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A competence framework for Eye Movement Desensitisation and Reprocessing (EMDR) therapy

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A competence framework for eye movement desensitisation and reprocessing (EMDR) therapy

The competences described in this report are designed to be accessed online and should be downloaded from the University College London (UCL) website.

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Contents

Executive summary

The report describes a method for identifying competences for practitioners delivering eye movement desensitisation and reprocessing (EMDR) therapy. It organises the competences into six domains:

- The first domain identifies **core professional competences** – the knowledge and skills needed to operate in a professional context.
- The second domain (**generic therapeutic competences**) identifies the competences required to manage clinical sessions and engage clients in a psychological intervention. It also identifies the competences for assessing and managing risk.
- The third domain identifies the areas of **generic knowledge** that professionals will need when working with people with post-traumatic stress disorder (PTSD), including knowledge of trauma and dissociation.
- The fourth domain is **EMDR-specific knowledge** of the Adaptive Information Processing (AIP) model
- The penultimate domain sets out **EMDR interventions**, and so details the eight phases of the standard EMDR protocol, as well adapting the EMDR protocol in the context of mental health presentations additional to PTSD, and the use of EMDR with complex PTSD.
- The final domain identifies **meta-competences** – overarching, higher-order competences that practitioners need to use to guide the implementation of any assessment or intervention.

The report then describes how the competences are organised into a 'map', which shows how the competences fit together and inter-relate. Finally, it addresses issues that are relevant to the implementation of this competence framework for EMDR therapy (referred to as 'the Framework), and considers some of the organisational issues around its application.

How to use this document

This report describes the model underpinning the Framework, and indicates the various areas of activity that, taken together, represent good clinical practice. It also describes how the Framework was developed and how it may be used.

The report does not include the detailed descriptions of the competences associated with each of these activities. These are available to download as PDF files from the website of the Centre for Outcomes Research and Effectiveness (CORE) at UCL.

Scope of the Framework

The Framework is relevant to clinicians delivering EMDR therapy for individuals presenting with PTSD.

Supervision clearly plays a critical role in supporting the development of competences, and the ability to make use of supervision is included in the Framework. Competences associated with the delivery of supervision are detailed in a separate framework, available at the UCL website (www.ucl.ac.uk/core/competence-frameworks).

The development of the Framework

Oversight and peer-review

The work described in this project was overseen by an expert reference group (ERG) comprising experts in EMDR therapy, selected for their expertise in research, training and service delivery. As well as face-to-face meetings, the ERG advised on process, and debated and reviewed materials as they emerged.

Adopting an evidence-based approach to framework development[1]

A guiding principle for the development of previous frameworks (Roth and Pilling, 2008) has been a commitment to staying close to the evidence base for the efficacy of

[1] An alternative strategy for identifying competences could be to examine what workers in routine practice do when they carry out a psychological intervention, complementing the observation with some form of commentary from the workers to identify their intentions as well as their actions. However, the strength of this method – that it is based on what people do when putting their competences into action – is also its weakness. Most psychological interventions are rooted in a theoretical framework that attempts to explain human distress, which usually links to a specific set of actions aimed at alleviating the client's difficulties. It is these more 'rigorous' versions of an intervention that are examined in a research context, forming the basis of any observations about the efficacy of an approach or intervention. In routine practice, these 'pure' forms of an intervention are often modified as workers exercise their judgment in relation to their sense of the client's need. Sometimes this is for good, sometimes for ill, but presumably always in ways that do not reflect the model they claim to be practising. This is not to prejudge or devalue the potential benefits of eclectic practice, but it makes it risky to base conclusions about competence on the work done by practitioners, because this could pick up good, bad and idiosyncratic practice.

therapies, focusing on those competences for which there is either good research evidence or strong expert professional consensus about their probable efficacy.

Extracting competence descriptions

The procedure for extracting competences started with the identification of representative trials of EMDR. The manuals associated with these trials were examined in order to extract and to collate therapist competences – a process detailed in Roth and Pilling (2008). As described above, draft competence lists were discussed and peer reviewed by members of the ERG.

