

## Town Hall Breakout Summary

### **Racial/Cultural/Ethnic Awareness: How should basic training and standards reflect values and knowledge here? What content regarding racial/cultural/ethnic awareness should be part of basic training?**

- Have a glossary of terms for referring to various cultures/races/ethnicities.
- How to effect repair if there is a misstep.
- EMDRIA curated videos of working with diverse populations that trainers can pull from to show in their trainings, so that the content is uniform across trainers. EMDRIA provide video for trainers re R/C/E awareness required to be watched prior to approval as trainer. Having a pre-recorded lecture on cultural awareness that is required for all trainings and is also made accessible to all of membership. Universal videos of working with diverse populations that trainers can pull from to show in their trainings, so that the content is uniform across trainers. Maybe EMDRIA needs to provide trainers with a cultural competence training if they think it's needed.
- Pool of research in classes for trainers to take.
- Monitor trainer evaluations from trainees.
- Consensus to encourage the development of other tools in organization (outside of BT) to encourage minority to be empowered to attend trainings and become members.
- It was suggested that we ask each trainee what they want covered and weave that in rather than try and bring a lot of different information that may or may not be relevant to the group.
- Content, preparation of training faculty, holding space for participants (some of which will be minority and marginalized), to be talked at by someone of another culture may be triggering.
- What kind of content can be in basic training, Trainers need to know who their trainees are/population and open that up, understand the subtle dynamics.
- Having a committee within training organizations that are comprised of faculty and consultants and encourage drafting a values statement and encouraging difficult conversations with the team.
- Consulting with experts in cultural awareness and having them review trainings for any micro-aggressions.
- White trainers to get consultation and mentoring from POC trainers, how you navigate so the people of color aren't the ones to take responsibility to teach us, Marginalized people are tired of educating white people. Either on their own or through EMDRIA. Culture, other populations, matter of intersectionality (how much stress does it put on a person to be loyal to their culture –attachment dynamic).
- Increasing training diversity/trainer diversity.
- Minimum level of training/knowledge surrounding diversity required by trainer to have
- Discussing epidemiology in areas of the training such as in history taking, Relate the topic back to AIP, Teach about generational trauma. How we even take history. How we frame "trauma." Marginalization is a traumatic experience. Homelessness, poverty, and trauma, all of the mechanisms of oppression, agency clinicians who are trained. Ongoing trauma (not single incident or early learning experience), we are confronting these things daily and politically. We can give examples of cultural challenges such as seeing microaggressions as a form of trauma. Having a couple slides about culture isn't enough as this should be naturally woven in throughout the training. Consensus to encourage open conversations and approaches to privilege, oppression, racial injustice.
- Group consensus is that it's not our job to add a unit or spend hours talking about cultural stuff. There are way too many cultures to possibly learn about and address them all. It's our job to bring the basic protocol to our participants. Concerns over people getting triggered by the current political climate. Separating out political discussions vs cultural competence. Concern about getting off subject (too much time on political hot topics) and losing time to teach basic material. Some suggested that participants who are from different cultures can bring their questions and expertise to the training. There's concern that we will become reductionists to the standard protocol teachings in order to make room for cultural topics.

**Trainee Readiness: What do trainees need to know before they start the basic training? How would trainee readiness be determined?**

- As EMDR is a treatment for trauma, require an EMDRIA curated and administered pre-course on Trauma 101, Dissociation, tools for Assessment of Dissociation resources. Trainee present completion doc for admission to basic training. Insures uniformity of content across trainers and basic introduction into those topics.
- General consensus on trauma 101 but not clear how. Required reading and pre-tests somewhat endorsed but also some said trainees are adults and “should” know that information from graduate school. Some agreement on importance of adding info on attachment and developmental psychology basics as well as neurobiology of trauma and dissociative symptoms and complex disorder.
- A glossary of terms in EMDR therapy would be helpful to jump start learning
- Many agreed that some level of trauma understanding is ideal (including): Trainee should have some basic understanding of Trauma- trauma 101; Trainee should have basic understanding of brain/neurology; Trainee should have some basic level of understanding around Polyvagal
- Trainees given videos and examples before training and told in advance that they would be asked to work on own experiences. Trainees should have a clear understanding of what that looks like and could be vetted for if they have done own counseling/psychotherapy work before attending BT (varying views on this)
- Requiring the textbook in advance can be a problem due to book shortages. If we have too many prerequisites it could discourage clinicians from registering. Consultation during and after the training is where we can work to bring a resistant or challenged participant “on board” and using EMDR as well as to more thoroughly assess and improve competency.
- Some divergence on if Francine’s book should be required- some trainers do things differently from the book and it can confuse the trainee

