed to be held mostly by people who were consultants or at least accredited. The practitioners who were not accredited seemed to hold the view that the standard training had been enough, although two of the four were planning to apply for accreditation.

The views on accreditation generally were very interesting. The two non-accredited therapists who were not intending to apply for accreditation had, understandably, the strongest views. Participant 002 had no intention of being part of the Association because:

> "*I like the freedom to integrate it without feeling I'm breaking the rules."*

003 had the strongest arguments against accreditation, saying:

> *"it would kill my creativity."*

She felt that the expense of having specific EMDR supervision, plus having to follow specific rules meant that she did not want to go for accreditation.

Interestingly, in May 2020, there was a 73 post thread on the EMDR Jiscmail (an email facility for therapists). It started with a therapist stating that she found it unacceptable that the "Find a Therapist" facility on the EMDR Association website only listed practitioners who

were accredited or consultants. She wanted all trained therapists to be listed. This resulted in many posts agreeing and a number strongly disagreeing. The latter felt that the Association could not endorse people who may simply have done the training and no subsequent supervision or CPD.

I think that the large number of practitioners who never go for accreditation presents a very serious issue for the EMDR Association. Perhaps like participant 003, they view accreditation as unnecessary, over-bureaucratic and as requiring them to jump through hoops.

On the other hand, it was difficult to see how the EMDR Association could attempt to ensure that people it suggests to the public as therapists are competent, without an accreditation process. Although participants are observed in conducting EMDR practice, the standard training gives only a certificate of attendance as opposed to one of competence.

My sense of talking to the two participants who had no intention of going for accreditation was that they were not really aware of what accreditation entailed. I am also aware here of the conflict between simply accepting their understanding and my own fore-understanding. The aforementioned conversation on the EMDR Jiscmail suggested that after a year of supervision following standard training, people could be signed off with a statement of competency by their EMDR supervisor.

It appears to be a failure of communication that people did not realise that this is basically what accreditation is. For practitioner accreditation, candidates must indeed demonstrate that they have worked with at least 25 clients, for consultancy it is 75. They also need to show their consultant video or in vivo evidence of their work. However, the process can be undertaken after a year of supervision and it is the consultant’s responsibility to submit the statement of competency.

The participants in my study were divided in their sense of whether accreditation was a duty or a joy. Clearly, those who had achieved accreditation saw the value of it. Only one participant (06) said that the process was painful and deskilling, although a number said that it had felt a little constricting. Participant 06 was also very aware that her painful process was largely caused by feeling her consultant was unavailable and rather unprofessional. Overall, for those who had achieved accreditation, it seemed to be positive and a joy once attained although the process was perceived to be difficult.

My sense from my findings here was that the EMDR Association needed to be clearer and more proactive in setting out the requirements for accreditation and in making it feel more achievable.

Perhaps a more pressing point was that a high number of people who have trained in EMDR are not members of the EMDR Association. Participant 002 was an example of this. The EMDR Association believed (Board minutes November 2019) that 10,000 people had been trained in EMDR in the UK. However, at this time the Association had slightly less than 4000 members. Shortly before the time of writing, free membership for a year had been offered to participants in standard training. This was to encourage them to join and resulted in a steady membership rise of about ten per cent per year over the last four years. However, there was clearly a reluctance for people to join and this needed to be addressed by the Association.

**The development of themes**

The ten themes I have developed represent an amalgamation of a large number of sub-themes contributed by each participant. This led to a much wider exploration of experience than was possible in my PEP when only five themes were identified. The PEP themes were:

- Structure and manualisation
- The relationship

- Rebellion and conformity
- Integration and learning
- Convergence and divergence

The themes I have been able to work on in this final project have, I believe, been fuller and more detailed, although interestingly all of the above themes have been integrated in some way into the new themes.

Some of the themes may be seen as reflecting experience of EMDR generally rather than of CPD. However, I think that my participants expressed that one's experience of the practice of EMDR strongly influences how one sees CPD and ongoing training.

There was generally a sense that CPD was very useful, but that sometimes adaptations could be made. I think that the fact that online CPD had been accepted by the Association in May 2020 made a huge difference to members' experience of doing CPD. Furthermore, regional groups have reported higher attendance of attending trainings now that they are online.

**Knowledge**

"In the banking concept of education, knowledge is a gift bestowed by those who consider themselves knowledgeable upon those whom they consider to know nothing" (Freire, 1993, p. 53).

I do not think this banking model is suitable for EMDR training. A more collaborative model is needed. I wonder if there is some sense that this is exactly what the model implies and that this contributes to the concept of right and wrong and the fear that we are getting things wrong?

My research indicates that there were a number of ways in which people gained knowledge in EMDR. Clearly, standard training and attendance at CPD was one way, but participants also

valued supervision highly as a vehicle for obtaining knowledge. Participant 12 stated that 80% of knowledge in EMDR was gained in supervision. People also had a sense that knowledge grew through experience and personal integration of ways of working.

There was a range of beliefs about the technical and general therapeutic knowledge required in EMDR. Some aspects like Standard Protocol were generally agreed on, and other aspects like AIP were overlooked.

I wondered if the theoretical underpinning of EMDR tended to get overlooked. It was interesting that, when asked to name the things a practitioner needed to know, only the consultants named AIP as essential knowledge. I wondered if this was one of the things that meant that EMDR was not always viewed as a therapy in its own right. Alvin Mahrer (1989) said that all psychotherapies needed to have a theory of human beings, a theory of therapy and a set of concrete operating principles. According to current thinking, EMDR certainly has a set of concrete operating principles (bilateral stimulation, Standard Protocol) and several competing theories of therapy, (working memory hypothesis, REM sleep hypothesis, dual attention stimulation eliciting an orienting response, hemispheric synchronous communication). AIP contributes the theory of human beings. It, therefore, seems to meet the criteria to be seen as a therapy but it may be that practitioners are not sufficiently aware of the theoretical underpinnings.

Traditionally EMDR has been taught as a technique rather than a therapy in its own right, and this was the criticism that Farrell and Keenan made in 2011 when they said that EMDR would always be a secondary therapy all the time that practitioners were required to have an existing mental health training.

**Development of Practitioners**

My findings on the development of practitioners relate to some of the literature in learning in my literature search.

Skovholt and Ronnestat (1995, pp. 101-123) discussed eight stages of practitioner development:

- Conventional
- Transitional to professional training
- Imitation of experts
- Conditional autonomy
- Exploratory
- Integration
- Individuation
- Integrity

I found these stages quite difficult to apply to the UK situation. In addition, all EMDR practitioners are required to have pre-existing mental health training. However, all the participants appeared to be in at least the "Conditional Autonomy" stage, and many of them surpassed this.

The 20 themes formulating the essence of Skovholt and Ronnestat's (1995) findings did seem to have relevance to my participants. Their point two was that "External and rigidity orientation increases through training, then declines". This seemed to have been true in my research. Most practitioners declared the need for creativity and a lack of rigidity in applying the protocol. It was notable, however, that a rigidity in doing this was laid at the door of the EMDR Association.

Point four said that “senior practitioners rely on internal expertise”. This also seemed to be true in my research. If we consider the Consultants to be the senior practitioners, they did appear to rely on internal expertise. This was the case even if it was an externalised knowledge that had been internalised, as with 009 and the metaphor of the highway code.

Point six suggested that “there is a movement away from received knowledge towards constructed knowledge”. Again, this seemed to describe the process that participants have gone through. As Participant 09 said:

> *“When you really understand what we think is going on, when you’ve got your head around it, it enables you to be a little creative with the protocol.”*

Point 10 said, “as the professional develops, there is a decline of pervasive anxiety.” I find this an interesting point. For the consultants, this did appear to be true. For accredited practitioners, I was not sure that there was a decline in pervasive anxiety. There still seemed to be a concern around right and wrong and getting things right. Participant 009, a Consultant, also fed into this when she described thinking that she had not been ready to become a consultant as she had still been getting things “wrong”.

My sense, rather sadly, was that “pervasive anxiety” was very much alive and well in the EMDR community. Arguably, the EMDR Association had a responsibility for this. If requirements are made clearer in the future there may be a reduction in anxiety.

Point nineteen said, “for the practitioner there is a realignment from a narcissistic position to a therapeutic position.” All the participants expressed concern and empathy towards their clients. Perhaps by definition, most of the discussion was focused on them and how they saw things. Some practitioners were very focused on their understanding of how to do EMDR and what they needed to know.

Point 20 said, “extensive experience with suffering produces heightened tolerance and acceptance of human variability.” This was an interesting observation particularly with regard to Participant 12. This participant felt that she had suffered a great deal with the EMDR Association, as well as working with the intense suffering of her clients. She seemed to have reached a point of acceptance of frailty and difficulties. This was in the sense that she had resolved to be re-accepted within the EMDR Association and to continue with her role despite difficulties.

The Dreyfus (2004) model of stages, comprising novice, advanced beginner, competent, proficient and expert, was adapted to EMDR by Farrell (2011). He postulated that the practitioner was a novice at the beginning of EMDR training, an advanced beginner by the end, that they became competent as they practiced and attended supervision and CPD. According to Farrell (2011), proficiency was attained with accreditation and expert status was attained with consultancy.

My participants did seem to fit roughly into this categorisation. Participant 002 may still have been considered an advanced beginner. She was not in regular EMDR supervision nor attending very much CPD. She might have accepted this as she was clear that she did not always do EMDR but rather simply continuous bilateral stimulation. It was also clear to me that 002 is a very experienced therapist. The other three non-accredited practitioners fit into the competent stage. The accredited practitioners appeared, largely, to be proficient and the consultants appeared to be expert. The latter was despite 009’s belief that she had been made a consultant before she was ready because she had still been doing things “wrong”.

Bateson (1972) suggested that advances come from a combination of loose and strict thinking. This was interesting in light of the themes of *structure versus creativity* and *right versus wrong*. My participants largely demonstrated a combination of these thinking styles.

This was also interesting in light of Participant 12's criticism of the rigidity of the Association's thinking.

Stratton and Vetere (2016) discussed the hermeneutic circle as "a way of thinking about how information is processed using the therapist's existing structures of meaning and will then be subjected to dialogue either with others or within the self."

It was interesting to speculate how this applied to some of my participants. 003 for example appeared to have a clear internal structure of meaning. She did not like to be told what to do and therefore saw herself as a rebel. She identified with others who were seen as being on the outside of the organisation. It seemed painful for her to think about conforming to the Association and she said of accreditation:

> "*It would kill my creativity"*

This participant had, therefore, decided that within her existing structure of meaning, becoming accredited would necessitate conforming and the process of accreditation would kill her creativity. This did not stop her from attending the same amount (or more) of CPD that she would have were she accredited. She, therefore, seemed to be continuing to learn and to develop as a practitioner without any validation of this.

**Issues with Accreditation**

Figures from EMDR Europe (2020) showed that the UK had one of the lowest percentages of accredited members to members of the thirty-two member countries of EMDR Europe. It is an issue for the EMDR Association UK that members have not been sufficiently encouraged to become accredited.

Of the four unaccredited participants, two had been working towards accreditation and two seemed to have made a definite decision not to do so.

Participant 01 had already attempted her accreditation twice and had not been successful. She had been moderately philosophical about this and intended to try again. She also expressed mild irritation:

> *"It was a faff"*

She had believed that all 25 of the required clients did not need to have worked through the entire eight phases of the protocol. Therefore, she had submitted her application with only about half of them having done so. She had had a number of clients who had only completed the preparation and resourcing elements of the work, and she had believed that this should have been enough.

She suggested that her supervising consultant had also believed this sufficient. She, therefore, found it rather irritating that only one or two of the 25 could be counted.

This made me question the process of accreditation. How accessible was it? How clear was the process to members (including consultants)? At the time of writing, the EMDR Association runs Consultants' days at which a great deal of work is done to ensure that consultants understand the process. Apparently, this is not always understood.

Clearly, Participant 01's consultant was not able to guide her accurately in seeking accreditation. However, Participant 01 was clearly in favour of accreditation and saw it as a useful step for her.

Participant 04 discussed her hesitation in applying for accreditation. She expressed her need to understand the process and feeling that she did not understand it. She also said that she was clear that accreditation required the Standard Protocol and implied this could be an issue for her.

> "*I think there was this thing about getting it right, doing it right, that is so not the way I operate…I might use modified protocol but because I'm going for my accreditation,*

> *probably this year, my understanding is I need to stick to standard protocol…I'm not quite sure what is required in terms of CPD."*

Participant 04 clearly demonstrated the strong link in EMDR between accreditation and CPD.

Participant 02 clearly believed that being unaccredited gave her freedom to do things her way. Participant 03 was clear in her feeling that the process of accreditation was all forms and protocols and it would block her creativity.