EMDR therapy

EMDR therapy is an empirically validated therapy that can be used to treat people presenting with PTSD (as well as with trauma in the context of other presentations).

EMDR therapy is carried out in eight phases and follows a standard protocol and procedure. These phases include a comprehensive assessment, client preparation and processing of:

a) past events that underpin current difficulties
b) current disturbing situations
c) future challenges.

A consistent (and recurrent) focus on the past, present and future is referred to as the 'three prongs' of EMDR.

A central feature of the processing phases of EMDR is the use of dual attention stimuli (referred to as bilateral stimulation), usually in the form of bilateral eye movements, but also as bilateral taps or bilateral auditory stimuli (such as tones, beats or buzzes).

EMDR therapy is guided by the AIP model, developed by Francine Shapiro (Shapiro, 2018). This posits that just as there is an innate process for healing physical injury, there is an innate process for healing psychological injury, and this can become blocked when a person is subjected to traumatic events that are too overwhelming to process in the normal adaptive way. Instead, the high level of arousal engendered by distressing life events causes them to be stored differently with the original emotions, physical sensations and beliefs, which remain unintegrated into the rest of the memory network. As a result, they continue to be re-experienced in the form of flashbacks, nightmares and intrusive thoughts that are characteristic of PTSD.

Three dominant hypotheses have been proposed as mechanisms of action of EMDR – that the eye movements a) tax working memory, b) elicit an orienting response, and c) link into the same processes that occur during rapid eye movement sleep.

According to the AIP model, current experiences can trigger unprocessed emotions, physical sensations and beliefs linked to memories of adverse life experiences. When

the past becomes present and clients react with symptoms associated with PTSD, it is because their perceptions of current situations are driven by unprocessed memories.

Processing of targeted memories using the three-pronged EMDR therapy protocol is assumed to transfer them from implicit memory to explicit and semantic memory systems (in other words, moving from fragmented, decontextualised sensory experiences associated with the traumatic event to a meaningful narrative that can be stored in memory in the normal way). As the targeted memory is integrated with more adaptive information, the associated negative emotions, physical sensations and beliefs are altered, resulting in affects, somatic experiences and cognitions that are no longer disturbing.

EMDR reprocessing sessions promote an associative process that reveals the connections of memories that are being triggered by current life experiences; the aim is to help the client to access an adaptive memory network. This contrasts with other therapies (particularly cognitive behavioural therapy [CBT]), which involve extended focused attention on the disturbing event and associated automatic negative thoughts, and which aims to restructure these cognitions by challenging the evidence used to support them.

The competence model for EMDR therapy

Organising the competence lists

Competence lists need to be of practical use. To achieve this, they need to be structured in a way that reflects the practice they describe, be set out in a way that is both understandable and valid (that is, recognisable to practitioners as accurately representing the approach, both as a theoretical model and in terms of its clinical application).

Figure 1 shows the six domains into which the competences have been organised.

The first domain identifies **core professional competences** – the knowledge and skills needed to operate in a professional context.

The second domain (**generic therapeutic competences**) identifies the competences required to manage clinical sessions and engage clients in any psychological intervention.

The third domain identifies the areas of **generic knowledge** that professionals will need when working with people with PTSD – specifically, knowledge of mental health conditions, and knowledge of trauma.

The fourth domain is **EMDR-specific knowledge** of the AIP model.

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The penultimate domain sets out **EMDR interventions**, and so details the eight phases of the standard EMDR protocol, as well as adapting the EMDR protocol in the context of mental health presentations additional to PTSD, and the use of EMDR with complex trauma.

The final domain in the model focuses on **meta-competences**, so-called because they permeate all areas of practice, from 'underpinning' skills through to specific interventions. Meta-competences involve making procedural judgments – for example, judging if and when something needs to be done, or judging the ways in which an action needs to be taken or to be modified. They are important because these sorts of judgments are seen by most clinicians as critical to the fluent delivery of an intervention; effective implementation takes more than the rote application of a simple set of 'rules', and so meta-competences attempt to spell out some of the more important areas of judgment being made.