General agreement (not entirely consensus) that some form of information be made available to trainees prior to the training, but not make it required. Suggestions were made about the following:

- When trainees register for trainings, giving them access to videos about intro to trauma
- Most participants in this group felt that having specific prerequisites around trauma would be a deterrent
- A list of books that are recommended for participants prior to training. (*The Body Keeps the Score, Trauma Made Simple, Getting Past Your Past*, to name a few)
- Having a pre-study link given to registrants with information on affect regulation, psychometrics, application of EMDR information.
- Send the manual out to everyone before the training.
- Some participants in the group integrate the trauma information into the training.
- Some recommended video content be made accessible prior to training.
  
- Can’t “legislate” a person’s readiness, clinician may not be there yet with regard to maturity. Don’t scrap graduate students who are in process of licensing. EMDR Institute requires trainees read the books at some point, hard to police that, difficult to monitor, mental health training, licensing track, not having to start by teaching about trauma first because they’ve read the basic text (first part), trainees cant just absorb the material from the air. Will need to be involved. Use the anxiety they feel about training and intensity. May want to give a test because people think they don’t work with trauma. Don’t put out unnecessary rules - Make guidelines, recommend things but not require them, less regulation is more. It’s best to assume people won’t read anything. Everything they want you to know is on the slides. Some will really want to learn and read everything. We’re creating the bed-rock with training. There are a million reasons why they read and don’t read. We can’t entirely expect them to do it. We would like for them to know traumatology, but we can’t guarantee. We can have an expectation to have it when they enroll. But can’t over-regulate. Part of the onus is on the trainees. Inspire and Aspirational rather than rules. What is our intention by asking this question? We all want our folks to come in with information about trauma. We have to have some expectation that they read the books and be licensed.

## General/Specialty areas: What are views on cost benefit, and how “weaving in” etc., might be reflected in standards?

- Basic remains basic – the content is already enough. Leave the standards for Special Populations as they are, not given more time. Consensus no specialty trainings in BT. Can add to core curriculum according to trainer. Agreement that basic protocol and research on other populations that EMDR can be used with but no specialty protocols presented in BT. General Consensus that there should not be specialty Basic Trainings & Felt curriculum should focus on the basics/foundation. Most agreed that the basic training should remain basic as to not overwhelm the participants. Several agreed that special populations already took up too much time in BT
- Greater utilization, beefing up, of the SIGs; to provide resources for specialties.
- Access to recorded Conference presentations by specialty.
- Create ‘Find a Consultant’ engine that allows trainees to search for a consultant by specialty.
- Trainers maintain specialty resource information on their website (google doc?, plus links) available to trainees after the training. (If google doc, easy to update) [possibly could be included on their LMS?]
- Do not want EMDRIA to become too restrictive- mention of being surprised by consultation packet
- Some consensus that a specialty training while has some benefits but the trainer needs to be able to teach to a general population to be able to meet the needs of all the diversity that trainees bring into the training.
- Specific populations only require adaptations to the basic protocol, not entirely different protocols. Approaching it as though there are entirely different protocols becomes confusing to new trainees.
- Make suggestions to other advanced trainings- mention options for advanced trainings but stick to the basics in basic training.
- Is there research support for added techniques? If not, no. (Lots of nodding heads here) Advanced workshops for additional training after the BT. Give them links about advanced trainings, need to be evidenced base or you’re in scary water. Seek out the expert on children to give a video presentation on that.
- Discernment (identifying) for Dissociation is foundational. Teaching people how to treat dissociation is not foundational but identifying/knowing how to screen and even diagnose dissociation is critical. They need to know the basics.
- 4 areas : addictions, children, first responders, dissociation, recent events, complex trauma (Need to understand the difference between “one-off trauma” and complex trauma – including basic understanding dissociation.
- Current training requires basic introduction working with special populations. Concerned that a training only about children may lose and drop the generalized knowledge about EMDR therapy. Opposed to splitting it up. Distance learning, do some recordings where they can ask more questions and learn more from these resources. Rosalie: Should any additional material be evaluated by EMDRIA S&T. Example of Flash which is being taught as woven into the BT. Evaluate this material as well. Added on or woven in.
- People don’t actually teach what they submit. Some people have a manual but no slides and vice versa.
- Shapiro’s book is the training manual and she includes many specialty areas such as kids and military and protocols such as recent events. There is concern over having manpower and funds to evaluate trainings with too many specialty components. One option for trainers would be to invite clinicians who work with same populations so they can bring that specific expertise to the training and the trainer can stick to the basics. An example given was one person did a training that was for midwives. She did all the basics and they brought much of the specialized learning to the class. It’s important to remember that dissociation is not a special population. Dissociation is woven into trauma for everyone to some degree. There should be some basic information given about dissociation. Consensus is to Bring the basic protocol to special populations in the training then refer participants to advanced trainings offered if they want to dig deeper. For example, we might say that we use the standard protocol for military folks but it’s important to understand their terminology and military culture. Then, refer them to take trainings by E. C. Hurley or someone.

