CRITERIA FOR THE CERTIFICATION OF AN EMDR EUROPE STANDARD TRAINING COURSE WITHIN EUROPE (June 2024)

This document sets out the minimum requirements that must be met by all EMDR training courses to be approved or re-approved by the EMDR Europe Association. (Approved EMDR Europe trainers may add to or expand any part of the training. The guidelines will be reviewed after five years.)

Eligibility criteria

To be eligible to participate in an approved EMDR training course, trainees must hold a current license or registration to provide psychotherapeutic services in their own country. Also, the trainee must meet the minimum eligibility criteria for the training set out by their National EMDR Association. When a trainee comes from a different country, it is the responsibility of the trainer to contact that country's national EMDR Association to determine whether or not the trainee meets their eligibility criteria.

Trainer criteria

All presenters of EMDR standard training must be members of a national EMDR association and must also be an approved EMDR Europe trainer. Wherever possible, the trainer should speak the native language of the participants. The trainer must hold a degree or equivalent in a mental health field and a license or certification by his/her country of residence to provide psychotherapeutic services.

The only exception to the above is when a presentation is part of the preparation to become an approved trainer. In this case, the presenter must be observed by an approved trainer throughout the training, and also be eligible as trainee trainer. (see Criteria for EMDR Trainers).

Training material

The syllabus should be consistent with Shapiro's latest edition of her book "EMDR: Principles, Procedures and Protocols".

As part of the approval process, the training course must be presented for approval to the Standards Committee of EMDR Europe with a detailed outline of the training content at least two months before the initial advertisement of the training. Handouts, timetables and manuals to be used in all training courses must be available for inspection upon request. Accreditation will be for five years, after which time the training must be re-submitted to the committee, highlighting any changes that have taken place.

Format and duration of the training

The training will take place over a minimum total of 6 days. The format of the instruction should include:

- Teaching for a minimum of 24 (60-minute) hours
- Supervised practice for a minimum of 18 hours.
- Clinical supervision for a minimum 10 hours.

The content of teaching (24 hours)

The trainer may determine the order in which material is taught. However, some advanced information should only be taught after the trainee has had time to practice EMDR skills.

The EMDR training should only include EMDR-related material. During EMDR training, it is unacceptable to train participants in the application of other intervention methods. All content should be consistent with the Adaptive Information processing (AIP) model and Shapiro's textbook.

The training should contain various exercises to build experience and skills in implementing standard EMDR and EMDR-related procedures.

The didactic instructions are listed in the appendix

Before going on to teach more advanced parts of the training, time should be given to assimilate and practice the previous teaching. There are didactic instructions that should only be given when the trainee has had a minimum of 8 weeks to begin to integrate the EMDR protocol into his/her clinical practice. (Appendix)

The EMDR therapy training should only include EMDR-related material. The training must contain various exercises to build experience and skills in implementing EMDR and EMDR-related procedures. The course content must also include relevant video examples of actual EMDR sessions with a psychotherapy client or live demonstrations. The purpose of video examples or live demonstrations is to illustrate client symptomatology, clinical situations and how to manage these during an EMDR session. Video/live practice material should also demonstrate specific aspects of the EMDR methodology and patient responses during EMDR which otherwise are difficult to teach during a training course (e.g. cognitive interweave).

Supervised practice (18 hours)

(A trainer or facilitator must supervise practical exercises and live experiences. See attached document for definition of an EMDR facilitator.)

Practical exercises: Trainees should be given the opportunity to reinforce learning with practical activities such as role-play. Role-play is essential in teaching the skills required to elicit Positive and Negative Cognitions during the Assessment Phase and also to understand and use Cognitive Interweaves and affect regulation techniques such as the Safe/Calm Place.

Supervised live experience: During the training, trainees should practice the EMDR protocol in twos or threes, taking a turn to be the client, clinician and if required, the observer. Trainees must use their own real-life experiences while receiving direct feedback from a trainer/facilitator

Training facilitator to participant ratio

The facilitator to participant ratio cannot be more than 1 for every 12 participants.