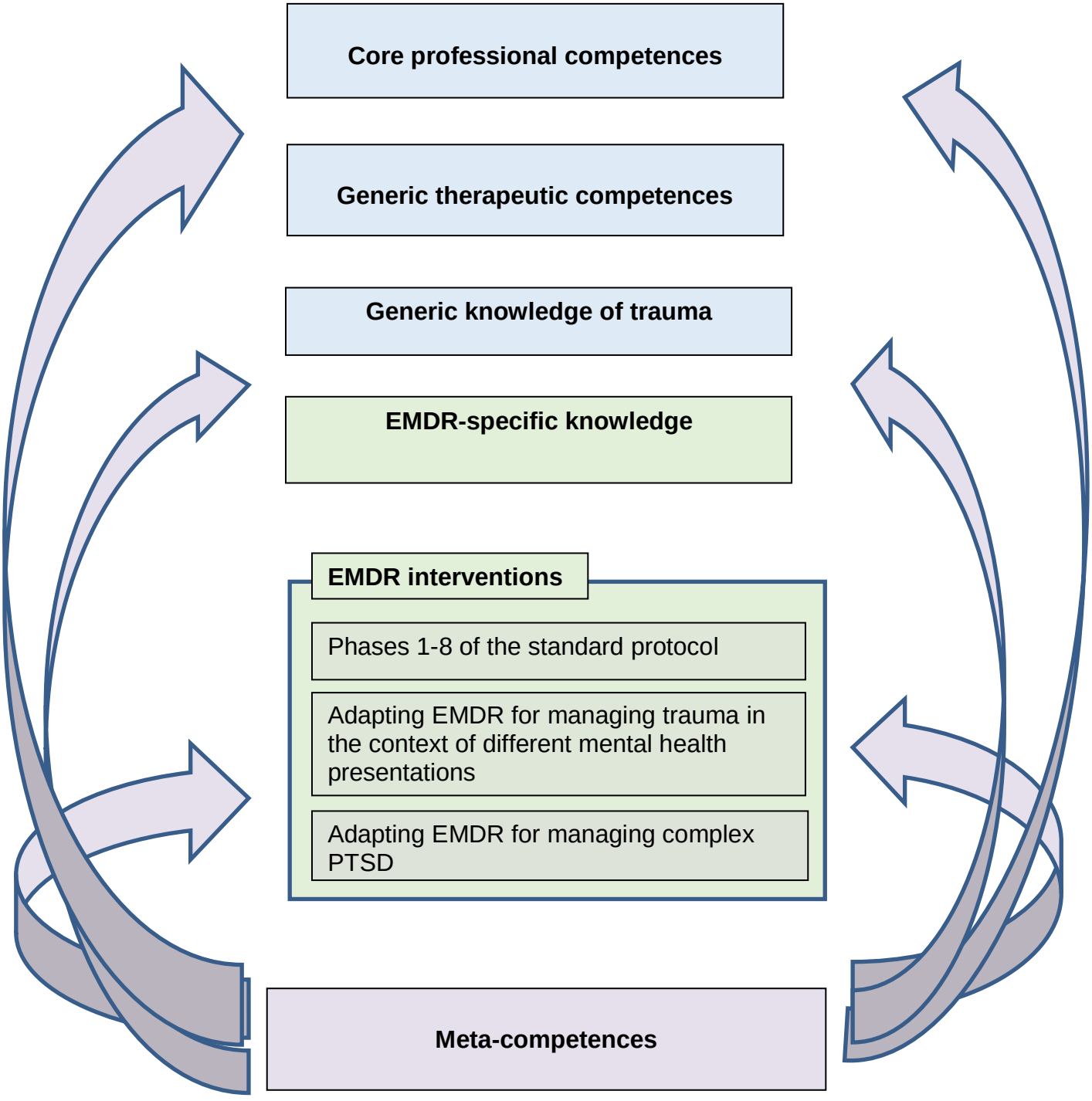

Figure 1: Outline model for the Framework

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Specifying the competences needed to deliver EMDR

Integrating knowledge, skills and attitudes

A competent worker brings together knowledge, skills and attitudes. It is this combination that defines competence; without the ability to integrate these areas, practice is likely to be poor.