**Recorded/Live/Interactive: Is the consensus reflected fairly? How would standards be developed for this content that could be equitably applied (over trainers and over time)?**

- All live all the time! for the basic training. EMDRIA video on History. EMDRIA video (updated annually) on research. Uniformity, consistency of content. To be available at EMDRIA prior to training for viewing by trainees and referred to by trainer in live presentation. Closing video on EMDRIA recapping value and resources for trainees re: membership; what is available to them with and without membership.
- General agreement- not consensus- that trainings should remain primarily if not entirely experiential. Segments could be pre-recorded or should have universal recordings, for sections on cultural awareness, research, history of EMDR. Record videos but show them live during class time to ensure people are paying attention.
- Most wanted all live all the time. Some value seen in prerecorded video however lots of concern over people then not implementing EMDR into proactive and not feeling really a part of the community- it was agreed that the trainer does a lot to connect with trainees and to “sell” EMDR. Concern that over recordings this would be lost. EMDRIA have universal video on History, research and AIP to all trainers to access. Requirement that if used videos would need to be undated often.
- Wide range of views from group. From all to nothing. General consensus to allow flexibility by trainers according to trainer preference. Importance of making these decisions based on pedagogy and not solely on trainer input.
- Consensus is for live and interactive trainings. The group doesn’t even like the idea of videotaping a segment and watching it with participants. Spontaneity, trainer syntax and engagement are lost on just watching a video. We don’t know what they have learned as tests don’t really measure learning very well. Participants may have questions in the moment that they can ask when live but forget or not bother to ask after watching a video. The group thought it was a good idea to video tape sections in case the trainer gets sick as a backup.
- Everyone learns differently. To limit it to only live online may not be conducive to everyone. Allowed to have a mixture. Trainers could offer different types based on their own preferences. Evaluate learning. Not having to show up live might make training less expensive. Quizzes, assessment, feedback forms, practicum. Answers are things that aren’t all powerpoints but are spoken.
- Easy to record virtual trainings but participants, they can access the recordings again and again. Get an expert to teach special pops and let them watch it again.
- What is essential and what is not – no data as to what we could and couldn’t. We’d need to collect data around this, (pilot?)
- Different learning styles. Have recordings available not to replace but as a supplement, not as a substitution but recorded as supplemental info when people want to review.
- Be careful that we say something can’t be done before we test it. Try a pilot program and test it before we assume it can’t be done asynchronously. Be open to what is possible.
- Live offers chance to answer misunderstanding right away rather than letting the misconception build over time.
- Can use polls to get feedback as to how much they are paying attention and retaining.
- Create some content on traumatology and a little on dissociation.

**Other Topics & Comments:**

- Rename ‘Certificate of Completion’ for Basic Training – consensus on Diploma but Document also ok. NOT certificate. One trainer now requires an acknowledgement that the training does not result in Certification (adds basic certification requirements) in her pre-training registration docs. Says that works well.
- No pass/fail standard for basic training. If they complete the course they get the diploma/doc that they completed the training.
- Elevated standards for Certification. Greater public/professional awareness of Certified vs Trained.
- Issues of concern = Trainee dissociation during lecture and/or practicum; apparent psychological issues; sleeping or lack of ‘proper’ attention during training.
- Require 6/10 EMDR therapy sessions as part of training. Rejected as too difficult to administer/verify, and in some locations, to obtain.