Unsurprisingly, the participants who had achieved accreditation were generally positive about it. Participant 06, however, described the process as painful and said it had made her feel deskilled. She was positive that she would not go for further accreditation as a consultant.

Again, there were mixed views on this from the accredited participants. Participant 07 was already working towards being a consultant, whilst Participant 05 was considering it. Participant 05's major motivation in thinking about moving towards consultancy, was that she was a child and adolescent therapist and there are very few child and adolescent consultants, so she considered that she would be filling a gap. Participant 08 seemed to have not considered moving towards consultancy and felt that being accredited was enough.

The consultants on the whole were very positive about accreditation, feeling that it was a very helpful stage. Participant 09 was clear that she would not put someone through accreditation if she felt unconvinced that they knew why they were doing what they were doing.

Participant 10 had strong ideas about the accreditation process:

> "*What I would say now is, having been on the accreditation committee for donkey's years, the process is now, well, it's not clear cut, certainly not for a practitioner status, no, it's not clear-cut. I think it's very confusing to become accredited in the first place, because of this stupid idea of twenty hours supervision, whilst at the same time is a competency based framework. So, er, that, that's confusing. I suppose I had*

*no real understanding of the process. I was just told I was a consultant and I've been acting as one ever since, I suppose."*

This consultant highlighted an anomaly in the accreditation process which also partly impacted Participant 01. He pointed out that accreditation was competency based but that in addition, people were told that 20 hours of EMDR supervision were required. This sometimes generated an expectation that once they had these 20 hours, they should be put forward for accreditation.

There was a further anomaly between the requirement of 25 clients but only 50 hours. This was clearly an inconsistency (as no EMDR process could be completed in two sessions), which led to confusions such as those of 001.

I will, therefore, recommend that these details are changed. I also understand, at the time of writing, that this is complicated for the EMDR Association UK, as the regulations are laid down by EMDR Europe.

Participant 10's experience was very interesting. He had been involved in EMDR for a long time and, therefore, his own experience of accreditation and consultancy had not been so bureaucratic.

Participant 12 said she was a "great fan" of accreditation, but that she had considerable criticisms of the process. She also stated that the EMDR Association was not an accrediting body and so the term used should be certification rather than accreditation.

**Creativity**

Structure versus creativity was one of my themes and was strongly emphasised in the interviews. Regarding this, Di Giorgio et al. (2004) researched three EMDR practitioners who were from different theoretical orientations. The authors found that they all deviated from Standard Protocol to some degree.

Eight participants in the current study accepted that they sometimes deviated from the Standard Protocol. Many attributed this to creativity. Interestingly nobody mentioned Interweaves. The notion of Interweaves was Shapiro's (2001) contribution to the concept of creativity and involved the therapist being more present rather than "staying out of the way".

Eatough et al. (2018), interviewed couple and family therapists about their experience of learning an evidence-based approach. They identified three themes: challenges in learning, the embodiment of learning and the experience of shame while learning. I think that the idea of the embodiment of learning contributes to EMDR practitioners' perceptions of creativity. Many practitioners seem to have assimilated or embodied the Standard Protocol so they experienced it as an intuitive and creative process, whereas EMDR Trainers saw it as a learned structured therapy.

# Chapter 23.Discussion

An issue that arose for me while conducting this research was the extent to which my analysis was consistent with IPA. I was concerned with trying to enter into the perceptual worlds of the participants and with grasping their meanings. However, there was also a body of knowledge behind the research which could sometimes make it seem as though I was hypothesis testing. I sometimes tried to move away from a discussion of how things "are" or "are not" in EMDR, but there was a problem in that, with the structure of the therapy, there can be seen to be a "correct" way of thinking.

An example here would be my discussion of "magic" which was raised by two of my participants. A more phenomenological way of seeing this might have been to inhabit the sense of awe and wonder that the participants may have had at something that seemed to be purely magical, rather than based on a specific theory.

Another example would be the theme of right and wrong. In the presentation I gave to the EMDR UK Virtual conference I spoke about my belief that we needed to move away from the concept of right and wrong and that some of my participants had expressed fear of getting it wrong which appeared to be unhelpful for the organisation.

However, because EMDR is a highly structured therapy there are aspects of things that people do that actually are "wrong" according to the structure. This has been a consistent tension for me in doing the work and I question whether my work is in fact good IPA. However, I take heart from Barton (2021) who said: "I offer my interpretation of IPA" and I believe that I also do this.

It is true that in EMDR knowledge is treated in a particular way and that the received wisdom of EMDR can indicate that knowledge is single and universal, as opposed to something that could be understood in a particular way.

My interpretative sections involve quite a lot of discussion about the EMDR Association. It may not be immediately obvious what the role of the Association is in my research question, but as far as CPD is concerned, the Association is heavily involved. It approves (or not) CPD trainings that are offered through the system of CPD points. It is also heavily involved in the question of what knowledge is needed, as this is prescribed by the EMDR Europe Standards Committee.

There has therefore been a consistent tension between what "is" in terms of the EMDR Association, and the perceptions of my participants. My feedback to the Board is already and will continue to be, based on the perceptions of my participants and things that the Board needs to consider about change.

A number of the participants made a very strong criticism about CPD within EMDR. They were critical that, at that time, CPD points were not awarded for online CPD. This decision was rapidly reversed in May 2020, when the pandemic had made face to face CPD impossible. The decision was indicated to be a temporary response to the pandemic. However, it now appears very difficult to return to the old position and it seems hard to justify the earlier decision that online training was unacceptable. This may be an ongoing tension however as at the end of the writing of this project (March 2021) the EMDR accreditation committee extended the period for acceptance of inline CPD to the end of 2021. I will be proposing that the change is permanently accepted.

Earlier I discussed the concept of "functional fixedness" (McCaffrey 2012) in wondering if practitioners sometimes had a fixed view of the process of therapy. It seems entirely fair to think about the fixedness of views of the EMDR Board and how some participants had seen these as the views of a "cult" or political party.

Participant 12's belief that the Board's concern had always simply been the purity of the protocol seemed to be reasonable criticism. Some of the views that the Board had maintained have been rigid and without foundation.

One of my products, therefore, will be to try to communicate to the Board (of which I am a member and a member of the Executive Committee) that the Association seems to perpetuate perceptions of itself that are not always helpful. In addition, the Association needs to see itself as serving its members.

My overall sense of the participants' views of CPD in EMDR was positive. There was a sense of enjoying the learning, although without a very clear sense of learning that needed to be achieved. There was, however, a pervasive sense of fear of getting things wrong. Participant 10 reflected the fear of the Association itself:

> "*The accreditation Committee has become very hawkish…it's like they think 'What if we accredit somebody and they kill their patient!'*"

There was perhaps a mirroring process at work here. The therapeutic process is about living with uncertainty, and so perhaps, attempts to foster too much certainty have generated a difficulty in EMDR.

I believe that the EMDR Association needs to revisit the concept of "schism". It would be useful to consider what has made some disagreements more unacceptable than others and what has led some members to feel that they are less acceptable and less welcome in the Association. This issue has been highly relevant to my research question as the issues of difference are all involved with CPD and the nature of knowledge within EMDR.

I would like to return here to Farrell and Keenan (2013). The authors suggested that while individuals were required to have a core profession in order to train, EMDR would always be seen as a secondary therapy. I think that this is an ongoing issue regarding CPD. EMDR

standard training is brief (most typically seven days in the UK) and therefore CPD will always be needed to fill in the gaps.

Notably, some practitioners felt that, although considerably less than other accrediting organisations, the requirements for CPD (75 points over five years) were too much.

I was interested in the disagreement between the perceptions of Participant 10 and Participant 11 about whether CBT requirements were greater or lesser than EMDR. Both participants were EMDR consultants and both were also CBT Therapists. Participant 10 believed that CBT requirements were considerably more than those of EMDR, while Participant 11 believed the opposite. It was interesting that two people with similar backgrounds and experience could have two completely different perceptions of the same phenomena.

This research has affected me both as a psychotherapist and as a supervisor. I have grown in pride as a therapist, at being part of a community that practices and perfects a very effective psychotherapy. I think that immersing myself in views of training and CPD within EMDR has caused me to introduce EMDR to more and more of my clients.

My views of the CPD that I attend, and deliver, have perhaps sharpened a little. I have become very aware of participant 007's opinion, that often in EMDR CPD, what was suggested to be a workshop was actually a lecture. I have worked hard on the CPD course that forms part of the product for this project, to make it very participative and not just a lecture.

As a supervisor, I am very aware of the fears my supervisees have of getting it wrong. This is a constant tension, as I do believe that a large part of the learning of EMDR takes place in supervision. The challenge is, therefore, to teach while at the same time not shaming the supervisee into thinking that they are wrong.

I am very aware of the possibility of shame in supervision (Kearns 2005: Dearing & Tangney 2011). I am also mindful of feeling strongly ashamed during the interview with Participant 10 when, as she was recounting her own experience, I felt that I also had done something wrong, as I also practised in the way she was describing as incorrect.

All of the consultant participants commented on their experiences of consultant training which is also part of CPD. Many of them felt that it had been harsh. I was told in consultant training that I was not teaching enough in my supervision practice and that in EMDR supervision should involve a strong emphasis on teaching. The balance for me, therefore, has been to maintain the practice of teaching whilst at the same time not shaming supervisees or making them feel as if they have been doing it wrong.

This research also opened for me, a series of questions concerning what CPD should provide to the EMDR community and what people feel they still need input on. This was extended by the responses to this question given at my first CPD course inspired by this research.

I was also interested in the responses of my participants to the question about knowledge. Interestingly, eleven of the twelve gave strong technical answers to the question, whilst the responses about the relationship seemed to apply to therapy in general rather than just EMDR. There is specific literature on the relationship in EMDR (Dworkin 2005) but this seemed not to be considered.

**Generalisability**

When I started this research, I wondered if studying the learning and CBT experiences of a group of EMDR practitioners would be generalisable to other groups of therapists. There are ten thousand trained EMDR therapists in the UK, with just over four thousand members of the EMDR Association.

My view of this now, is that although some attitudes may be generalisable the EMDR Association has a fairly unique position. Other therapeutic bodies (BACP, BABCP, UKCP) generally oversee a wide variety of different therapies. Even BABCP which could be seen as representing a specific approach oversees a wide set of variations within that approach.

The EMDR Association is a small, rather closed, group of people. If I compare this to other small organisations I have been involved with in my career (Coherence Therapy (Ecker, Ticic & Hulley 2012): Sensorimotor Psychotherapy Ogden & Fisher 2014)) they have been involved with certifying practitioners, but also being open to other approaches. Both Coherence Therapy and Sensorimotor Psychotherapy, for example, also advocate the use of EMDR. Neither of these approaches has become involved with running large RCTs or trying to get approved by NICE. In common with EMDR, however, both see themselves as secondary therapies.

My experience of these modalities would suggest that attitudes to the therapy and CPD are different. This is perhaps because the therapies are more outward-facing and do not see themselves as having such a wide body of knowledge to disseminate. It seems to me now that as EMDR has tried (and increasingly succeeded) to become a treatment of choice for trauma, that it has been seen as a rival to CBT but without the resources that CBT has. It may follow then, as Participant 11 pointed out, that inevitably groups will split off and operate independently. A few existing examples of this include David Grand’s Brainspotting (2013). However, this has been dismissed as not EMDR and Brainspotting practitioners are not necessarily part of the EMDR Association.

My conclusion then, is that largely EMDR practitioners form a small, rather cut-off group. This group has very specific requirements for accreditation and reaccreditation which are not generalisable to other groups as far as I am aware. This will influence my recommendations

to the Board in terms of trying to open up the understanding of how the EMDR Association works.

However, the first of my products to be discussed below was a general CPD course on personal and professional development. I have only delivered this course once in 2018 but will deliver it again in the future as the learning theory I have considered for this research does have an impact on all practitioners.

# Chapter 24.My Products – Impact of the Research.

The need to produce products was a strong influence in this DPsych and remained a tension throughout my research. The decision to use IPA meant that I had been trying to enter the life-world of my participants and make sense of them making sense of their experiences. At the same time, I was required to turn this into specific products. In my products, therefore, I tried to take the difficulties that the participants expressed into account whilst creating structures to help them make the best use of their practice of EMDR and their CPD experience.