Clinicians need background knowledge relevant to their practice, but it is the ability to draw on and apply this knowledge in clinical situations that marks out competence. Knowledge helps the practitioner understand the rationale for applying their skills, to think not just about *how* to implement their skills, but also *why* they are implementing them. Beyond knowledge and skills, the clinician's attitude to and stance on an intervention is also critical – not just their attitude to the relationship with the client but also to the organisation in which the intervention is offered, and the many cultural contexts within which the organisation is located (including a professional and ethical, as well as societal, context). All of these need to be held in mind because all have a bearing on the capacity to deliver interventions that are ethical, conform to professional standards, and that are appropriately adapted to the client's needs and cultural contexts.

The map of competences

Using the map

The map of competences is shown in Figure 2. In the map, the competences have been organised into the six domains outlined above and in Figure 1, and shows the different activities which, taken together, constitute each domain. Each activity is made up of a set of specific competences. The details of these competences are not included in this report, but can be downloaded from the UCL website. (www.ucl.ac.uk/core/competence-frameworks).

The map shows how the activities fit together and how they need to be 'assembled' for practice to be proficient.

Layout of the competence lists

Specific competences are set out in boxes.

Most competence statements start with the phrase, 'An ability to…', indicating that the focus is on the clinician being able to carry out an action.

Some competences are concerned with the knowledge that a practitioner needs so that they can carry out an action. In these cases, the wording is usually, 'An ability to draw on knowledge…'. The sense is that clinicians should be able to draw on their

knowledge, rather than having knowledge for its own sake (hence, the competence lies in the application and use of knowledge in the furtherance of an intervention).

As far as possible, the competence descriptions are behaviourally specific, and so are there to identify what the clinician needs to do to execute the competence.

Some of the boxes are indented, when a high-level skill is introduced and needs to be 'unpacked'. In the example below, the high-level skill is being 'collaborative and empowering'; the indented boxes that follow are concrete examples of what the clinician needs to do to achieve this.

An ability to work in a manner that is consistently collaborative and empowering, by:
translating technical concepts into plain language that clients can understand and follow
taking shared responsibility for developing agendas and session content

The competences in indented boxes will make most sense if the clinician holds in mind the high-level skill that precedes them. So, regarding the first indented box of the above example, although using plain language is always a sensible thing to do, there is a very good conceptual reason for emphasising its use here: it will impact on (and, therefore, contribute to) clients' sense of collaboration in and engagement with the therapy process. Bearing in mind that the conceptual idea behind an action should give the clinician a 'road map', and reduce the likelihood that they apply techniques by rote.

