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The Peanut Butter and Jelly Problem: In Search of a Better EMDR Training Model

Ricky Greenwald
Child Trauma Institute, Greenfield, MA, USA

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Abstract

The evolution of EMDR training is presented through the lens of the author's personal experience. Current issues and concerns about EMDR training practices and outcomes are highlighted, particularly regarding trainees' high dropout rate, inadequate case conceptualization and client preparation, and infrequent, inappropriate, or incorrect use of EMDR. Tentative solutions are proposed, along with a call for data to be gathered on outcomes of the various training approaches, to guide future policy re EMDR training models.

The Peanut Butter and Jelly Problem:
In Search of a Better EMDR Training Model

Did you ever have this assignment in school, to write down clear instructions on how to make a peanut butter and jelly sandwich?[1] My teacher cautioned us that the reader would be a "Man From Mars" who doesn't know anything about Earthling ways. When the assignment was completed, we took turns reading our instructions while the teacher demonstrated, obeying each set of instructions in turn. Bad things happened! One set of instructions didn't include the knife. Another didn't specify bread. You get the idea. We had failed to spell out the instructions in sufficient detail, and because the Man From Mars did not share our assumptions, the jelly ended up in a puddle on the floor.

That was, more or less, what happened to Francine Shapiro when she tried to tell the world about eye movement desensitization and reprocessing (EMDR; it was "EMD" then) and how to do it. At first, she published step-by-step instructions (Shapiro, 1989), and then taught the procedure in a large 2-day workshop. Then she found out that many of the people who had learned from her were doing very different things than she thought she had taught. Therapists from Mars! She quickly realized that her assumptions as a therapist were not shared by others, and that in fact the *procedure* was nested within a more comprehensive *method*. She then revised her training program to spell things out in more detail, and to include closely supervised practice sessions, to make sure that the people she was trying to teach were actually doing what she wanted them to do (Shapiro, 1991). Shapiro's revised training program entailed two 2.5 day weekends separated by a period in which participants were expected to practice EMDR with clients. Furthermore, she recommended follow-up consultation or *study groups* of EMDR practitioners, hopefully including more experienced practitioners who could answer questions and provide guidance to the newer people.

I had the good fortune to be trained by Shapiro in 1992, after she had already upgraded her training program. I was electrified by learning EMDR, and immediately began using it with many of my clients. I experienced many successes as well as several problems. I started a weekly study group with fellow graduate students who had also attended the training; this fizzled after a few weeks when the others stopped coming. I was again fortunate in being able to attend the monthly study group in Honolulu, which was run by some of the early experts in EMDR. I went on to complete the second part of the training, continued to gain experience and skill in EMDR, and eventually became an expert myself.

But many others did not. Despite the initial enthusiasm, most of my colleagues who had attended the training--including three of my professors--did not attend the study groups, nor did they attend the second part of the training. And most of them did not get very good at EMDR, or integrate it into their practice, the way I did. I asked myself: "Why didn't they grasp the value of EMDR the way I did? How could they hold this in their hands and then not use it?" I didn't know the answer at the time, but I never stopped asking.

Early Innovations

In 1996 I taught what I believe was the first EMDR International Association (EMDRIA)-approved EMDR training outside of either EMDR Institute or a university setting. It was a good opportunity to test out some of my ideas re how to train people in a way that they would "get it"--get good at EMDR, and actually integrate it into their practice. I made several modifications

(Greenwald, 1997) to Shapiro's training model.

Teaching the whole course as a package. The weekend workshop model initially made sense, because at first Shapiro was the only trainer, and she had to travel around. Also, when EMDR was considered experimental, it was reasonable to offer the "taste before you buy" option, allowing people to try EMDR out before investing in the entire course. However, when I started teaching in 1996, I did not have to travel to teach, and EMDR's efficacy was already supported by a number of studies. So there was no reason to offer a partial course. Furthermore, I did not want people in my professional community practicing EMDR with my "label" on them--claiming that they had been trained by me--unless they had been fully trained.

Including follow-up group consultation. There was a general consensus in the EMDR community that participation in study groups (or some alternative type of supervision) was essential to mastering EMDR. So I included a series of monthly 2-hr group consultation sessions as part of the training package. Participants in my course did not receive the certificate of completion until they had completed the entire program, including the follow-up meetings.