Products so far have been:

- An initial CPD course on the process of personal and professional development delivered to twelve participants in 2018. (Notes for the course are in Appendix Four).
- A CPD course entitled "What does an EMDR therapist need to know?" delivered once to 20 participants in person. There was a second delivery planned for June 2020 in person, but this was cancelled due to Coronavirus. I have now delivered the updated course, taking account of the feedback from the first delivery, to seventy-two online participants on the 27th February 2021and eighty-six online participants on the 13th March 2021. (Notes for this course in Appendix Five, Feedback in Appendix Six.)
- A PDP plan presented to the Virtual EMDR Association Conference in 2020 by Farrell, Knibbs, Mackinney and Miller. (Appendix One).
- A Conference Presentation 2020 at the EMDR Virtual Conference.
- A beginning skills model.
- Recommendations to the EMDR Board
- A future CPD course on achieving Accreditation

## The Initial CPD Course

This course focussed on the nature of CPD and what personal and professional learning actually is. I asked participants to do an exercise to elucidate their understanding of the terms Personal Development, Self-awareness, Self-reflection and Reflexivity.

We then explored notions of self and what this meant in professional development. This was followed by exploring theories of professional development and the actual process of CPD. Participants were encouraged to develop a Professional Genogram (Vetere and Stratton 2016). We considered whether it was helpful to develop a CPD portfolio and how people planned their learning.

11 of the 12 participants on this initial course were members of BACP. This meant that they were required to keep a record of CPD. However, only two participants stated that they did so. The usefulness of this was discussed. The notes for this course are in Appendix Four.

I presented this course to counsellors and psychotherapists who were not necessarily EMDR practitioners. At this time I was trying to help people to develop their sense of understanding of the CPD process, and the feedback from this course was very positive. In the future, I will offer this course again to therapists who are not necessarily EMDR therapists using some of the insights I have gained about learning theory and the development of expertise.

## Presentation at EMDR Conference

This was presented at the virtual EMDR Association Annual Conference in June 2020, having initially planned to have been in Cardiff in March. The virtual conference was attended by five hundred and fifty people.

My process in presenting this was interesting to me. I presented my themes as reported in this paper, but I very clearly fudged the schism theme, presenting it as differences. I did not talk

about this very much at all. In conversion with my Academic Consultant, I said that the reason for not clearly stating it was that some people do shoot messengers!

I thought about the work I did in a Professional Knowledge Seminar with Dr Deborah Kelly. We were asked to come up with an image for our research process and my image was of a tug of war with two sides desperately trying to win. I sensed that if I presented some of the ideas represented here, I would be in the middle of the two sides and either vilified or falsely claimed by one or both. This felt like a very uncomfortable possibility.

As I recorded my presentation it felt more like an appeal for peace. This interested me in terms of my own process of negotiating these ideas.

My Academic Consultant suggested that the full results should be presented at the EMDR International Association Conference in 2021. (This has now been postponed and hopefully will happen in 2022). He suggested that it was wise to “keep my powder dry” until then. Otherwise, I felt that although the presentation was only 45 minutes I presented my findings honestly and straightforwardly with information that was helpful for people to know.

One of the difficulties for me is that I have now been writing this piece over quite a considerable period of time. I am currently making revisions. The presentation has now been made and I have received some feedback.

I asked people to email me if they had comments to make. There is obviously a difficulty with this in that the content was recorded. If the presentation had taken place at the Cardiff Conference as originally planned, I imagine feedback would have been fairly instantaneous but as people had 28 days to watch the recorded presentations, the feedback trickled in.

My response to the feedback was slightly mixed. Several people contacted me to say that they had enjoyed my presentation and liked what I had had to say. Three of the participants in my research also contacted me.

Participant 12 said in her email:

> *"just to say how excellent it was, and how good it was to hear and read your observations, carefully modulated, in what could usefully change in training and experience of EMDR. Delighted that you got the magic in so elegantly*"

Participant 10 also said:

> "*Great to be so clear about standard protocol and EMDR as a psychotherapy*"

I had an uncomfortable sense here of being appropriated by "both sides" and I was also aware that I was still thinking in the sense of sides, the image of the tog-of-war appear to be very apposite.

The new President of the Association also emailed me to say:

> "*I really enjoyed your presentation and it made me think, which I guess is what you wanted.*"

Of course, this was exactly what I wanted and I was pleased that the President noted this. I hope this will mean that some of my recommendations will be accepted by the Association.

**The CPD Course on EMDR Knowledge**

I developed this course as a direct product from my research. The course is titled "What does an EMDR Therapist need to know?" The analysis of my interviews had brought up issues for me around what therapists do need to know and how this can be disseminated. I, therefore, developed a course that comprised initial information on CPD and developmental models. It included information on my research and Techne and Phronesis, the participants' responses to the question "What does an EMDR therapist need to know?", information on common errors in EMDR, feelings about the PDP plan and collaboration with the group on a skills model and how we could use this in EMDR.

As this course was initially a pilot I decided to offer it free to EMDR therapists who were on the Kent EMDR contact list. The course was held in person in September 2019 in Canterbury, with twenty participants. I had obtained six CPD points from the EMDR Association. The intention then was to develop the course further and present it to a larger audience in the summer of 2020. This plan did not come to fruition due to the intervention of the coronavirus pandemic. I then needed to think about the possibility of creating a CPD opportunity online. This had not previously been a possibility as CPD points had not been granted for online courses. Over time I publicised (through EMDR UK under the auspices of the Kent Regional Group) and delivered the course online to 73 participants on 27th February 2021, and to 86 on the 13th March. I will be continuing to offer this course to EMDR therapists. However, I did experience some technical issues in the second training and I found that I did not enjoy the larger groups as much as working more collaboratively with smaller groups. Therefore, my plan going forward will be to offer this CPD course in person, when this is permissible, and will limit it to smaller groups.

The feedback from the courses was interesting (attached in Appendix Six). Mostly the feedback was very positive, 97% of people rating the course and myself as a presenter as excellent or very good. There was however one response that said the course was poor and I as the presenter was satisfactory. This person said that the content of the course was incomprehensible, and in answer to the question of whether they had been able to get a clearer idea of their own progress and what they need to develop the individual said that they had no idea and this course had given them no idea about this. I was a little disturbed by this feedback, although understanding the reassurances from colleagues that this was just one person among many positive responses. This did however bring up for me a sense that I was trying to do something that was perhaps rather grandiose. I also remembered that in talking to a colleague on the Board about the course I was about to deliver, she said: “It’s good for

Regional groups to be doing that, but don't you think the trainers should be doing things like that?" I recognise that this could have been a straightforward comment that this kind of course should be delivered regularly by trainers, and I think this would be a good idea, but I took it that she thought that I was elevating myself above my position in the Association.

This has therefore brought up for me another very interesting question around what right I have to have done this research, and what right to disseminate findings from it. I also tell myself that this was a question that had never been asked or at least never studied, in the EMDR community. There were comments in the feedback that this was a very important question that needs to be worked on, and the idea of a skills framework was favourably received.

The participants in the initial training particularly liked the list of common errors in EMDR which had been drawn from my own training and my experience as a consultant, as well as references from Hensley (2018). In retrospect, I wonder if this type of input increased the sense of right and wrong that persists in EMDR, but it was also gratefully received by the participants. I wondered whether to keep this aspect of the training day but did do this for the online training and again it was well received.

For the initial in-person CPD course, I presented some background on CPD and areas of learning, I then presented some of my interview participants' answers to the question of what they thought an EMDR therapist needed to know. We then went over the common errors and I introduced the old Personal Development Plan (PDP) and asked people how they would like to improve this. I then introduced my concept of a basic skills model for EMDR and asked people to build up a developmental programme for themselves. There was some individual writing and some working in small groups.

By the time I was ready to offer the training as an official online CPD course that people paid to attend, I had modified the content somewhat. I had a shorter introduction to CPD and how people learn. I then introduced more on existing research in EMDR, and particularly the Farrell and Keenan (2013) study on participants' experience of EMDR training. In this study, Farrell and Keenan had suggested that the existing EMDR Standard Training was not fit for purpose. They set out a curriculum of what they believed practitioners needed to know by the time they had complete Standard Training. Not all this curriculum is covered by the current training. I, therefore, presented this research, and then discussed my participants' answers to the question of what they thought they needed to know. I then introduced a section on discussing some of the themes of my research, including right versus wrong and structure versus creativity. I did on this occasion talk more about the issue of difference and disagreement in the community. However, I still referred to this as "Differences" rather than "Schism". I am aware that I am still slightly nervous about discussing this issue in full. We then went back to the section on common mistakes in EMDR and I asked the participants to go into breakout rooms to discuss this.

I then introduced the new PDP (Farrell et al., 2020) and again asked people to spend some time looking at this and working out what they think they need to work on. I followed this by discussing my revised skills framework.

This later iteration of the training seemed to me to be more complete but over time I believe it can be improved further. Largely, participants seemed to benefit from the CPD. The notes for the course are in Appendix 5 and the breakdown of feedback sent to the EMDR Association is attached in Appendix 6.

One very important aspect of the workshop feedback was that although people liked the concept of the full training discussed by Farrell and Keenan, which was then made into an MSc course in EMDR therapy, they indicated that were this level of training made mandatory

it would become unaffordable. I thought this was a very significant point and it confirmed my recommendation of a suggested programme of CPD which people could undertake over time.

**Personal Development Plan**

The EMDR Therapy Personal Development Plan II (Farrell et al., 2020, Appendix One with comparisons to the old plan in Appendix Seven) is a revision of the original PDP plan. The preamble to the plan is as follows:

> The purpose of this EMDR Therapy Personal Development Plan is to enable you to reflect on your current knowledge, understanding and clinical application of EMDR therapy. Secondly, to provide an insight into areas of your EMDR therapy practice that may require further development and skills enhancement. This tool can be used both as a structured means of subjective / self-assessment, or in conjunction with your EMDR Therapy Clinical supervisor/consultant as part of clinical supervision, or as part of an EMDR Europe Accredited training programme.
>
> This EMDR Therapy PDP II is in five sections:
>
> Section 1: The Adaptive Information Processing (AIP) Theoretical Framework, Neurobiology of Trauma and Psycho-traumatology.
>
> Section 2: EMDR therapy as an Eight Phase Treatment Approach.
>
> Section 3: Further Skills in EMDR Therapy and Wider Applications
>
> Section 4: EMDR Therapy Clinical Supervision and Consultation Skills
>
> Section 5: EMDR Therapy Personal Development Plan – Strategic Action.

This sets out the parameters of the plan and gives a clear understanding of how it may be used.

Sections 1 and 2 are then set out with a 6-point proficiency scale which is partly drawn from Dreyfus (2004). The Dreyfus scale is *novice*, *advanced beginner*, *competent, proficien*t and *expert*. Farrell (2011) has previously mapped these ideas onto EMDR training as follows:

| | |
|---|---|
| Novice | Beginning of training |
| Advanced beginner | Ending training |
| Competent | Using EMDR Therapy, in supervision and attending CPD. |
| Proficient | Accredited |
| Expert | Consultant. |

The new proficiency scale assesses knowledge and competency and is as follows:

None

Limited

Basic

Proficient

Advanced

Expert

In my opinion, this scale is an improvement on the previous scale which was simply:

Not strong……………………………………………………………………Strong.

The previous plan was also in two versions: The Standard Plan (Farrell et al., 2013) and the Consultant/Clinical Supervisor Version (Farrell & Keenan, 2011), the new 2020 plan combines the consultant material into one plan.

The 2013 standard plan has three aspects:

Section 1: EMDR Protocol and Practice

Section 2: Possible areas for consideration for your own EMDR Personal Development

Section 3: EMDR Personal Development Plan – Strategic Action.

The 2011 Consultant Plan has four aspects:

Section 1: EMDR Protocol and Practice

Section 2: Possible areas of consideration for EMDR PDP

Section 3: EMDR Clinical Supervision and Consultation.

Section 4: EMDR Personal Development Plan – Strategic Action.

The new plan is, therefore, clearer in identifying appropriate areas for EMDR practice as it combines elements of the two previous plans.

In Appendix Two I compare the questions on the new 2020 plan and the 2013 plan.

The 2020 version is more succinct. I think it is also clearer in the process that needs to be followed and leaves out unnecessary details whilst keeping the essential elements of the protocol. The new version is intended to create more of a framework rather than represent an exhaustive set of instructions. I think it is set out more clearly and does not appear to be so overwhelming. For example, the 2011 version contained some highly technical questions, such as question 34: “Understand the difference between sweeps, sets, targets and channels” This question and several like it have been excluded from the 2020 version because of their very technical nature and because it is probably not helpful for people to see EMDR therapy in this way.

The new 2020 version is still a fairly detailed questionnaire but is focused in a slightly different way. I think the introduction of the Likert scale is much more helpful than the

previous simple Not Strong-Strong scale. I hope that this version will be more user-friendly and lead to people using it in supervision.

The 2020 plan is clearer on naming protocols although some of the special populations are named in the same way. The 2020 plan reflects developments in the understanding of the application of EMDR, including psychosis and humanitarian activity, in a way that the 2013 plan did not.