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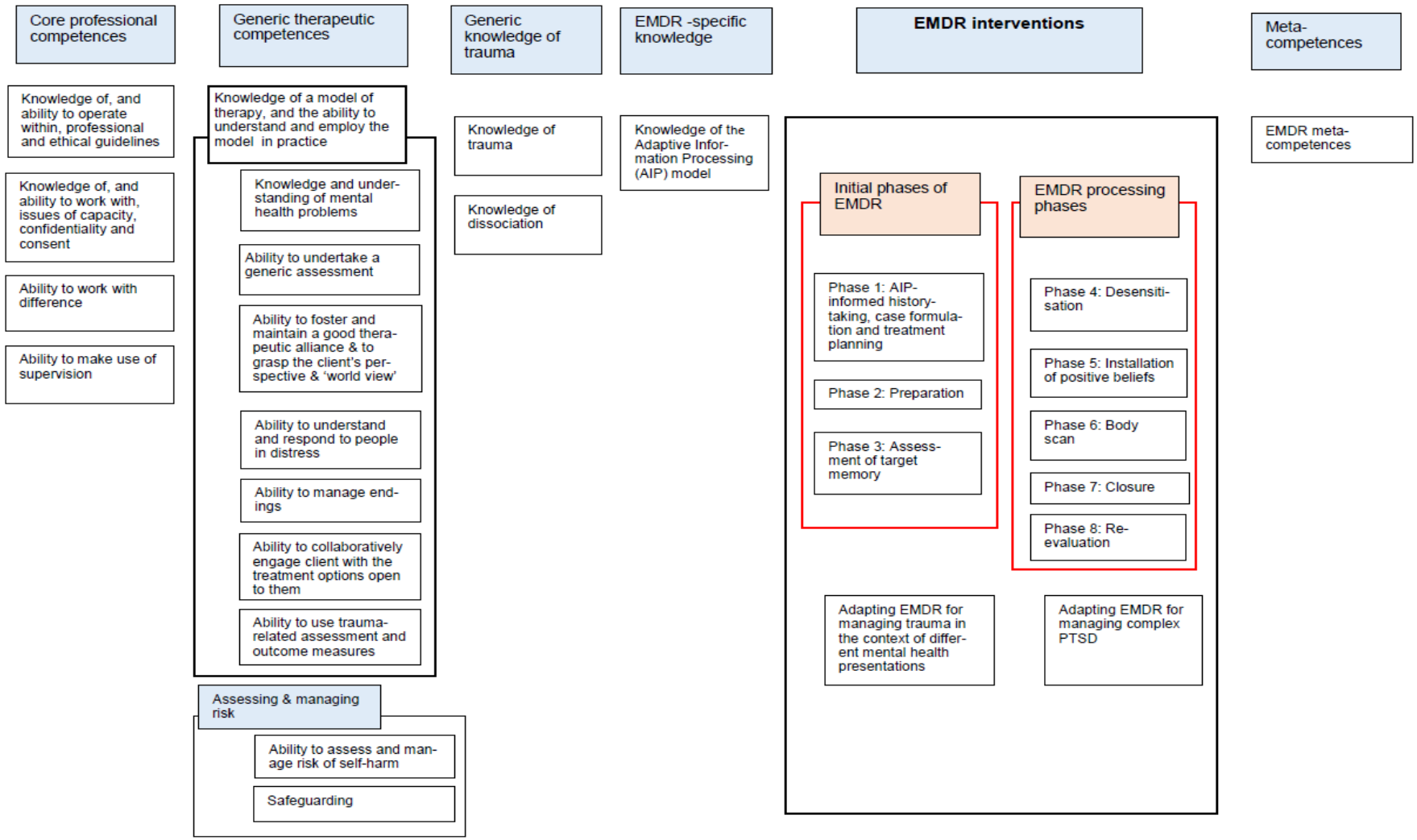

Figure 2: The map of EMDR therapy competences

The contribution of training and supervision to clinical outcomes

Elkin (1999) highlighted that when evidence-based therapies are 'transported' into routine settings, there is often considerable variation in the extent to which training and supervision are recognised as important components of successful service delivery. Roth, Pilling and Turner (2010) examined 27 major research studies of CBT for depressed or anxious adults, identifying the training and ongoing supervision associated with each trial. They found that trialists devoted considerable time to training, monitoring and supervision, and that these elements were integral to treatment delivery in clinical research studies. It seems reasonable to suppose that these elements make their contribution to headline figures for efficacy – a supposition obviously shared by the researchers themselves, given the attention they pay to building these factors into trial design.

It may be unhelpful to see the treatment procedure alone as the evidence-based element, because this divorces technique from the support systems that help to ensure the delivery of competent and effective practice. This means that claims of implementing an evidence-based therapy could be undermined if the training and supervision associated with trials is neglected.

Applying the Framework

This section sets out the various ways that the Framework can be used, and describes the methods by which these may be achieved. Where appropriate, it makes suggestions for how relevant work in the area may be developed.

Commissioning EMDR training

In relation to training, the Framework identifies the mix of generic therapeutic competences and EMDR-specific competences that a competent practitioner needs to demonstrate.