Including the text book. There was also a general consensus in the EMDR community that Shapiro's (1995 at the time) text was an essential source for learning EMDR. Also, when people read a text ahead of time, it's easier for them to absorb what is being taught in class. Because having and reading the textbook seemed so important to learning EMDR, I included it in the packet of materials that I distributed to all participants.

Spreading out the training over several months. The locally-based full-package model of training allowed for mastering EMDR through supervised practice over time. This schedule also allowed participants to read the appropriate portion of the text to prepare for a given class. It allowed me to teach fewer concepts and skills in a given session, so participants would be less likely to feel overwhelmed with information. It also allowed for multiple cycles of participants practicing with their clients and then receiving feedback and consultation, then more practice and more feedback.

More Problems

Although I have continued to use the essential components of this training model, my ideas about EMDR training have continued to evolve, in response to both personal experience and developments in the field. The late 1990's saw the proliferation of university-based and independent EMDR training programs. Also, EMDRIA instituted the *certification* credential, which, among other things, formalized the consensus regarding the value of completing the full training as well as follow-up consultation. Along with certification, the *consultant* industry was born.

There have been many opportunities to talk shop with other consultants over the years. Many of these conversations have involved confirmation of shared experiences. Here are the types of experiences that consultants have reported over and over again:

- Consultees who talked a good game but when you saw a video of their session, you realized that they were deviating from the standard protocol, often in significant ways.
- Consultees who said, "I like EMDR and I feel that I'm good at it. I just don't have very

many EMDR cases right now."

- Consultees who were using EMDR often, but inappropriately--perhaps without adequate client preparation, without any rationale for target selection, or with a target that was not specific enough for EMDR to make sense.

From these repeated experiences reported by so many consultants, I came to the conclusion that we had not yet solved the peanut butter and jelly problem; people were still not learning what we were trying to teach. I also came to understand why I had taken to EMDR so easily while many of my colleagues had not.

Where is Planet Earth, Anyway?

The key point here is that EMDR is a trauma resolution method. A trauma resolution method is most appropriately offered as a late-stage intervention within a comprehensive trauma-informed treatment approach (Greenwald, in press). As therapists who use EMDR, we don't just say to a new client, "Hi, I'm Dr. X. Tell me the worst thing that ever happened to you and follow my fingers." The treatment approach must include a case conceptualization that specifies how the trauma memories are contributing to the presenting complaint--otherwise why do EMDR? And the treatment approach must also provide a systematic way of helping the client to get to a point of being willing and able to tolerate, and benefit from, EMDR.

When I was trained in EMDR, I was already a trauma therapist. I had already articulated a trauma/loss treatment model as my primary orientation (encompassing other approaches such as family systems, psychodynamic, and cognitive-behavioral). When I learned EMDR, it fit neatly into my existing framework, while allowing me to handle the trauma resolution component of treatment that much more efficiently.

When I was trained in EMDR, the primary focus of the training was on the trauma resolution components of the 8-phase protocol (Phases 3-7--setting up the target, through desensitization/reprocessing, installation, body scan, and closure). There was some brief mention of the preliminaries (Phases 1 and 2 of the standard protocol--[1] client history and treatment planning and [2] preparation) but even then, much of the focus was on EMDR-specific preparation (e.g., explaining EMDR to the client). The brief coverage of the non-EMDR-specific preparatory tasks worked for me, because I had already been practicing these things, and the training served to remind me and orient me to the steps. Or from the EMDR trainer's point of view, we were both from Planet Earth and shared assumptions regarding the trauma treatment context of EMDR.

However, most therapists are not specifically trained in trauma-informed treatment, and have some other primary orientation--or none at all. For them, the brief mention was just not enough, because it referred to concepts and interventions that they didn't already know. This is the peanut butter and jelly problem again. Then the therapists end up following some specific piece of advice without really understanding its context or purpose. For example, many therapists will religiously teach their clients Safe Place as a preliminary to doing EMDR, without necessarily understanding that Safe Place is only intended as one example of a class of interventions that can help clients to learn to self-soothe and build affect tolerance. The real point, of course, is not to teach Safe Place but to accomplish the task of helping clients to be in a position to tolerate, and benefit from, EMDR.

In other words, the EMDR protocol is nested within yet another, broader method of trauma-informed treatment. Actually Shapiro has been saying this all along, and it is included--or

at least implied--in the 8-phase protocol. However, as a community of EMDR trainers we have not done a very good job of teaching this. And after all this time, hopefully we have learned that just mentioning it isn't enough.