Some of my interviewees' criticisms of the plan have been resolved and some not. The Not Strong – Strong scale has been replaced with a 5-point Likert scale. The questions are more targeted and more clearly focused. There are more open boxes for people to consider. I think, though, that for some people the PDP will still seem to be too long and too intimidating. There is perhaps a balance to be achieved.

There are several amendments to the plan that I actively initiated. The 2020 plan incorporates material for consultants. The 2011 plan had given a list of adjectives to describe the supervisor, asking them to consider how much these words applied to them.

The 2020 plan uses the same words but changes them to nouns instead of adjectives. At my suggestion *controlling* was changed to *an ability to manage the supervision/supervisee* and *domineering* was changed to *assertiveness*. I had found the use of the term domineering rather odd in a list of otherwise relatively positive words. Likewise, the word controlling seemed inappropriate when referring to a supervision scenario.

The 2011 plan then refers to other abilities:

- Ability to manage boundaries
- Ability to structure clinical supervision sessions
- Maintain focus during clinical supervision sessions
- Establishing a clear agenda

- Keeping to an agenda
- Awareness of ethics and governance
- Providing feedback to supervisees
- Receiving feedback from supervisees
- Contracting for EMDR Clinical Supervision
- Educative
- Supportive
- Managerial
- Awareness of the EMDR client
- Awareness of the EMDR supervisee
- Self-awareness
- Willingness to share from your own clinical experience/expertise
- Knowledge and familiarity with the EMDR Europe Competency-Based Frameworks

The 2020 plan removes the items concerning setting agendas and replaces *Educative* with *Various theoretical models. Frameworks for clinical supervision*. It also adds the word *constructive* to the items about feedback. This seemed to me to be important as all of my consultant participants had referred to the difficulty of the consultant training, particularly in the past. Participant 10 referred to it as "brutal" and Participant 09 said that she did "*the worst consultants' training ever*". The emphasis in consultant training is definitely on the educative and consultants are very strongly encouraged to teach. In retrospect, I think the reference to the Kadushin (1974) model of supervision as educative, supportive and managerial would be better replaced by the Supervision Alliance Model (Inskipp & Proctor, 1995) which talks about the formative, normative and restorative aspects of supervision. In future revisions of

the plan, I will ask for this replacement. I am mindful here of Participant 06 who indicated that the restorative was missing from her EMDR supervision.

In the 2020 plan, there are additional boxes in terms of strategic action. People are asked:

1. What do you need in order to achieve your EMDR Therapy PDP in the short, medium and long term both as an EMDR Therapy Clinician and an EMDR Therapy Clinical Supervisor/Consultant?
2. What blocks or obstacles do you envisage you may encounter along the way?
3. Consider what strategies might be necessary to try and overcome these?
4. Is there a mentor you could approach for guidance and support? And if so who might this person be?
5. How will you know when you have met the targets within your EMDR PDP?

There is then a large open box for people to write their plans.

This goes some way towards fulfilling the requests that there should be more open boxes in the PDP made by my interviewees. I was also mindful of the feedback obtained in the CPD course in June 2019 which suggested that a mixture of open boxes and fixed questions was more helpful.

I am happy with my part in developing this new PDP although I think it can still be improved. It was launched at the EMDR Virtual Conference in June 2020 and used at a Consultants' Day in Ireland in the same month. I am now starting to use it with my own EMDR supervisees and encouraging feedback on this process. I have also used it in the online training courses I have delivered, and people have given feedback that they found it extremely useful.

I gave a presentation on its use to the Networking group of the Kent EMDR Regional group in September 2020, with 27 participants.

I hope that over time, another new PDP can be introduced which includes more open boxes and gives people more freedom in its interpretation.

This PDP is now beginning to be used more generally and I am using it with my supervisees. They have reported it to be useful because it helps them to focus on skills, learning and needed CPD.

**Skills Framework for EMDR Therapists**

Initially, I developed a suggested skills framework as there has never been a skills framework for EMDR therapy. I have adapted this through the feedback received by my participants on the CPD course.

**TABLE 12**

*NEW SUGGESTED SKILLS FRAMEWORK*

| General therapeutic abilities | Basic EMDR competences | Awareness of Presenting Issues | Meta competences | Specific Protocol awareness |
|---|---|---|---|---|
| Knowledge and understanding of mental health problems | Understanding of AIP model and application to PTSD | Phobia | Ability to use clinical judgement | Standard Protocol |
| Knowledge of, and ability to operate within, professional and ethical guidelines | Understanding of neurobiological underpinnings of EMDR | Panic disorder | Capacity to adapt interventions in response to client | Phobia Protocol |
| Ability to form a therapeutic alliance with the client | Understanding of the three prongs | Depression | Capacity to use and respond to humour | DeTur Addiction Protocol |
| Ability to manage emotional content | Ability to undertake Phase One: History-taking | Pain | Capacity to implement EMDR in a way that reflects its underlying philosophy | Feeling State Addiction Protocol |
| Ability to undertake | Ability to create a case formulation | Bereavement | Capacity to apply the EMDR model | Pain Protocol |

| General therapeutic abilities | Basic EMDR competences | Awareness of Presenting Issues | Meta competences | Specific Protocol awareness |
|---|---|---|---|---|
| assessment and history-taking | | | to the individual client | |
| Ability to manage endings | Ability to utilise Phase 2 according to the resourcing needs of the client | Addictions | Capacity to select and use the most appropriate adaptation of the Standard Protocol. | Blind 2 Therapist |
| Ability to make use of supervision | Understanding of and ability to undertake Phase 3: Assessment | Eating Disorders | Capacity to structure sessions with appropriate pacing | Recent Events Protocol |
| Ability to assess and manage risk | Understanding of how to move through Phase 4: Desensitisation | Dissociation | Capacity to manage resistances to EMDR | Parnell Modified Protocol |
| Ability to understand attachment | Understanding of when to move to Phase 5 | OCD | Ability to deal with ruptures | Flashforward |
| Ability to manage transference / counter-transference | Ability to operate Phase 5 and install positive cognition | Personality disorders | Ability to manage abreaction | Flash Technique |
| Understanding of cultural issues and diversity | Appropriate use of Phase 6: Body Scan | Neuro-diversity | Able to monitor own competency and apply self-care | Inverted Protocol |
| Understanding of online working | Ability to close down a session in Phase 7, including incomplete session | Psychosis | | RTEP /GTEP |
| | Going back to re-evaluate the work | GAD | | CIPOS |
| | Ability to manage blocks and looping | Work with couples | | “Tip of the finger” |

This suggested skills framework was adapted according to some of the suggestions made by participants at my CPD course. I hope that this will be fed into a discussion at the 2021 Council of Scholars. This meeting, established in 2018 (although unfortunately not meeting at the time of writing due to the pandemic), has established four workgroups as follows:

- Training and credentialing

- Research
- Clinical practice
- What exactly is EMDR?

My Academic Consultant has suggested that I present to the EMDRIA Conference in 2022. This will hopefully also mean that through him, I can feed into the Council of Scholars.

Having a skills framework for EMDR therapy could be very helpful for therapists as it gives an outline of skills and awareness that a therapist needs to achieve.

**Recommendations to the EMDR Board**

1. That a structured programme of CPD after initial training could be developed so that therapists have a concept of what there potentially is to know in EMDR therapy.
2. That requirements for Accreditation are very clearly explained on the website and consultants are informed of this.
3. That there are online webinars explaining the benefits of accreditation for members.
4. That courses are offered explaining the process of accreditation.
5. That consultants are encouraged to use the new PDP (Farrell et al. 2020) and this is explained at a Consultants' Day.
6. That the EMDR Association should consider a way of creating more oversight of consultants and checking that all consultants are following the same processes.
7. That online CPD should be accepted for CPD points permanently and not just as a response to the Covid-19 crisis.
8. That the EMDR Association Board makes more efforts to explain thinking and processes to the membership. I have some ability to be proactive in this as Secretary of the Association and I am beginning to produce more information to be sent out to Regional Groups to explain thinking and policies.

**CPD Course on Accreditation**

This would first involve going through the requirements for accreditation and explaining exactly what the process was.

I would then use the new PDP and help participants to begin to work through this. This would allow them to develop a personal plan in terms of what they needed to do and to learn.

The benefits of accreditation would be explained (ability to be listed in the EMDR Association "Find a Therapist" listing; ability to take insurance clients; an assurance of competence.)

We would then work on possible hindrances for people becoming accredited.

This course would be a development of the course I am currently running on "What does an EMDR therapist need to know?"

# Chapter 25.Conclusion

My initial title for this work: "A duty or a joy" has been rather superseded by the focus on what a therapist needs to know. However, the general outcome of my 12 interviews has been that therapists are mostly very enthusiastic about EMDR and find learning about it generally to be a joy. There were aspects of CPD that seemed to be more of a duty and there were considerable criticisms of certain aspects of EMDR practice. Some of these, such as the ban on CPD points for online training, have now been (temporarily) resolved. It is notable, however, that the reversal of this decision only came about because the pandemic made face to face CPD impossible for a period of time. The decision was couched as a temporary one, but I think it is now important that this decision is not reversed. As I finally revised this conclusion, a decision was reached at the Board meeting of 20th March 2021 to extend CPD points for online training to the end of 2021. I will be supporting the idea that online learning should continue outside the requirements of the pandemic, as this was a very strong theme for my participants.

Initially, I wondered if my study of a small group of practitioners in a specific discipline could lead to some general conclusions about therapeutic practitioners and their use of CPD. This hope has not been realised as it seems to me that EMDR is a very particular type of therapy and it is difficult, therefore, to make generalisations. What was interesting was that a number of my participants were insistent on the importance of being psychotherapists already and that this was a core identity for them. I wonder about the extent to which peoples' sense of themselves as psychotherapists influences their decisions about CPD?

It is also true that the beginning stages of this research caused me to create a general CPD course about personal and professional development which I will continue to disseminate to non-EMDR professionals.

Several participants also made comments on their general CPD. In some cases, they found this more helpful. Participant 10, for example, said that his CBT CPD was sometimes more useful than EMDR CPD.

Generally, however, participants were fairly enthusiastic about their CPD and the knowledge that they acquired in EMDR. They also felt that some changes needed to be made and these are reflected in my recommendations to the Association.

My research seems to have demonstrated very clearly that generally, EMDR practitioners find their work to be a joy and that they have very positive experiences of conducting EMDR.

There has also been a very strong sense in my research that general therapeutic concepts such as the importance of the therapeutic relationship are seen as being just as important as technical knowledge in EMDR.

Conducting this research over some time has immersed me in the experiences of practitioners. As a result of my interest and knowledge in EMDR CPD, I have become a Board member during this period. I believe that I will, therefore, be able to influence the Association in helping practitioners to understand some of the processes involved.

This research has already made an impact on the EMDR community. I have delivered an online presentation to 560 participants at the 2020 Virtual Conference and delivered the CPD course associated with this research to a total of 178 people. I hope to extend this number in the future.

The New Personal Development Plan (Farrell et al., 2020) is beginning to be used in other workshops and has been presented to the Council of Scholars committees. I think that the dissemination of this will make a real difference to the EMDR community.

For me, this research has largely been a joy, although there have been difficulties for me in conducting and presenting it. I am anxious about submitting this research as I worry about the

ethics of presenting my participants, and as Josselson (1996) said, I have moved from putting my attention on them as participants to placing my attention on the reader. However, I value the trust that my interviewees have placed in me and I believe that I can take their views forward to the EMDR Association to increase communication between the Board and the membership.