Clinical supervision (10 hours)

The primary goal of the supervision is to enable the trainees to develop a basic level of competence in safely and effectively integrating EMDR into their clinical practice. This will require a minimum of 10 hours of supervision, working with a minimum of 3 clients.
Supervision must begin after attending the first part of the training. Supervision can be an integrated part of the training or can take place outside the training. Before attending parts of the training where more advanced parts are taught, there must be a minimum of 5 hours of supervision, this must be completed before the start of the last part of your training. At least one of the presented cases should be using phase 3-7

The trainer does not need to provide this consultation, although it is preferable that he/she does so. However, the trainer must provide information as to how the trainee can acquire supervision. Clinical supervision can take any of the following formats:

- As an integral part of the EMDR training programme
- Group consultation
- Individual consultation
- Telephone/video consultation

To do fair consideration to the different time models in which supervision is provided, the following is defined: the average time that is needed for a case supervision is about 20-30 minutes per participant. This means that the ratio of 1 supervisor to 2 supervisees must be maintained for 1 hour of supervision, 1 supervisor to 3 supervisees for 1.5 hours and so on. The maximum number of supervisees on a supervision day is 12.

Supervision must be undertaken by a clinician who is an accredited EMDR Europe consultant, facilitator or a trainer.
The supervision received as part of a full EMDR training course will count towards becoming an accredited practitioner.

The announcement of the training

The announcement of the training, e.g. advertisements or application form, should specify:

- The name of the EMDR accredited trainer(s) presenting the training;
- The number of training hours;
- Eligibility criteria for applicants (e.g. registration as a licensed or registered mental health professional);
- The training is EMDR Europe Association accredited.

The organisation of the training

Training courses should take place within the trainer's national boundaries. If the trainer wishes to train outside his/her own country, he/she should have the consent of the EMDR national association where the training takes place. (See "Powers and responsibilities of national associations with external trainers"). Any conflict about consent must be settled first and before the announcement of the training. If a dispute cannot be resolved, both parties can appeal to the Executive Committee of the EMDR Europe Association. A written statement of the decision must be

received before the training is advertised.

Linking with the national association

Before the end of the training, the trainer must make sure that trainees are fully informed about how to join their national EMDR Association and how to become an accredited EMDR practitioner. The trainer is responsible for ensuring that trainees are encouraged to continue their professional development by becoming accredited EMDR practitioners. Although it remains optional for a trainee to become accredited, the trainer must make sure that trainees are linked to an appropriate accredited supervisor or supervision network.

Final approval

The training course must be presented for approval to the Standards Committee of EMDR Europe with a detailed outline of the training. Handouts, timetables and manuals to be used in all training courses must be available for inspection.

It is not permissible to announce training courses before receiving the written approval of the training from the EMDR Europe Standards Committee.

Accreditation will be for five years. The course must then be re-accredited every five years to demonstrate that its contents continue to adhere to current EMDR Europe guidelines.

Violations

Violation of any of the above criteria will result in the course not being recognised as an EMDR Europe training course. Accordingly, participants will not receive an EMDR Europe certificate and will not be eligible to join any European or international EMDR organisation. Violation may also lead to the withdrawal of that person’s approval as an EMDR Europe accredited trainer and EMDR Europe accredited consultant and exclusion from membership of both the national and the European EMDR associations. The same applies to any EMDR trained facilitator/consultant who knowingly assists in such training.

Appendix

EMDR Standard Training Minimum Content

PTSD – a model for introducing EMDR's efficacy.

EMDR works at a cognitive, emotional, body and neurobiological level, speaking the language of trauma

PTSD is related to the dysfunctional way the experience is encoded and stored in memory. It is a disorder due to the process of memorization of the traumatic experience.

That is why in EMDR we are focused on the memory. It is the memory that is treated therapeutically.

The role of pathogenic memories in the different disorders. This broader view includes the so-called effect of "T" and "t" (relational and interpersonal traumatic experiences like attachment trauma and neglect)

According for the developing evidence of treating other disorders beyond PTSD the focus should tend to be towards a transdiagnostic treatment approach focussing on pathogenic memories.

History of EMDR – Background – The walk in the park

Research on EMDR and International guidelines recommending EMDR for trauma and stress related disorders.

The State of the Art of EMDR in the different disorders – Research and publications. The empirical support of EMDR about different clinical populations.