Attempts to Solve the Problems

Teaching trauma treatment. I started to include a "level 0" introductory day, focused on Phase 1--Client history and treatment planning, in the basic EMDR training package (Greenwald, 2002a). This new first day featured an overview of trauma-informed treatment, and taught specific skills involved in evaluation and treatment planning/contracting. For example, rather than just telling therapists to ask their clients for the ten worst memories (a dubious proposition with certain types of clients), we spent over an hour practicing, using a scripted interview (see Greenwald, in press) to obtain a detailed, comprehensive trauma/loss history, in a way that carefully contains the emotions and helps the client to leave the session in good condition. We also spent over an hour role-playing (again with step-by-step guidelines) delivering trauma-informed case formulations to clients (Greenwald, in press). By the end of this day, participants had an overall system of trauma-informed treatment in their minds, and had practiced specific skills that they could use to get the treatment onto an EMDR-friendly track.

This grounding in a trauma-informed treatment approach was continually reinforced throughout the rest of the EMDR training, and participants did gain skill in conducting their treatment accordingly. This seemed to be a reasonable way of addressing the concerns that many consultants had reported re therapists who did not know how to get their clients to EMDR, or therapists who were using EMDR inappropriately. When I started telling other trainers about this approach, I learned that Oliver Schubbe (personal communication, June 2002) in Germany had also been putting a lot of emphasis on teaching the trauma-informed treatment preliminaries.

I had been hoping that with better case conceptualization and treatment planning skills, the course participants would find more occasions to practice EMDR before they forgot how to do it right. Unfortunately, I found that many participants were still reluctant to practice EMDR with their clients. So although teaching more of the trauma-informed therapy approach was valuable, it did not address the other main concern that I had heard (and shared): that many EMDR-trained therapists were just not using EMDR.

There are two parts to this concern. First of all, if people are afraid to use EMDR, they may not use it at all, or only rarely. Secondly, if they don't get practice while they still remember how to do it properly, they may be more likely to develop bad habits and deviate from the protocol. Given the evidence that deviation from the protocol leads to worse outcomes (Maxfield & Hyer, 2002), it is very important for graduates of EMDR training programs to learn, practice, and use the standard protocol.

Providing a more intensive practicum experience. I had conversations with Laurel Parnell (personal communication, June 2002) and with John Hartung (personal communication, June 2002), each of whom had been experimenting with more intensive EMDR training models. For example, Parnell has been offering 7-day-straight trainings at sleep-over conference centers. Both Parnell and Hartung were enthusiastic about what they had seen in these intensive courses. Each told me that their participants were getting so much practice within the course itself that they got "over the hump" and were readily using EMDR with their clients.

This approach intrigued me, so I tried it. I did like the intensive element and the opportunity for participants to get so much supervised practice with each other before being expected to try it with their clients. I still included the follow-up group consultation sessions, so participants could have some supervision for their work with clients as well, and a better chance for mastery over time.

However, because of my other teaching preferences, I encountered problems with the intensive model that neither Hartung or Parnell had to face. First of all, I was teaching more material than others, namely the added emphasis on trauma-informed evaluation, case formulation, and treatment planning. I believe that this contributed to information overload and made it harder for participants to absorb what was being offered. Also, with the all-at-once format, there's no opportunity to give participants the text book and expect them to read it before class. They don't have any chance to read until the class is over. This also makes it harder to absorb material in class, because without the reading preparation, there is much more that is new.

So I went back to the approach of starting with the Level 0, and then giving time for some practice and reading, before teaching the trauma resolution portion of the protocol. Meanwhile, I have continued to be frustrated with participants' general (not universal) failure to practice standard memory-focused EMDR. The participants are also frustrated; they are willing to practice the feel-good stuff with eye movements (e.g., Safe Place, RDI) but are very cautious about trying the standard protocol. Then they end up feeling that they are failing my expectations and that they are not using what they came to learn.

Putting it all together. It is my good fortune to have some close colleagues who are involved with EMDR training, and we have discussed these issues repeatedly over time. Nancy Smyth (personal communication, March 3, 2004) recently told me that she has had good luck getting her trainees to practice the standard protocol by requiring them to make regular entries in a *blog*-- an on-line journal that can be accessed, and responded to, by classmates as well as the instructor. According to Smyth, this seemed to accelerate the effect that we normally see in study groups, in which people learn from and get inspired by each other's examples.