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# Appendices

# Appendix 1

# EMDR Therapy Personal Development Plan II

**(Farrell, Knibbs, Mackinney & Miller, 2020)**

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

This EMDR Therapy PDP II is in five sections:

- Section 1: The Adaptive Information Processing (AIP) Theoretical Framework, Neurobiology of Trauma & Psycho-traumatology
- Section 2: EMDR therapy as an Eight Phase Treatment Approach
- Section 3: Further Skills in EMDR therapy & Wider Applications
- Section 4: EMDR therapy Clinical Supervision & Consultation Skills
- Section 5: EMDR therapy Personal Development Plan – Strategic Action

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

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

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

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

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

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

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

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

| 1.6 Understanding of Attachment Theory | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

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

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

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

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

## Section 2: EMDR Therapy Eight-Phase Protocol

### Phase 2.1: History Taking

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

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

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

| 2.1.4 EMDR therapy Treatment Planning and Target Memory Sequencing |
|---|

| 0 | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|

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

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

**Phase 2: Preparation**

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

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

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

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

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

**Phase 3: Assessment**

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

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

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

| 2.3.4 Identifying associated, and presently held, emotions and body sensations in connected with the target memory | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Phase 4: Desensitisation**

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

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

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

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

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

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

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

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

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

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

**Phase 5: Installation**

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

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

**Phase 6: Body Scan**

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

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

**Phase 7: Closure**

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

| 2.7.2 Utilise an effective debrief | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

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

**Phase 8: Re-evaluation**

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

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

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

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

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

## Section 3: Further Skills in EMDR Therapy & Wider Applications

***Part 1: Knowledge AND clinical application of the following:***

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

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

| 3.1.3 Future Template | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

| 3.1.4 Future Anticipatory Anxiety | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

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

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

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

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

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

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

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

***Part 2: Clinical Populations***

| 3.2.1 Phobias and Aversions | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

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

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

| 3.2.4 Children and Adolescents | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

| 3.2.5 Addictions | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

| 3.2.5 Pain | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

| 3.2.6 Perinatal PTSD | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

| 3.2.7 Eating Disorders | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

| 3.2.8 Schizophrenias and Psychosis | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

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

| 3.2.10 Performance Enhancement | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

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

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

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

| 3.2.14 EMDR Therapy with Couples | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

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

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

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

| 4.1 Empathy | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

| 4.2 Non-judgmental | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

| 4.3 Validation | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

| 4.4 Affirmation | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

| 4.5 An ability to manage the supervision/ supervisee | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

| 4.6 Exploratory | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

| 4.7 Experimental | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

| 4.8 Assertiveness | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

| 4.9 Authenticity | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

| 4.10 Flexibility | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

| 4.11 Involvement | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

| 4.12 Mutuality | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

| 4.13 Empowerment | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

| 4.14 Support | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

| 4.16 Managerial | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

| 4.17 Governance & Ethics | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

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

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

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

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

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

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

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

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

## Section 5: EMDR Therapy Personal Development Plan – Strategic Action

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

Try and consider the following questions:

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

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

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

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

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

Please use the section below for matters to discuss with your EMDR Europe Consultant/ Clinical Supervisor or EMDR Europe Accredited Trainer in connection with this EMDR therapy PDP II:

Possible areas to consider:

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

# Appendix 2

**Comparison of the new 2020 PDP Plan with the 2011/2013 Plan.**

I will now compare the questions on the new plan initially with the 2013 plan.

**Table A1**

*Comparison of old and new PDPs*

| 2013 Plan Questions | 2020 Plan Questions |
|---|---|
| 1. Understanding of the Adaptive Information Processing (AIP) Model | 1.1 Understanding of the Adaptive Information Processing Paradigm as a Theoretical Model<br>1.2 Adaptive Information Processing Case Conceptualisation.<br>1.3 Neurobiological Mechanisms of Psychological Trauma<br>1.4 Neurobiological understanding of EMDR Therapy and potential mechanisms for action<br>1.5 Understanding of Adverse Childhood Experiences (ACES)<br>1.6 Understanding of Attachment Theory<br>1.7 Understanding of the Theory of Structural Dissociation<br>1.8 Current empirical status of EMDR Therapy, International Treatment Guidelines and up-to-date knowledge of existing academic literature, research and development<br>1.9 Knowledge and understanding of Post-traumatic Stress Disorder (PTSD).<br>1.10 Knowledge and understanding of Complex Post-Traumatic Stress Disorder (C-PTSD) |
| 2. Neurological Mechanisms of Action in EMDR (1.4 in 2020 model) | |
| 3. Ability to integrate EMDR into your existing clinical practice | |
| | 2.1.1 Capacity to complete a comprehensive History Taking: Past, Present and Future<br>2.1.2 Assessing client appropriateness for EMDR Therapy<br>2.1.3 Undertaking a thorough Risk Assessment and assessing the |

| 2013 Plan Questions | 2020 Plan Questions |
|---|---|
| | availability of support structures with each client.<br>2.1.4 EMDR therapy treatment planning and Target Memory Sequencing<br>2.1.5 Ability to provide a rational and cogent strategy when working with multiple distressing memories.<br>2.1.6 Able to clarify the client's desired state following EMDR Therapy treatment. |
| 4. EMDR / AIP History taking and treatment planning (part of 2.1.1.) | |
| 5. Assessing client's suitability for EMDR (2.1.2) | |
| 6. EMDR / AIP case conceptualisation | |
| 7 Identifying appropriate safety factors including the utilisation (where appropriate) of the Dissociative Experiences Scale II (DES). | |
| 8 Undertaking a thorough Risk Assessment with each client (part of 2.1.3) | |
| 9 Considering client's life constraints, ego strength and availability of existing support structures. | |
| 10. Clarifying the client's desired state following EMDR Therapy. (2.1.6) | |
| | 2.2.1. Teaching clients self-regulation strategies<br>2.2.2. Testing out the Bilateral Physical Stimulation<br>2.2.3 Providing a "client-centred" explanation on EMDR therapy<br>2.2.4 Demonstrates an ability to address client's fears, concerns, queries, anxieties or trepidations<br>2.2.5 Ensuring the client is able to engage in effective "Dual Attention" (Past and Present). |

| 2013 Plan Questions | 2020 Plan Questions |
|---|---|
| 11. Determining that the client is able to effectively deal with high levels of physical and emotional levels of disturbance. | |
| 12. In cases of multiple targets, effectively utilises either prioritising or clustering techniques | |
| 13. Identifying a touchstone memory event that relates to the client's issues. | |
| 14. Preparing the client for EMDR | |
| 15. Carrying out the Safe / Secure / Calm Place exercise with clients. | |
| 16. EMDR Resource Installation / Resource Development Installation | |
| 17. Psychoeducation of Trauma / Psycho-Traumatology | |
| 18. Psychoeducation of disturbing memories | |
| 19. Ability to explain EMDR to various client groups of various ages, culture and emotional intellect | |
| | 2.3.1. Identifying an appropriate distressing memory for EMDR Therapy trauma processing<br>2.3.2. Understanding of the characteristics of cognitions, both positive and negative<br>2.3.3. An appreciation in applying the Validity of Cognition (VOC) and the Subjective Units of Disturbance (SUD) Scales<br>2.3.4. Identifying associated, and presently held, emotions and body sensations connected with the target memory. |
| 20. Identifying appropriate targets for selection for processing | |
| 21. Considering the three-prong "Past, Present and Future" in relation to targets | |
| 22 Identifying an appropriate stationary image as an appropriate target | |

| 2013 Plan Questions | 2020 Plan Questions |
|---|---|
| 23. Identifying appropriate Negative cognitions | |
| 24. Identifying appropriate Positive Cognitions | |
| 25. Ensuring that cognitions are in the same domain. | |
| 26. Rating the Validity of Cognition (VOC) correctly | |
| 27. Ascertaining Subjective levels of Distress / Disturbance (SUD) correctly | |
| 28. Location of body sensations | |
| | 2.4.1. Activation of the distressing memory and engaging in bilateral physical stimulation<br>2.4.2. Timing each set to the client's needs (approximately 25 – 30 seconds).<br>2.4.3. Understanding of what "trauma processing" looks like.<br>2.4.4. Obtaining feedback from the client after each set.<br>2.4.5. Recognising when processing is blocked and able to intervene accordingly.<br>2.4.6. Knowledge of cognitive interweaves and how to apply them<br>2.4.7. Familiarity in returning to the target memory at the end of a channel.<br>2.4.8. Able to recognise when clients experience heightened levels of affect and be able to manage these therapeutically.<br>2.4.9. Have a clinically effective understanding as to when Phase four might be completed.<br>2.4.10 Recognising when to use an "incomplete session" closure and carry out accordingly. |

| 2013 Plan Questions | 2020 Plan Questions |
|---|---|
| 29. Beginning Desensitisation by requesting the client to just notice the image, negative cognition, emotion and physical reaction | |
| 30. Performing bilateral stimulation (BLS) / Dual Attention Stimulus (DAS) at a good tempo. | |
| 31. Applying the duration of the BLS for approximately 25-35 seconds. | |
| 32. Offering reassurance during a set | |
| 33. Able to effectively manage abreactions | |
| 34. Consider the importance of therapeutic attunement and dyadic regulation. | |
| 35. Obtaining short feedback from clients after each set of BLS. | |
| 36. Returning to target and the end of a channel. | |
| 37. Managing blocks that occur during processing. | |
| 38. Floatback and floatforward techniques. | |
| 39. Knowing when to accelerate during processing | |
| 40. Knowing when to decelerate during processing | |
| 41. Recognising, managing and integrating Therapeutic Interweaves in EMDR | |
| 42. Working with Primary Dissociation | |
| 43. Working with Secondary Dissociation | |
| 44. Working with Tertiary Dissociation. | |
| 45. Managing incomplete sessions in EMDR | |
| 46. Knowing when to proceed to Phase 5 – Installation. | |

| 2013 Plan Questions | 2020 Plan Questions |
| --- | --- |
| | 2.5.1. Checking the appropriateness of the Positive Cognition in relation to the original target memory.<br><br>2.5.2. Installation of the Positive Cognition to a VOV level of either 6 or 7. |
| 47. Checking out the Positive Cognition for "best fit" at the start of Phase 5 – Installation | |
| 48. Installation of the Positive Cognition using BLS | |
| 49. Maintaining momentum of BLS/DAS in installation phase. | |
| 50. Know when to proceed to Phase 6 – Body Scan. | |
| | 2.6.1. Enables the client to bring the original target memory to mind, holding the associated Positive Cognition, and then mentally scan the body for any undue disturbance or discomfort. |
| | 2.6.2. Addressing any residual disturbance that may arise during the Phase 6 Body Scan |
| 51. Carrying out the body scan in an appropriate manner | |
| | 2.7.1. Allows sufficient time for closure and ensures that the client is "grounded" and in the present.<br><br>2.7.2. Utilise an effective debrief<br><br>2.7.2. Encourage the client to engage in in-between session activity and monitoring. |
| 52. Allowing sufficient time for closure | |
| 53. Carrying out an effective debrief as part of Phase 7 | |
| 54. Utilisation of containment exercises as grounding techniques. | |
| 55. Encouraging clients to maintain a log between sessions. | |

| 2013 Plan Questions | 2020 Plan Questions |
|---|---|
| | 2.8.1. Returning to the previous target memory activated in the last EMDR Therapy session<br>2.8.2 Identifying any evidence of progress or re-adjustment since the last session.<br>2.8.3. Determine if any additional material has been activated since the last session.<br>2.8.4. Ensures that all necessary target memories have been processed – past, present and future.<br>2.8.5. Is effectively able to conclude therapy. |
| 56. At the next session carrying out Phase 8 – Re-evaluation. | |
| 57. Addressing issues that may arise since last session | |
| 58. If necessary, returning to previous target (following incomplete session). | |
| 59. Ensuring all past, present and future targets have been addressed. | |
| 60. Addressing the Future Template. | |

Up to this point, the 2013 version is exactly the same as the 2011 Consultants' version. The 2020 version is therefore more succinct and, I think, clearer in the process that needs to be followed, leaving out unnecessary details but keeping the essential elements of the protocol. The new version is intended to create more of a framework than an exhaustive set of instructions. I think it is set out more clearly and does not appear to be so overwhelming.

It is still a fairly detailed questionnaire but it focuses in a slightly different way and I think the introduction of the Likert scale is much more helpful than the previous simple Not Strong….Strong scale. I hope that this version will be more user-friendly and lead to people using it in supervision.

The next section of the 2013 Plan is Question 61 and addresses EMDR scripted Protocols. In the new plan, it is Section 3: "Further Skills in EMDR Therapy and wider applications."