A core professional training in a psychological therapy and experience of delivering the therapy is a prerequisite for entry into EMDR foundation training. This is in line with the training and background of EMDR therapists employed in the clinical trials which have demonstrated the efficacy of EMDR therapy, and is consonant with the accreditation standards of EMDR Association Europe.

Supervision

Supervision is critical to maintaining fidelity to the EMDR model and to assure its effective and safe delivery. EMDR therapists should be supervised by individuals

with sufficient training in, and experience of, EMDR, and services will need to ensure that supervisors meet these criteria.

Used in conjunction with the competence framework for supervision, the Framework is potentially a useful tool to improve the quality of supervision of EMDR. It does this by focusing the task of supervision on a set of competences that are known to be associated with the delivery of effective treatments. Supervision commonly has two aims – to improve outcomes for clients and to improve the performance of practitioners. The Framework will support both these, through:

- providing a structure by which to identify the key components of effective practice
- allowing for the identification and remediation of suboptimal performance.

The Framework can achieve this through its integration into professional training programmes and through the specification for the requirements for supervision in both local commissioning and clinical governance programmes.

Commissioning services

The Framework can contribute to the effective use of healthcare resources by enabling commissioners to specify the appropriate levels and range of competences that need to be demonstrated by workers to meet identified local needs. It could also contribute to the development of more evidence-based systems for the quality monitoring of commissioned services by setting out a framework for competences that is shared by both commissioners and providers, and which services could be expected to adhere to.

Service organisation – the management and delivery of services

The Framework represents a set of competences that (wherever possible) are evidence based, and it aims to describe best practice for the activities that individuals and teams should follow to deliver interventions.

Although further work is required on the competences' utility and on associated methods of measurement, they should enable:

- the identification of the key EMDR competences that a practitioner needs
- the likely training and supervision competences of people managing and delivering the service.

Because the Framework converts general descriptions of clinical practice into a set of concrete specifications, it can link advice for the implementation of EMDR (as set out in National Institute for Care Excellence or Scottish Intercollegiate

Guidelines Network guidance, or National Service Frameworks, along with other national and local policy documents) with the interventions that are delivered. Further, this level of specification carries the promise that the interventions delivered within NHS settings will be closer in form and content to those of the research trials on which claims for the efficacy of specific interventions rest. In this way, it could help to ensure that evidence-based interventions are likely to be provided in a competent and effective manner.

Clinical governance

Effective monitoring of the quality of services provided is essential if service users are to be assured of optimum benefit. Monitoring the quality and outcomes of interventions is a key clinical governance activity; the Framework allows providers to ensure that EMDR interventions are provided at the level of competence that is most likely to bring real benefit by allowing for an objective assessment of clinician's performance.

Concluding comments

This report describes a model that identifies the activities that characterise effective delivery of EMDR and locates them in a 'map' of competences.

The work has been guided by two overarching principles. First, the Framework stays close to both the evidence-base and expert professional judgment, meaning that an intervention carried out in line with the competences described in the model should be close to best practice, and therefore is likely to result in better outcomes for service users. Second, it aims to have utility for the people who use it, clustering competences to reflect how interventions are delivered, and therefore facilitating their use in routine practice.

Putting the model into practice – as an aid to curriculum development, training, supervision, quality monitoring or commissioning – will test its worth, and indicate the ways in which it needs to be developed and revised. However, implementation needs to be holistic: competences tend to operate in synchrony, and the model should not be seen as a 'cook book'. Delivering effective interventions involves the application of parallel sets of knowledge and skills, and any temptation to reduce it to a collection of disaggregated activities should be avoided. Clinicians need to operate using clinical judgment in combination with their technical and professional skills, interweaving technique with a consistent regard for the relationship between themselves and service users.

Setting out competences in a way that clarifies the activities associated with a skilled and effective practitioner should prove useful for clinicians training in, and delivering, EMDR therapy. The more stringent test is whether it results in more effective interventions and better outcomes for clients.

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