I have come up with a few other ideas, too, through experimentation and discussion with my team of trainers. Although we have not yet tried Smyth's on-line journaling approach, we have further modified our program as follows:

- Start with a 2-day introduction, focusing on Phase 1--building rapport, conducting a trauma-informed evaluation, case formulation, treatment plan--and Phase 2--building safety, stability, self-management, and affect tolerance--of the protocol, respectively. These skills are taught within the context of a comprehensive phase model of trauma-informed treatment. This introductory session also includes the EMDR lit review and AIP theory, so we don't have to cover that later while participants are focused on learning Phases 3-8.
- Then a few weeks off, to practice the not-scary eye movement interventions (e.g. Safe Place, RDI) in the context of taking clients through the early phases of treatment in preparation for EMDR. During this period, participants are also expected to read quite a bit of the text book, so that when they come back to learn Phases 3-8 of the protocol, they'll already be familiar with the material.
- Then four straight days of training, including plenty of practice. This takes participants from target selection and set-up through the standard protocol, the protocols for recent

events, anxiety, etc., and finally the cognitive interweave. With all that supervised practice, many participants get reasonably good at EMDR and come closer to feeling comfortable in using it with their clients.

- Finally, the usual series of monthly group consultation sessions. We may still experiment with the blog, perhaps with a twice-weekly requirement for participants to enter something in their own on-line journals, with the option of viewing others' entries as well. This should help participants to gain confidence and competence by practicing EMDR while receiving ongoing feedback, guidance, and support. The live group consultations also give them a head start on their practice and group supervision hours (if the groups are small enough), which makes obtaining certification seem a bit less daunting.

I was hopeful that this training format would solve all the problems. It is at least getting closer. Of course, every solution highlights the next problem to be addressed.[2]

Discussion

I presented this personal journey as a way to highlight several problems, and possible solutions, in EMDR training. I have asserted, based on personal experience and the comments of some other trainers and consultants, that as a community of trainers we have not been good enough at helping trainees to:

- Conceptualize cases and conduct treatment so that EMDR fits in, gets used often enough and at the right time.
- Do the EMDR standard protocol properly.
- Be willing to use EMDR with their clients.

I like the solutions I have worked out, but there are surely other effective ways to address these issues. For example, I understand that some trainers in Europe and Israel are now adding a couple of days to the basic training, in an intermediate session sometimes called a "bridge" or a "level 1.5", intended to improve participants' competency and their willingness to practice EMDR with their clients. Quite a number of training programs are using some variant of the full-package extended training model. I have also heard of at least one training program in which EMDR is not offered until participants have completed other trauma-related courses. Although there are many possibly effective training strategies, it's hard for me to imagine an adequate EMDR basic training program that does not include the following:

- In-depth teaching of trauma-informed case conceptualization and the preparatory phases of trauma-informed treatment (Phases 1 and 2 of the EMDR protocol), including hands-on skills training. Alternately, documentation that a given participant has previously completed equivalent training.
- Teaching the standard protocol as well as variations and the cognitive interweave, along with plenty of supervised in-class practice. This portion (primary focus on Phases 3-7) is what is currently considered the minimum requirement for a basic EMDR training in the USA (EMDRIA, 2006a).
- Supervised practice with clients over a period of several months.

It doesn't take too much reading between the lines to discern that I am calling many of the existing EMDR training programs inadequate. My intention is not to be harsh or denigrating. Rather, I am suggesting that we have had some years to experiment with different models of

EMDR training, and now it's time to learn from our experience, and from the relevant literature, and draw conclusions.

When we do draw conclusions, we should act on them. Why should EMDR professional associations continue to accredit training programs that are unlikely to be successful? Doesn't that just lead to the proliferation of half-baked EMDR practitioners? When clinicians are trained in EMDR and then don't use it, or don't use it properly, what impact does that have on their clients? On the future of EMDR? Is this what we want?

This is not the first time that I have raised such concerns or proposed such solutions. Over the years I have been pleased to learn that many trainers and training organizations have adopted one or more of the strategies I've recommended in previous papers. I hope that will happen again following publication of this paper. That would be one possible appropriate individual response to participating in this type of discussion.