**Table A2**

*Further comparison of old and new PDPs*

| 2013 Plan | 2020 Plan |
|---|---|
| 61. EMDR Scripted Protocols | Part 1: Knowledge and clinical application of the following: |
| Phobia | 3.1.1.EMD Restricted Processing (EMDr) |
| Panic Disorder | 3.1.2 Eye Movement Desensitisation (EMD) |
| Depression | 3.1.3. Future Template |
| Pain | 3.1.4. Future Anticipatory Anxiety |
| Grief, Loss and Bereavement | 3.1.5 Flash-Forward (FF) |
| Children and Adolescents | 3.1.6. Blind-2-Therapist (B2T) |
| Addictions | 3.1.7. Recent Traumatic Experience Protocol (R-TEP) |
| Performance Enhancement | 3.1.8. Group Traumatic Events protocol (G-TEP) |
| 62. Specialist EMDR Populations | 3.1.9. Integrative Group Treatment (IGTP) |
| Complex PTSD | 3.1.10. Feeling State Addiction Protocol (FSAP) |
| Depression | 3.1.11. Urge Reduction Protocol. (DeTUR) |
| Eating Disorders | Part 2: Clinical Populations |
| Forensic Populations | 3.2.1. Phobias and aversions |
| Older Age Populations | 3.2.2. Major Depressive Disorders (MDD) |
| EMDR and Couples Therapy | 3.2.3. Traumatic Grief, Bereavement and Loss |
| Dissociative Disorders | 3.2.4. Children and Adolescents |
| Obsessive Compulsive Disorder | 3.2.5. Addictions |
| Non-psychotic morbid jealousy | 3.2.6. Pain |

| 2013 Plan | 2020 Plan |
| --- | --- |
| | 3.2.7 Perinatal PTSD |
| | 3.2.8. Eating Disorders |
| | 3.2.9 Schizophrenias and Psychosis |
| | 3.2.10 Obsessive Compulsive Disorder (OCD). |
| | 3.2.11 Performance Enhancement |
| | 3.2.12. Bodily and Medically based conditions |
| | 3.2.13 EMDR Therapy and the Older Person |
| | 3.2.14 EMDR Therapy with Forensic Populations |
| | 3.2.15 EMDR Therapy with Couples |
| | 3.2.16 Application of EMDR Therapy as part of Trauma Capacity Building / Humanitarian Activity |
| Possible areas of Consideration for your EMDR PDAP | |
| More EMDR Clinical experience in general | |
| More specific EMDR Clinical Experience | |
| EMDR and Dissociation | |
| EMDR and Ego States | |
| Medico-Legal aspects of EMDR | |
| EMDR Research and Development | |
| Teaching and Learning of EMDR | |
| EMDR Europe Accredited Practitioner | |
| EMDR Europe Accredited Consultant | |
| EMDR Europe Accredited Trainer | |
| EMDR Europe Accredited Child and Adolescent Trainer | |
| Involvement in EMDR Humanitarian Assistance Programmes | |

| 2013 Plan | 2020 Plan |
|---|---|
| EMDR Continuous Professional Development | |
| Related areas of Continuous Professional Development | |
| EMDR Academic Writing and Publication | |
| Wider reading of EMDR literature | |
| Presenting at EMDR Conferences | |
| Participating in EMDR Regional Groups | |
| Gaining more experience as a supervisee in clinical supervision | |
| Gaining more experience as a supervisor in clinical supervision | |
| In relation to the above areas consider what action is needed to best develop your EMDR PDAP Plan? Try and consider your individual plan period in the short, medium and long term. | |

The 2020 plan is, therefore, clearer on naming protocols, although some of the special populations are named in the same way the 2020 Plan reflects the moving on of the understanding of the application of EMDR, including psychosis and humanitarian activity in a way that the 2013 plan did not do.

Considering my interviewees' criticisms of the plan, some of these have been resolved and some not. The Not strong – strong scale has been replaced with a five-point Likert scale and the questions are more targeted and more clearly focussed. There are more open boxes for people to consider. I think though that for some people the PDP will still seem to be too long and too intimidating. There is perhaps a balance to be achieved.

Up to this point, the 2013 plan was the same as the 2011 Consultant's Plan. The new plan incorporates the consultant material. Consultant material is Section 4 in the 2020 version and Section 3 in the 2011 plan.

The 2011 plan asks consultants to rate themselves as "not strong" to "strong" on factors involved within their clinical supervision style. These are:

- Empathic
- Non-judgmental
- Validating
- Affirming
- Controlling
- Exploratory
- Experimental
- Domineering
- Authentic
- Flexible
- Involved
- Mutual

The 2020 plan uses the same words, but changing them to nouns instead of adjectives, and at my suggestion changing controlling for "an ability to manage the supervision/supervisee" and changing domineering for assertiveness. I had found the use of the term "domineering" in particular rather odd in a list of otherwise relatively positive tinged words.

The 2011 plan then goes on to other abilities:

- Ability to manage boundaries
- Ability to structure clinical supervision sessions
- Maintain focus during clinical supervision sessions
- Establishing a clear agenda
- Keeping to an agenda
- Awareness of ethics and governance

- Providing feedback to supervisees
- Receiving feedback from supervisees
- Contracting for EMDR Clinical Supervision
- Educative
- Supportive
- Managerial
- Awareness of the EMDR client
- Awareness of the EMDR supervisee
- Self-awareness
- Willingness to share from your own clinical experience/expertise
- Knowledge and familiarity with the EMDR Europe Competency Based Frameworks

The 2020 plan takes out the items around setting agendas and instead of Educative adds "Various theoretical models. Frameworks for clinical supervision". It also adds the word "constructive" to the items about feedback.

In the 2020 plan, there are then additional boxes in terms of strategic action. People are asked:

6. What do you need in order to achieve your EMDR Therapy PDP in the short, medium and long term both as an EMDR Therapy Clinician and an EMDR Therapy Clinical Supervisor/Consultant?
7. What blocks or obstacles do you envisage you may encounter along the way?
8. Consider what strategies might be necessary to try and overcome these?
9. Is there a mentor you could approach for guidance and support? And if so who might this person be?
10. How will you know when you have met the targets within your EMDR PDP?

This goes some way towards fulfilling the requests made by my interviewees that there should be more open boxes in the PDP. I was also mindful of the feedback obtained in the CPD course in June 2019 that a mixture of open boxes and fixed questions was useful.

# Appendix 3

Responses to my Skills Framework introduced in the first "What does an EMDR therapist need to know" workshop.

There were two questions asked:

- Do you agree with the four categories of skills/competencies I have chosen? What else would you put in?
- Are there any omissions in the lists that you think should be there?

For the first question, one person queried the term "meta-competency" and wondered if it should be "therapist skills/proficiency" or "core knowledge." They also thought that there should be Advanced EMDR competencies such as the Flash Technique.

Six people said that they agreed with the four categories.

One person said they agreed and would like to add the word "additional" to the problem-specific competencies to reflect different professional specialisms. Another person suggested "Competencies with client presentations" instead of "Problem specific Competencies"

Another person also said "Additional Competences" would be better than "Problem Specific Competences"

Another person wanted to change the same category to "Presenting Problems".

Another person wanted to distinguish between therapist skills and personal competencies.

One person again queried the term "meta-competencies" and wanted them labelled "advanced skills". Another person wanted them labelled "advanced proficiencies".

For the second question, one person wanted more capacity to assess oneself within the framework and more questions.

One person suggested the addition of more problem-specific areas. These were: attachment rupture, body dysmorphia, performance anxiety, health anxiety, complex trauma, loss and abandonment/attachment and chronic fatigue.

They also suggested that I should add the capacity to manage abreaction, the capacity to communicate the model to different client groups, and the capacity for self-care to the meta-competencies.

Another person gave a similar list of problem-specific issues s/he thought were missing. These were: attachment, body dysmorphia, social anxiety, performance anxiety and health anxiety. They also felt that I should add recognition of attachment styles and the ability to manage ruptures to the general therapeutic competencies. Again, for meta-competencies, they suggested the addition of abreaction, the ability to communicate to different groups and awareness of self-care.

I wondered if these two people were sitting together, or if they had coincidentally come up with the same things?

Another person wanted to change “Dissociation” to “Disorders of Dissociation” and add “the ability to manage transference/counter-transference” to the general therapeutic competencies. They also wanted to add client groups such as children and adolescents and older adults, or couples.

Three other people wanted attachment added.

Another person simply said it would be useful to develop a brief questionnaire for clients at the end of their work regarding their experience of EMDR.

Someone else suggested, again, that working with children and vulnerable adults should be in “meta-competencies”. They also wondered about “humour” and “clinical judgement”.

“Containment” was suggested as a meta-competency. Another person said the working alliance was not mentioned and advanced techniques should be added. The working alliance was in fact in the first column.

Several people said that PTSD was not mentioned. I think I had assumed this but agreed that this should be adapted.

I considered these comments when developing the final working version of the Skills Framework included in my Products above. I adapted many of these ideas and also added a fifth column of suggested protocols.

# Appendix 4

This comprises the notes for the original workshop I developed for non-EMDR practitioners on CPD.

**NOTES ON CONTINUING PERSONAL AND PROFESSIONAL DEVELOPMENT**

**What do we mean by CPPD?**

CPD is a term used to denote a process of ongoing education and development for professionals involved in providing services to others. It is intended to maintain competence to practice and increase professional proficiency and expertise.

The NHS (Department of Health 1999) defined CPD as:“ the systematic maintenance, improvement and broadening of knowledge and skill and the development of personal qualities necessary for the execution of professional and technical duties throughout the practitioner’s working life”

The Institute of Continuing Professional Development defines it as: “A process by which a professional person maintains the quality and relevance of professional services throughout his / her working life.”

So CPD, following Alsop (2000) could be seen as:

- A process
- Lifelong
- Systematic
- Embracing formal education and informal learning
- Something to assure competence
- Development of personal qualities

- Enhancing professional and technical skills
- Maintaining, enhancing and broadening professional knowledge
- Expanding and helping to fulfil potential
- Maintaining quality and relevance of professional services
- Developing and enhancing practice

The BACP Directory defines CPD as:

> "Any learning experience that can be used for the systematic maintenance, improvement and broadening of competence, knowledge and skills to ensure that the practitioner has the capacity to practice safely, effectively and legally within their evolving scope of practice. It may include both personal and professional development.

**Professional Requirements**

All professional therapy bodies require accredited professionals to undertake CPD. BACP requires 30 hours a year, UKCP 250 hours over 5 years.

Bodies are not always clear over what constitutes CPD and people have very different ideas about this.

Also, what is the distinction between personal and professional development?

Exercise

What, for you, is the difference between:

Personal development

Self-awareness

Self-reflection

Reflexivity

Your definition of these concepts is likely to have some relation to your understanding of the self. People who talk a lot of self-awareness tend to be people who believe in a unitary self – a self that can be moved away from, or lost, or found again. This is the assumption of some major theoretical responses. Winnicott for example talks about the true and false self. In the person-centred approach, there is an assumption that the person is moving away from their self-concept to a more actualised sense of self. Later, however, in the PCA, Mearns and Thorne have debated the idea of "configurations of self". This accords more with some other humanistic approaches such as gestalt. More transpersonal approaches tend to see the concept of the higher self.

In Internal Family Systems Richard Schwartz talks about everyone having a self which is clear. Consistent, compassionate, calm, connected and curious. In addition to this, we all have parts which are exiles, managers or fire-fighters.

Other approaches are less clear about the unitary self. Kohut suggests that "there is no self without an other". Even Winnicott also leaned towards this in his famous statement that there is no such thing as a baby. So, if we believe that the self is dependent on others and is in a constant movement of change then this changes our perspective on therapy and our awareness of ourselves.

Reflexivity can be defined as the systematic attempt to include the spokesperson in accounts of the social world. It is used a great deal these days in accounts of qualitative research, but in clinical practice, it means the understanding that in therapy there is a mutual, reciprocal influence.

Bolton says: “reflective practice is an approach in which the learner is encouraged to be as reflexively aware as possible of their social, political and psychological position, and to question it, as well as their environment”.

Theoretical orientation also influences our views of personal awareness and development, see separate handout from McLeod.

**Professional Development**

Many different writers have developed models of professional change. Dreyfus (2004) has a model of skills acquisition which has been applied to counselling and psychotherapy, although originally it started with medicine and nursing. The stages are:

- Novice
- Advanced beginner
- Competent
- Proficient
- Expert

The novice here is the person who must rely on context-free rules because they have no experience to guide practice. The advanced beginner has some experience that guides practice. This person has some “aspect recognition”. Aspects are overall, global characteristics that a person can use for decision making. Competent is the highest level of performance using textbook rules. The individual has had enough work experience to know what to look for. For the proficient person, Aspects are replaced by Maxims. Maxims are characteristics of a situation that, to a novice are only nuances of a situation. Maxims provide direction as to what is important in a situation. The Expert has the richest experience base. This enables the individual to operate from an intuitive level.

An important aspect of the Dreyfus (2004) model is that it replaces the theories of experts with one's own relevant experience as the essential guide for practice. This is also reminiscent of Casement's notion of "internal supervision".

Development is often seen as the acquisition of knowledge. Therapeutic knowledge can embody Aristotle's concepts of Techne and Phronesis. Techne is best described as procedural and scientific knowledge, that can often be formal, explicit and predictable, and yet tailored to an individual's needs. Phronesis, on the other hand, refers to practical reasoning engaged by experts in the field. Phronesis uses the relationship itself to guide action.

There are many specific developmental models. You have a handout on the Stoltenberg and Delworth model. The other famous one is the research done by Skovholt and Ronnestad which identifies eight stages in practitioner development.

First though, in 1953, Joan Fleming proposed three different learning methods that characterise the learning process of students at different experience levels. They are:

- Imitative learning
- Corrective learning
- Creative learning.

In the first level learning occurs through imitating the supervisor. In corrective learning, the supervisor assumes the role of the potter, and in creative learning, the supervisor assumes the role of the gardener.