The AIP Model – 3 challenges for the clinician when working with EMDR: focus on memories and not in symptoms, do not intervene during the session, trust the process.

The clinical implications of the AIP model and how it guides case conceptualisation, treatment planning, intervention, and predicts treatment outcome.

Difference in encoding and storage of traumatic experiences vs. positive or neutral experiences.

Different kind of trauma (physical abuse, sexual abuse, emotional abuse, psychological abuse, neglect)

Mechanism of action of EMDR – different hypothesis and state of the art of the research

Experiential contributors in the different approaches (psychodynamic, CBT, family systems, Gestalt, etc.). Differences and common grounds between EMDR and other therapeutic approaches

Phase 1 – History taking, case conceptualization and treatment planning.

Different ways to gather information for case conceptualization: identifying the precipitating factor, floatback to identify touchstone memories, TOP TEN, negative beliefs (floatback), exploring attachment trauma and family disfunctions, life events. ACE questionnaire, DES or SCID-D, initial clinical interview from Francine Shapiro's manual.

Treatment planning; past – present- future

Phase 2 – Timing, informed consent, explanation and introduction of EMDR therapy, safe place, (optional RDI), stabilization, stop signal. Legal, ethical and research issues regarding EMDR utilisation.

Necessary precautions in the use of EMDR.

Phase 3 – Assessment

Dimensions of the negative cognitions

Phase 4 – Desensitization – Changes indicating processing – Examples – How to get back to target

Phase 5 – Installation of the positive cognition – the steps

Phase 6 – Body scan – different reactions

Phase 7 – Closure – closing an incomplete and a complete session – final comments regarding the Session

Phase 8 – Re-evaluation – different situations. How to proceed after re-evaluation

Reprocessing of intense emotions and abreactions

Procedures for dealing with blocked processing – feeder memories, blocking beliefs, secondary gains, fears, etc.

EMDR with children – adaptations of the protocol – examples (short)

EMDR with grief – targets, blocked processing, complicated grief

EMDR self-administration

How to work with the whole clinical picture – integrating EMDR in the participants' clinical practice, exercise thinking of a case (focus his targets, make a therapeutical plan)

Working with triggers and with the present

Working with the future template- examples

Demonstration: video and/or a live session

Practicum (groups of two/three)

Before teaching more advanced parts of the training, time should be given to assimilate and practice the previous teaching. The following didactic instruction should only be given when the trainee has had a minimum of 8 weeks to begin to integrate the EMDR protocol into his/her clinical practice.

The following should be applied to more complex cases to make the learning experience new and not having just a repetition. So e.g. AIP-Model in relation to complex cases. Three pronged protocol and it's challenges for complex cases etc.)

Short review of the AIP-model and component of memories with complex cases

Short review of the three pronged protocol and the eight phases with complex cases: challenges and pitfalls

Phase 1 and 2 from the perspective of more complex presentations – considerations for pacing, symptoms vs themes vs underlying issues, comparison of less complex and more complex cases, clinical themes, additional resources and stabilization (RDI, additional resource-exercises), case conceptualization and treatment planning – different sequence plans for simple conditions (standard-, recent-, unique- events) and for more complex conditions (inverted, multi-targeting, chronological…), planning of where to begin reprocessing – past, present, future, case discussion, (inverted protocol)

Phase 3 applied to complex cases (which includes review of simple way): deepening: NC/PC

Phase 4 with complex cases – overreacting – underreacting, double attention, blocked processing, focused reprocessing and reprocessing continuum (EMD, e.g. CIPOS)

Cognitive interweaves

Strong emotional responses

Additional obstacles to reprocessing

Dissociative symptoms and reactions and how to handle them, differentiation between occurrence of peritraumatic dissociation phenomena and more severe dissociative reactions

Phase 5 Installation

Phase 6 Body scan

Phase 7 Closure and decision for closure

Short introduction into theory theories of dissociation and application of EMDR therapy (challenges and pitfalls)

Overview of application of EMDR therapy in relation to other disorders

optional

- Anxiety and Phobias
- Grief and traumatic loss
- Depression
- Addictions
- Pain and injury
- Intensive treatment?
- Application of virtual EMDR-therapy

Review developing future template / flash-forward

The practicum (groups of two/three) should have the focus on using Cognitive Interweave