However, higher level policy decisions concerning the format, curriculum, and credentialing of EMDR training programs should not be based solely on Ricky Greenwald's opinions, no matter how much sense he makes or how many times he says it. At the level of policy, and at this time in the history of EMDR, we should be making decisions based on data.

The literature on EMDR training. Unfortunately, the literature on EMDR training offers little in the way of hard data. Adherence to the standard protocol has been highlighted--and documented--as predictive of good outcomes (Maxfield & Hyer, 2002), but completion of EMDR training has not guaranteed treatment adherence (Greenwald 1996). The perceived importance of formal supervised training and supervision/consultation has been emphasized repeatedly (e.g., EMDRIA 2006b; Greenwald, 1996; Shapiro 1991). There have been several opinion pieces (Greenwald, 1997, 2002a, 2002b; NOET, 2004) addressing some of the issues also discussed in the present paper.

So we know that treatment adherence is important, but we only have opinions regarding the respective value of various training strategies, or even regarding the value of training itself. My group has found encouraging results regarding the effectiveness of our training modules on trauma-informed case formulation and treatment planning (Greenwald, Smyth, Greenwald, Johnston, & Weiss, 2006). However, this research did not evaluate participants' use of EMDR.

With such limited data directly pertaining to EMDR training, it is well to consider related literatures, which can shed light on at least some of the areas of concern.

Research on psychotherapy effectiveness. One relevant line of study focuses on the question of whether some treatments might be better than others, at least for certain conditions. There is now ample reason to consider EMDR an indicated treatment for post-traumatic stress disorder (Chemtob, Tolin, van der Kolk, & Pitman, 2000) and possibly even the treatment of choice (Rogers & Silver, 2003). So at least we can feel good about teaching EMDR (although EMDR training has still not been definitively linked to its effective use).

Another relevant line of study focuses on the *common factors* that seem to promote treatment effectiveness across methods and conditions. Regarding the basics such as empathy, warmth, positive regard, and establishing a helping relationship (Beutler, Machado, & Neufeldt, 1994), most extant EMDR training formats probably do a pretty good job, in that the EMDR method itself guides therapists to be responsive and respectful of the client's process.

However, other effective behaviors such as presenting a convincing rationale for

treatment activities (Messer & Wampold, 2002), and agreement on treatment goals and tasks (Horvath & Greenberg, 1994) are more complex and difficult to implement, requiring an advanced level of skill (Mallinckrodt & Nelson, 1991). EMDR-trained clinicians are widely perceived as (typically) falling short when it comes to trauma-informed case formulation and treatment planning, though these skills are necessary for preparing clients for EMDR. Case conceptualization has become a major focus both in individual consultation and in conference presentations--a fair indicator that it is not being taught effectively in the basic EMDR training.

Research on psychotherapy training. The good news is that formal training in psychotherapy, at least as conducted in graduate programs for mental health professionals, does lead to improved client outcomes (Stein & Lambert, 1995). This encourages us to believe that EMDR training might also be worthwhile; the questions is, how to do it? A didactic approach may be adequate for imparting facts (Bootzin & Ruggill,1988), but a mix of facts and practice is more effective for teaching clinical skills (Binder, 1993). So far, so good, in that extant approaches to EMDR training typically emulate this more effective style.

The use of manuals can help trainees to learn specific procedures, but sometimes at a high cost, in that trainees may become overly rigid, less responsive, and worse therapists on that account (O'Donovan & Dawe, 2002). Therefore manuals and other highly structured therapy training procedures should be used with caution, primarily as early-phase learning tools. This should be followed up with training and supervision activities that support integration of the new skills in such a way that the therapist regains the responsiveness, flexibility, and clinical judgment that makes for effective therapy. Again the extant approaches to EMDR training seem to do well in this regard, by initially teaching the standard protocol in a highly structured manner, and then later teaching more problem-solving strategies (e.g., the cognitive interweave) along with a greater emphasis on choice points and clinical judgment.