**Skovholt and Ronnestad** proposed eight stages of development:

- Conventional stage
- Transition to professional training stage
- Imitation of Experts stage

- Conditional Autonomy stage
- Exploration stage
- Integration stage
- Individuation stage
- Integrity stage.

In the conventional stage, the person is engaged as a helper but is as yet untrained in counselling or psychotherapy. In the transition stage, the task is the assimilation of a considerable amount of information that is being absorbed through training. At the imitation of experts stage, the person is a senior student and is engaged in selecting theories and techniques that suit them. At the conditional autonomy stage, the person is no longer a student but is engaged in practice which Skovholt and Ronnestad say is the most intense period of training as a practitioner. Earlier, experienced practitioners were used as models, now the focus is on using the skill level of experienced practitioners as the criteria for judging one's own competence. At the exploration stage, the exploration "is for self by self with self as director". (Skovholt & Ronnestad**,** 1995, p. 50), the practitioner is beginning to develop an individual style. In the UK sense, they are now moving towards accreditation or in the early stages of accreditation.

At the integration stage, the practitioner has been practicing for a number of years since training and has experience in different settings.  The central task is to develop a professional authenticity. This is about the consolidation of training and experience. At the individuation stage, the practitioner has been accredited for a number of years and interestingly these practitioners are found to be both highly heterogeneous and also highly homogeneous. This is reminiscent of Fiedler's research in 1950 that showed that experienced practitioners in different approaches were more like each other than inexperienced practitioners in their own

approach. In this stage, there is highly individualised growth with a strong vision for one's future.

Finally, the Integrity stage. Individuals here have practised for about 25-35 years as qualified practitioners and typically are aged 60 plus. Retirement is probably close. This group is also both homogeneous and heterogeneous. They use experience now, as opposed to experts' theories, as a primary base for work decisions.

In addition to their stages, Skovholt and Ronnestad developed 20 themes that formulate the essence of their findings.

They are as follows:

1. Professional development is Growth towards Professional integration.
2. An external and rigid orientation in role, working style and conceptualising issues increases throughout training then declines continuously.
3. As the professional matures, continuous professional reflection becomes the central developmental process.
4. Beginning practitioners rely on external expertise, senior practitioners rely on internal expertise.
5. Conceptual system and role-working style become increasingly congruent with one's personality and cognitive schema.
6. There is a movement from received knowledge towards constructed knowledge.
7. Development is impacted by multiple sources which are experienced in both common and unique ways.
8. Optimal professional development is a long, slow and erratic process.
9. Post training years are critical for optimal development.
10. As the professional develops, there is a decline of pervasive anxiety.

11 Interpersonal encounters are more influential than impersonal data.

12 Personal life is a central component of professional functioning.

13 Clients are a continuous major source of influence and serve as primary teachers.

14 Newer members of the field view professional elders and graduate training with strong affective reactions.

15 External support is most important at the beginning of one's career and at transition points.

16 Professional isolation becomes an important issue with increased experience and age.

17 Modelling and imitation is a powerful and preferred early – but not later – learning method.

18 There is a movement towards increased boundary clarity and responsibility differentiation.

19 For the practitioner there is a realignment from a narcissistic position to a therapeutic position.

20 Extensive experience with suffering produces heightened tolerance and acceptance of human variability.

It is worth saying at this point that Carol Gilligan as a feminist commentator critiques developmental models as biased towards male development and neglectful of interpersonal connectedness as a critical adult developmental issue.

**The Actual Process of CPD**

Alsop has a model of the process which you have as a separate handout. She discusses the process of developing a CPD portfolio and how that would look, as well as actively planning for CPD. She discusses learning preferences and learning styles, which we will look at.

The BACP register has a mandatory CPD record, which I suspect many people do not keep. We will look at this.

What do you think about the idea of developing a CPD portfolio?

**The Professional Genogram.**

Vetere and Stratton (2016) introduce the idea of the Professional Genogram. In the centre of a piece of paper, you put your name. Then across the bottom, you write the names of the key professional mentors, tutors and supervisors who have influenced your professional development from the time you started your professional education until now. Under each name write the year that your relationship commenced and a word or phrase that represents the significant learning from this relationship. Connect yourself to these names.

Then across the top of the page put in sequence the names of the key theoreticians who have influenced your work.

In the middle of the genogram place the influences and general perspectives that shape your understanding of yourself as a person and your relationship to the world: e.g. feminism, social justice, Buddhism.

Connect themes/people that are related to each other.

Then stand back and consider your professional ancestry. What do you notice? Are some parts more connected than others? Are there any gaps? What possibilities do you see?

Louise Mackinney September 2017

**Appendix 5**

# What does an EMDR therapist need to know? Notes.

"What could be more difficult to know than to know how we know? (Damasio: 1999: 4)

## Introduction

In this course we will be thinking about some of the issues around the process of CPD, and then thinking about the nature of knowledge in EMDR and what practitioners actually may need to know, beyond their standard training. This course is part pf the product of my DPsych research into EMDR Practitioners' experience of CPD and what they think they need to know.

## What do we mean by CPD?

CPD is a term used to denote a process of ongoing education and development for professionals involved in providing services to others. It is intended to maintain competence to practice and increase professional proficiency and expertise.

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So CPD could be seen as:

- A process
- Lifelong
- Systematic
- Embracing formal education and informal learning
- Something to assure competence
- Development of personal qualities
- Enhancing professional and technical skills
- Maintaining, enhancing and broadening professional knowledge
- Expanding and helping to fulfil potential
- Maintaining quality and relevance of professional services

- Developing and enhancing practice
  Alsop 2000

The BACP Directory defines CPD as “any learning experience that can be used for the systematic maintenance, improvement and broadening of competence, knowledge and skills to ensure that the practitioner has the capacity to practice safely, effectively and legally within their evolving scope of practice. It may include both personal and professional development”.

## Professional Requirements

All professional therapy bodies require accredited professionals to undertake CPD. The EMDR Association requires accredited individuals to undertake 75 hours of CPD in a 5 year period (from January 2020). The EMDR Association issues CPD points which makes it different to BACP or UKCP.

## Professional Development

Many different writers have developed models of professional change. Dreyfus (2004) has a model of skills acquisition which has been applied to counselling and psychotherapy, although originally it started with medicine and nursing. The stages are:

- Novice
- Advanced beginner
- Competent
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An important aspect of the Dreyfus model is that it replaces the theories of experts with one’s own relevant experience as the essential guide for practice. This is also reminiscent of Casement’s notion of “internal supervision”.

Development is often seen as the acquisition of knowledge. Therapeutic knowledge can embody Aristotle’s concepts of Techne and Phronesis. Techne is best described as procedural and scientific knowledge, that can often be formal, explicit and predictable, and yet tailored to an individual’s needs. Phronesis, on the other hand, refers to practical reasoning engaged by experts in the field. Phronesis uses the relationship itself to guide action.

In EMDR Derek Farrell has taken the Dreyfus model and characterised the Novice and Advanced beginner stages as people going through training, the Competent practitioner is the one preparing for accreditation, Proficient is the Accredited practitioner and the Expert is the Consultant.

## EMDR Research

There is actually no pedagogical research in EMDR. There is some research into training and accreditation, notably Farrell and Keenan's 2013 mixed methods study with 485 participants conducted between 2005-2011. Their findings indicated that EMDR accredited practitioners reported better treatment outcomes.

They argue that EMDR will always be a secondary psychotherapy while individuals are required to have a core mental health profession. The two prominent groups in their research were psychotherapists and clinical psychologists. They discovered that 30% of the psychotherapists who participated in their research were not accredited as EMDR Practitioners, whereas 65% of the psychologists were not accredited. It is interesting to speculate about this.

Farrell and Keenan criticise the current training model and suggest that training should cover:

EMDR as a psychotherapy approach, which comprises definitions of EMDR, the AIP model, the three-pronged protocol (past, present and future), the eight phases, managing processing and treatment planning, resourcing, methods of bilateral stimulation and cognitive interweaves.

Background information including psychotraumatology, PTSD, research evidence base, psychometrics, wider applications of EMDR.

General Information, including vicarious trauma, clinical supervision, international perspectives of EMDR, Humanitarian Assistance Programmes, EMDR Association and regional networks, EMDR and the law.

Scripted Protocols including Recent traumatic events, dissociation, somatic disorders, phobias, children and adolescents, bereavement loss and grief, pain, addictions, OCD, eating disorders, phantom limb pain, medical or health-related conditions.

EMDR and other client groups, including EMDR and ego states, depression, highly disturbed clients, forensic settings, military populations, refugees, oncology, cultural aspects of trauma, couples and families.

On examination of the current EMDR training manuals, many of these elements are already included in the seven day training, but many issues under the heading of EMDR as a psychotherapy approach are touched on very briefly, whilst others, such as the eight phase protocol are heavily emphasised. Many of the scripted protocols and most topics under other client groups, are not taught.

## Dunne and Farrell

In 2011 Dunne and Farrell published research on how EMDR trained clinicians have integrated EMDR into their practice. There were 83 participants in the study and it was established that over 40% had had considerable difficulty in the integration of EMDR. Interestingly they indicated that analytic and humanistic clinicians had more difficulty with this than CBT and integrative practitioners.

## What do EMDR therapists need to know?

Eraut (1994) describes the complexity of defining professional knowledge. He suggests knowledge is competence, involving procedural, propositional, practical and tacit knowledge and skills. How do we know that professional knowledge is true? Procedural knowledge is knowledge that can be used, or "knowing how" and is acquired by doing. Propositional knowledge involves knowledge of something, ("knowing that") with the key attribute being knowing something is true: e.g. Francine Shapiro's walk in the park. Tacit knowledge is difficult to communicate and can only be acquired through experience.

Eraut says "the process of using knowledge transforms that knowledge so it is no longer the same knowledge" (P. 25).

He quotes Braudy is saying there are four modes of knowledge:

- Replication
- Application
- Interpretation
- Association

In EMDR the modes of replication and application are seen through Standard Protocol, but all theory has to be interpreted, and associative knowledge can be seen through individuals for example discussing creativity.

## Responses of my interview Participants

| Techne? | Phronesis? |
|---|---|
| You need the basic protocol drilled into you | That we are not "Doing things" to people. Relationship building. It's an art not a science.<br><br>That it's profound, spiritual, creative. There's magic. |
| About Janet – the three stages. Bilateral Stimulation. Dissociation. The Window of Tolerance. Neurobiology. | The trauma processing isn't the work. Containment and stabilisation. |
| Neurobiology | Need to know how to be a therapist. To know about people. |
| Standard Protocol. Dissociation. Attachment. Knowing how to do thorough assessments. Neurobiology. | The client is in charge of the process. It's magic. |
| Standard Protocol. History and main names. How it works. Blocking beliefs. Stuck clients. | |
| | They need to know their client |

| | |
|---|---|
| Assessment. Dissociation. Neuro-science. Affect tolerance. Stabilisation. Window of Tolerance. The body. Attachment. Standard Protocol. BLS. | The therapeutic relationship. |
| How to do Standard Protocol, and when not to do it. | The therapeutic relationship. Don't get too hung up on the protocol. See your client in context, know that they are ok to go home. |
| How to deliver EMDR by the book. Why they do what they do. AIP. The mechanics of the brain. Know when people are processing and when they're not. | You need to understand why you are doing what you're doing. |
| AIP. Psychological trauma. Neurobiology. Attachment. They need to know that they need clinical supervision and they need to read and keep up with their CPD. It's a proper psychotherapy, not a technique. | They need to know it's not a manualised process. They need to know why it works – and that's also because of the therapeutic relationship. They need to have faith in the protocol. |
| | It's a passion. They have to follow it whole-heartedly. They have to know how to attune. |
| Neurobiology. Attachment. AIP, 8 phase protocol, 3 prongs. Case conceptualisation, target identification, structure. | Creativity. They need to know why they are doing what they are doing. Imagination. No ideology. |

## Further Answers

At a Kent Regional Group networking morning in February 2019 I asked participants to write down what they think an EMDR Practitioner needs to know. I had twelve further responses.

| Techne? | Phronesis? |
|---|---|
| Basic counselling skills. Ability to manage abreactions. Standard Protocol. Adaptations to SP. Technically EMDR is very simple. | Therapeutic alliance. Need to know value of supervision and CPD. Expertise comes with practice. |
| Taking a comprehensive history. Dissociation. Complex trauma. Needs to know how to spot looping and when to take the client back to target. Inverted protocol. Float back technique. Research. | How to use EMDR in a flexible way. The magic happens between sessions. Hold faith in EMDR. |
| Rogers – Core Conditions. CBT. Neurobiological understanding. | Systemic understanding. Relational awareness. |
| How to explain EMDR to the client. Resourcing. How to help client manage difficult emotions. Dissociation. | How to give client hope. How to set up the therapeutic relationship. How to listen to the client. How to use the protocol. |

| | |
|---|---|
| Theory of trauma and how EMDR works. History-taking. Dissociation. DES. How to work with abreaction. CPD. Interweaves. Other relevant theory. | Creating a "contactful" relationship. To know what you don't know. |
| Detailed knowledge of 8 phase protocol. Neurobiology. Interweaves. Knowledge of variations to SP. Dissociation. Stabilisation. When not to use EMDR. | |
| Neurobiology. General issues client might present. Dissociation. Resourcing. | Developing a relationship with the client. EMDR therapists should have their own EMDR outside training. |
| AIP. 8 phase protocol. Grounding. | When to ask for help |
| Affect tolerance. Target identification. What to do if client can't find a safe place or there are intrusions there. Attachment. | |
| Resourcing. How to work with BPD. Target identification and prioritisation. How to get unstuck. | Trust the process and yourself. Tolerate abreactions. |
| | How to be confident in using protocols. How to adapt to each client. How to be a therapist. How to establish the relationship. Keep the client safe, contained and grounded. |
| AIP. History-taking, trauma, self-soothing, time scale, dissociation, interweaves. When not to use EMDR. | |

Do you agree with the way I have categorised the responses? Which side seems to have more energy for you?