Clinical supervision is generally perceived by both supervisors and trainees to be the most effective component of training, especially for more complex skills involving things like case formulation and clinical judgment (Holloway & Neufeldt, 1995). Learning complex clinical skills is best accomplished when trainees can practice under supervision and receive immediate feedback with opportunity for correction; when there is repeated opportunity for such practice; and when learning, practice, and supervision/feedback can occur over an extended period of time (O'Donovan & Dawe, 2002). EMDR trainings are mixed in this regard. They typically do provide a series of small-group supervised practice sessions, affording opportunity for immediate feedback, correction, and repeated practice. However, although supervised practice over an extended period of time is universally recommended by EMDR trainers, it is not generally provided by EMDR trainers. Inexplicably, although we seem to agree that this is a critical activity for mastering EMDR, we leave trainees to their own devices in this regard.

Call For Research

Anecdotal evidence from EMDR trainers and consultants can be informative, and the psychotherapy training literature tends to support these impressions regarding the perceived strengths and weaknesses of current training practices. Even so, without evidence derived directly from research on EMDR training, we can't really be sure that these impressions are accurate. Until we take the trouble to find out, we just don't know.

It is easy enough to say that we need data; it's a bit more tricky to say exactly what data

we need, and how we should get it. Designing research entails a process of getting the best quality of data possible within the context of available resources. That generally means that compromises are made, for example we often settle on measuring a *construct* that represents the outcome of interest, rather than measuring the outcome itself. To obtain data on the relative effectiveness of the various EMDR training models, we are probably talking about a large-scale study of many individuals who have participated in many training programs. Assuming limited resources (who's paying for this, anyway?), what do we care most about, and how close can we get to measuring that?

The bottom line is that we want EMDR-trained therapists' clients to get as better as possible, as quickly and safely as possible. Rather than studying EMDR trainees' clients--an impossibly resource-intensive endeavor--perhaps we could agree that an indication of a successful EMDR training program would be that EMDR-trained therapists are using EMDR *appropriately*--often enough and at the right moment in the course of treatment--and *properly*, according to the standard protocol. Unfortunately, conducting this type of study, on the large scale needed to meaningfully compare training models, would also be impossibly daunting in terms of resources.

Here are some proposed constructs that arguably represent the outcomes of interest, if imperfectly, and that can realistically be measured in a modest-budget large-scale study.

Completion of the basic training. I would anticipate widespread agreement with the proposition that completion of the full basic training--not just some "part" or "level"--is a bare minimum indicator of what might be necessary to use EMDR both appropriately and properly. We probably all share a concern regarding how partially-trained therapists might be using EMDR in their practices. Therefore, rate of completion of training, by those therapists who initiate training, is one important indicator of a successful training program.

Any other outcome measures, however, should only include those who have completed a full training program. There are two main reasons for this. First of all, we would expect non-completers to do worse on all other outcomes than completers. In a training program that is otherwise effective but has a high dropout rate, including the non-completers would obscure the actual effectiveness of the program, for those who did complete the training. Secondly, certain other outcome measures would be difficult to interpret. For example, if we consider high frequency of EMDR use to be a positive outcome, what would we think if a half-trained person reported that? We wouldn't know whether to be pleased or worried.

The flip side here is that including only completers in other outcomes may lead to a reverse bias, in favor of those programs that offer an easy option for non-completion. In such programs, the "star" participants may be more likely both to complete the training and to perform well on other outcomes. This would lead to an unfair comparison with programs in which virtually all participants are completers. Perhaps this can be adjusted for by performing additional analyses only including top tier performers from the universal-completer programs.

Certification. EMDRIA's certification credential is currently the USA EMDR community's best representation of indicators of appropriate and proper use of EMDR. Requirements for certification (EMDRIA, 2004b) currently include completion of the full basic training, some hours of supervised practice with clients, some hours of continuing education related to EMDR, and endorsement by an EMDR consultant. In the USA, counting the

proportion of trainees from a given program who have become certified could provide a meaningful indicator of the training program's success.

Components of certification. The problem with the certification construct, in this context, is that even in the USA relatively few EMDR-trained therapists obtain certification, and in other countries the credential does not exist (to the best of my knowledge--unless someone chooses to obtain it from EMDRIA). Because this outcome is dichotomous and rare (it's either yes or no, and mostly no) it only provides a very limited type of information. Therefore, we could also measure the extent to which therapists from various training programs have completed any of the activities that comprise the certification requirement, including: participation in EMDR-focused supervision or consultation; participation in EMDR-related continuing education; and actual use of EMDR. Including such outcomes would allow us to include a more international sample. Also, the continuous nature of these data (not just yes or no, but how much) would yield meaningful information on virtually all participants.