## Themes of my Research

### Nature of EMDR

Many of my participants were insistent that EMDR is a therapy in its' own right, and not a technique. This ties in with Shapiro's suggestion in 2014 to refer to "EMDR therapy" rather than just EMDR.

Andrew Leeds (2016) suggests that EMDR has evolved through 4 main periods:

1. A simple technique (Eye movements).
2. An initial procedure (EMD)
3. A protocol (EMDR) for the treatment of one main condition (PTSD)
4. An overall approach to psychotherapy (EMDR Therapy.)

There was also discussion around the importance of the therapeutic relationship and the actual nature of the relationship in EMDR. Dworkin suggests that the real relationship is the most significant aspect of the relationship in EMDR therapy. In the responses above I wondered what was particular about the EMDR relationship?

Dworkin suggests that the differences between the relationship in EMDR and other types of Psychotherapy are that reflective empathy and interpretations are contra-indicated in EMDR. He says that in EMDR "The clinician's role is to assist the information processing abilities of the client's brain to do their own healing by re-establishing the excitatory-inhibitory balance."

Empathic attunement however is essential in EMDR. In discussing counter-transference Dworkin talks about the need to notice in our own bodies what is happening, and to check if there is any discomfort for us when processing becomes blocked. He suggests that we may have blocking beliefs which are similar to the client's and he says that sometimes a *relational interweave* can be helpful, acknowledging our own part in the issue.

## Structure vs creativity

Although participants accepted the structure of EMDR therapy they felt that it allows the therapist to express their own creativity. This may also be connected to the decision to either stay out of the way or be more active in the process.

## Right vs wrong

This was a very active theme. Therapists seem to strongly fear "getting it wrong" which feeds in to the structured nature of EMDR therapy. I realise I may feed in to this by later talking about common mistakes in EMDR Therapy, and it seems to be true that fidelity to the protocol creates better results. However, there is something about addressing this fear in ourselves.

## Being vs doing

This again feeds in to the debate about the relationship and to what extent the therapist is present in the work. Again Dworkin clearly states that EMDR is a two-person therapy.

## Disagreements

This was a strong theme, with some participants feeling that disagreement is frowned on within EMDR therapy.

## Accreditation

It is interesting to speculate on why many EMDR therapists do not choose to become accredited practitioners. I suggest this may be about misconceptions about the process.

## Common Mistakes in using the EMDR Standard Protocol

1. Insufficient history-taking.
2. Failure to do DES and proper preparation.
3. A vague target with no worst moment or image (e.g. feeling anxious).
4. Targeting the whole incident and not the worst image.
5. Investigating, exploring after the client has identified the image or worst moment.
6. Accepting NC and PC which are not in the same domain.
7. Having a long discussion on the NC.
8. Asking for an NC with reference to the past instead of what they believe now with regard to the target.
9. Unnecessarily exploring the PC.
10. Asking for the VOC in general without defining the target, the NC and the PC. Or asking for a VOC of the NC.
11. Asking for emotions as they were experienced then, rather than now when the client thinks of the image.
12. Initiating BLS without asking the client to bring up the target, NC and body sensation.
13. Doing sets which are too slow, too short or too long.
14. Repeating the description of the image.
15. Talking with the client between sets.
16. Using continuous BLS.
17. Failing to observe client's non-verbal cues during BLS.
18. Using interweaves when this is not necessary.
19. Repeating the client's words.
20. Distancing the client from the image when this is not necessary.
21. Stopping the desensitisation when the client gets upset.
22. Asking for the SUD often during sets.
23. Going back to target before the client reaches the end of a channel.
24. Asking for the SUD without going back to the original target.
25. Asking the client to go back to the image rather than the memory.
26. Asking for specific information at the end of a set instead of "what did you notice?"
27. At the beginning of a new set failing to say "notice that" or "go with that".
28. Installing the PC when the SUD is above 0/1.
29. Failing to check if the PC is still appropriate before installing it.
30. Starting the body scan without linking it to the target and the PC.
31. Asking a client to go back to the worst moment and taking a SUD to close an incomplete session.
32. Going through a complete Phase 3 again at the session after closing an incomplete session. (no NC, PC, OR VOC needed.)

## EMDR PDP II

You have been sent a copy of the EMDR Personal Development Action Plan (Farrell, Knibbs, Mackinney and Miller 2020) which maps on to the competency framework for accreditation. This

sets out a clear plan for what EMDR Europe and EMDR UK think a person should know. You will have the opportunity to go through this and devise a plan for yourself.

## Necessary Skills for EMDR Therapists

There is no recognised skills framework for EMDR therapy. I have suggested a framework here. Please note that the columns are separate headings and not related across the lines. What do you think of this?

| General therapeutic abilities | Basic EMDR competences | Awareness of Presenting Issues | Meta competences | Specific Protocol awareness |
|---|---|---|---|---|
| Knowledge and understanding of mental health problems | Understanding of AIP model and application to PTSD | Phobia | Ability to use clinical judgement | Standard Protocol |
| Knowledge of, and ability to operate within, professional and ethical guidelines | Understanding of neurobiological underpinnings of EMDR | Panic disorder | Capacity to adapt interventions in response to client | Phobia Protocol |
| Ability to form a therapeutic alliance with the client | Understanding of the three prongs | Depression | Capacity to use and respond to humour | DeTur Addiction Protocol |
| Ability to manage emotional content | Ability to undertake Phase One: History-taking | Pain | Capacity to implement EMDR in a way which reflects its underlying philosophy | Feeling State Addiction Protocol |
| Ability to undertake assessment and history-taking | Ability to create a case formulation | Bereavement | Capacity to apply the EMDR model to the individual client | Pain Protocol |
| Ability to manage endings | Ability to utilise Phase 2 according | Addictions | Capacity to select and use the most appropriate | Blind 2 Therapist |

| | | | | |
|---|---|---|---|---|
| | to the resourcing needs of the client | | adaptation of the Standard Protocol. | |
| Ability to make use of supervision | Understanding of and ability to undertake Phase 3: Assessment | Eating Disorders | Capacity to structure sessions with appropriate pacing | Recent Events Protocol |
| Ability to assess and manage risk | Understanding of how to move through Phase 4: Desensitisation | Dissociation | Capacity to manage resistances to EMDR | Parnell Modified Protocol |
| Ability to understand attachment | Understanding of when to move to Phase 5 | OCD | Ability to deal with ruptures | Flashforward |
| Ability to manage transference / counter-transference | Ability to operate Phase 5 and install positive cognition | Personality disorders | Ability to manage abreaction | Flash Technique |
| Understanding of cultural issues and diversity | Appropriate use of Phase 6: Body Scan | Neuro-diversity | Able to monitor own competency and apply self-care | Inverted Protocol |
| | Ability to close down a session in Phase 7, including incomplete session | Psychosis | | RTEP /GTEP |
| | Going back to re-evaluate the work | GAD | | CIPOS |
| | Ability to manage blocks and looping | Work with couples | | “Tip of the finger” |

Do you think these are reasonable skills /competencies?

How would you adapt them?

## References


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# Appendix 6

What does an EMDR Therapist Need to Know? 28th September 2019

Feedback Results

This was a small workshop and 20 people attended. 20 feedback forms were filled in

Question 1: Overall, how would you rate the workshop?

Excellent: 16 Very Good: 4

Question 2: Overall, how would you rate the presenter?

Excellent: 19 Very Good: 1

Any Comments for the Presenter?

Very well-structured

Thought provoking

Fabulous balance of information and activities

Well done Louise, this really was a workshop!

Brilliant

6 people just said “thank-you”.

Question 3: What did you like about the workshop?

There was a range of replies:

Very relaxed, very informative, good interaction

So much food for thought

Good materials to take away and use

Gave me confidence

Having to think about my practice.

There were no negative seeming comments.

Question 4: What improvements could I have made?

18 people said none.

1 person said would prefer a shorter day, 1 person said needed more explanation.

Question 5: Ideas for future events.

Dissociation, BPD, EMDR with couples, days for practice and “Back to Basics”

Question 6: Comments on location and suitability of the venue.

Everybody said it was good. 1 person said too stuffy.

Louise Mackinney 29/9/19

## Feedback for "What does an EMDR therapist need to know" 27/2/21

72 people attended with 59 feedback forms received to date (12th March 2021.)

Overall, how would you rate the training?

| Excellent | Very Good | Good | Satisfactory | Poor |
|---|---|---|---|---|
| 33 | 18 | 6 | 1 | 1 |

How would you rate the presenter?

| Excellent | Very Good | Good | Satisfactory | Poor |
|---|---|---|---|---|
| 34 | 19 | 5 | 1 | |

Any comments for the presenter?

"Good presentation at a good pace. Very engaging. Extremely knowledgeable. Took feedback openly and valued it. Very clear and professionally delivered training. Well presented, informative and exceeded my expectations."
One person said could be less ums and ers which I will try to take on board.
One person felt the advertising was completely misleading and said they could not understand what I was saying.

What did you like about the workshop?

Break-out rooms
Balance between group work and training
Information
Common mistakes in the protocol

What could we have done differently?

Videos or visual presentations
Shorter day (3 people)
More time on common mistakes (4 people)
Record the workshop (8 people)
Over half of the respondents said nothing

Do you have a clearer idea now of your developmental needs in EMDR?

58 people said yes, with varying levels of enthusiasm.
1 person said they were absolutely no clearer at all.

This is not required, but I would be very grateful if you would tell me what YOU think an EMDR practitioner needs to know?

About 50% of the participants responded to this, most stating a balance between technical knowledge and relationship awareness.
I will be analysing these replies more fully.

Thank you for your feedback.

Louise Mackinney for Kent Regional Group February 2021

## Feedback for “What does an EMDR therapist need to know” 13/3/21

86 people attended with 69 feedback forms received to date (21st March 2021.)

Overall, how would you rate the training?

| Excellent | Very Good | Good | Satisfactory | Poor |
|---|---|---|---|---|
| 27 | 33 | 7 | 2 | |

How would you rate the presenter?

| Excellent | Very Good | Good | Satisfactory | Poor |
|---|---|---|---|---|
| 38 | 24 | 6 | 1 | |

Any comments for the presenter?

“Interesting and helpful.” “You are so articulate and clever.” “Overall very good.” “Brilliant presentation. Evidence of a huge underpinning of knowledge and experience.” “Nice relaxed presentation.” “Very knowledgeable and conveys concepts simply.” “Incredibly clear and articulate.” “Very knowledgeable, helpful and interested in other peoples’ ideas and opinions.”
“There was too much detail.” “You need to define your terms more.”

What did you like about the workshop?

Break-out rooms, 28 people said this.
The PDP – 6 people.
Handouts. Lear structure.
Common mistakes in the protocol – 9 people.

What could we have done differently?

Slides (7 people)
Shorter day (5 people)
More small groups (5 people).
1 person said don’t do groups as they are a waste of time.
Iron out IT issues (3 people)
More break (4 people).
Over half of the respondents said nothing

Do you have a clearer idea now of your developmental needs in EMDR?

66 people said yes, with varying levels of enthusiasm.
1 person no, and 1 person said “Not much.”

This is not required, but I would be very grateful if you would tell me what YOU think an EMDR practitioner needs to know?

About 50% of the participants responded to this, most stating a balance between technical knowledge and relationship awareness.
I will be analysing these replies more fully.

Thank you for your feedback.

Louise Mackinney for Kent Regional Group February 2021