Written examination. Finally, there are questions that we might ask research participants that could indicate the extent to which they are likely to be using EMDR appropriately and properly. The exam items should represent critical elements of knowledge, competency, and practice habits. It would take some work to devise such an exam, but it could be done, and maybe we should have one for other purposes anyway. Or maybe it couldn't be done and maybe we shouldn't have one, I'm really not sure. I can imagine many potential problems entailed in devising and using such an exam.

There may be other useful constructs that can effectively and inexpensively represent the true outcomes of interest. This list is a start, and enough for this stage of the discussion. The actual researcher(s) can take it from here.

Who is *paying for this, anyway?* The problem with conducting research is that those most qualified and most interested in conducting the research are likely to be those with expertise and vested interests. For example, imagine the potential problems if I were to conduct such a study myself. Suppose the outcomes reflected favorably on my own institute's EMDR training program. Wouldn't the results be suspect? On the other hand, suppose the results showed that various other training programs were just as good, or even better, than mine. Wouldn't I at least be tempted to find some way of minimizing the findings, or even failing to report them?

For research findings to be credible, it's important for researchers to be perceived as having conducted and reported the research with integrity. No single trainer or training institute can conduct a study on EMDR training models, because of the risk of perception of bias. This does not mean that the researcher would actually do anything improper--only that the results would not be perceived as coming from a "clean" source.

Therefore, the study of EMDR training models should be initiated and conducted by an independent EMDR professional association, a group of such associations, and/or a group of EMDR trainers/training institutes. Even if a professional association initiates the study, it should invite collaboration from other professional associations, and from trainers representing a variety of training models, to preclude the perception that the association favors one model over another. Inviting representative collaborators can also keep the study from being unintentionally biased in its design. If a group of trainers initiates the study independently of a professional association, the

group should likewise represent a variety of models and sources of training. It is probably best, however, for one or more EMDR professional associations to initiate the study. The associations are responsible for credentialing the trainers, and an association-sponsored study would be most likely to gain co-operation from trainers and training organizations as well as graduates of the training programs.

As for who literally pays, again the concern is to keep the results credible. If the association funds such a study itself, that is probably the cleanest. There are other possible solutions to getting funding, but any scheme should keep the integrity of the study foremost.

Conclusion

Following the peanut butter and jelly analogy, we are allowing Earth-based EMDR trainers to train therapists from a variety of planets without requiring the trainers to include a module on acculturation to Earthling ways. So we should not be surprised to find bread stuck to the wall and jelly on the floor. In EMDR terms, we are not teaching the overall trauma treatment model and interventions that comprise the foundation for the practice of EMDR. We are neglecting other essential elements of training as well, such as follow-up supervised practice. So first of all, many therapists are not completing their training, and we don't know why. Of those who do complete the training, many are not using EMDR appropriately; and when they do use it, many are not using it properly. We may think we are teaching it, but we also have to admit that they are often not learning--or doing--what we think we are teaching.

EMDR is well into its second decade and by now we have a lot of experience under our collective belt. It is time to face the serious problem that appears to exist in our policies and practices regarding EMDR training, and to do something constructive about it. The first step is to acknowledge that such a problem exists, or at least may very well exist. The second step is to gather relevant data to determine the extent of the problem, and hopefully to identify training models, or components of training models, that are associated with successful outcomes. Then we will be in a position to make meaningful policy decisions to ensure that EMDR training programs have the best chance of training clinicians to use EMDR appropriately and properly.

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Author Note

Ricky Greenwald, Child Trauma Institute.

The author is the director of the Child Trauma Institute, which is accredited by the EMDR International Association to provide training in EMDR.

Correspondence concerning this article should be addressed to Ricky Greenwald, Child Trauma Institute, P.O. Box 544, Greenfield, Massachusetts 01302, USA. E-mail: rg@childtrauma.com.

Footnotes

[1]In my generation, growing up in the USA, the peanut butter and jelly sandwich was the classic kid lunch, probably accounting for more meals than burgers, hot dogs, and pizza combined.

[2]I already know one problem that will persist, though it's beyond the scope of this paper. Many therapists may be uncomfortable with helping clients to face issues that touch on the therapist's own "sore spot." It is said that the therapist cannot take the client farther than the therapist has gone. Although this issue is not specific to EMDR, it is particularly relevant because if a therapist shies away from the client's trauma, EMDR will be under-utilized.