The TraumaClinic Model of EMDR Basic Training in Brazil: A Country Case Study for In-Person and Online Training

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This article utilizes a country case study design to describe the implementation of eye movement desensitization and reprocessing (EMDR) therapy training in Brazil. The primary focus is on the methodology, adaptations, adjustments, and cultural considerations necessary to incorporate in-person and virtual training in this country. Additionally, the article will explore the impact of the COVID-19 pandemic to address National Government Guidance related to social distancing. This guidance required adjustments to training delivery, clinical and self-practice, clinical supervision, and consultation. Finally, the article outlines the advantages and disadvantages of implementing EMDR therapy training in Brazil, expanding to how models of good practice could be implemented in other countries, such as Angola and Mozambique, to include cultural adaptation, sensitivity, and replication.

Keywords: EMDR therapy; online training; EMDR basic training; consultation; supervision; Brazil

The first eye movement desensitization and reprocessing (EMDR) therapy training workshop, taught by a native Portuguese speaker, took place in Rio de Janeiro, Brazil, in August 2004 for 17 professionals. Over the years, the movement spread to Curitiba, Porto Alegre, São Paulo, and Recife, eventually reaching over 20 cities. Presently, there are more than 420,000 psychologists (Conselho Federal de Psicologia, 2021) in a country with a population of 213,000,000 people (Instituto Brasileiro de Geografia e Estatística, 2021). By August 2022, over 3,500 EMDR therapists will have been trained in EMDR therapy by the TraumaClinic Group/EMDR Treinamento e Consultoria, which includes 26 facilitators/approved consultants. EMDR therapy training is carried out regularly in over 17 Brazilian cities and locations. Since 2004, EMDR therapy training has evolved to incorporate meaningful cultural adaptations. These cultural and language aspects are essential to meet the Brazilian community's needs and develop a more specific and distinct EMDR therapy network throughout such a vast country.

More specific adaptations included the development of additional, accredited EMDR therapy trainers and a network of available consultants and facilitators to support EMDR therapists in integrating theory and practice. It was necessary to adapt a North American-based EMDR therapy training model not only into the Portuguese language for translation but also to test and accommodate cultural, social, and financial peculiarities. Training manuals for organizers and trainers were developed beyond the existing North American facilitator training manual. These helped standardize the EMDR therapy training for organizers, trainers, facilitators, and participants. Essential to this process were regular online meetings to ensure updates and enhance community cohesiveness and adhesion.

Per EMDR Institute guidance, within the EMDR training, a ratio of nine participants to one EMDR facilitator was used. However, in the early years of

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training, a participant dropout rate between 40% and 60% between EMDR levels 1 and 2 was observed, creating challenges to teaching and training. Pragmatically, the drop in numbers for level 2 presented significant economic restrictions to the viability of an ongoing training schedule. This resulted in essential teaching and learning on working with complex, vulnerable populations not being taught to half of those who began EMDR therapy training, since this was covered in level 2.

The EMDR training team explored potential reasons for such a high dropout rate between levels 1 and 2. First, EMDR therapy was a novel treatment intervention in Brazil, and participants had high anxiety levels using such a structured (and unusual) protocol. Several of the factors were identified, including concerns about dissociation and how to handle it clinically. Second, participants were paying for levels 1 and 2 separately. The net result demanded adjustments.

One such change, implemented in 2007, was the creation of an intermediate module that allowed participants to engage in mandatory consultation. The intermediate and level 2 modules included 5 hours of EMDR consultation each. An additional requirement implemented was that participants complete 25 EMDR clinical sessions before each level (See Figure 1 and Figure 2).

By the time participants finished level 2, they had completed *a minimum* of 10 hours of consultation and 50 client sessions using EMDR therapy. From a pedagogic perspective, the distinct advantage was maximizing experiential learning.

The phenomenological outcomes resulted in higher participant levels of confidence and engagement, more robust theory–practice integration, and greater longevity in continuing to use EMDR therapy in clinical practice. Implementing a further change in registration for EMDR therapy to include all aspects of the training—level 1, intermediate, and level 2—resulted in a 99% training completion rate.

Publication and Resources

The lack of printed and published EMDR therapy material in native Portuguese posed a significant gap for therapists' continued learning and growth. It also kept the general public from accessing reliable information about EMDR therapy. Consequently, addressing this required the creation of a small publishing house. To date, 30 key EMDR texts have been translated and larger publishers have invested in EMDR therapy titles, including Shapiro's third edition (Shapiro, 2020). In the last 4–5 years, we have also seen the emergence of nationally authored EMDR therapy specialized books and book chapters. Three doctoral theses on

Figure 1. Training needs addressed, implemented modifications, and observed results in TraumaClinic EMDR Basic Training Model.

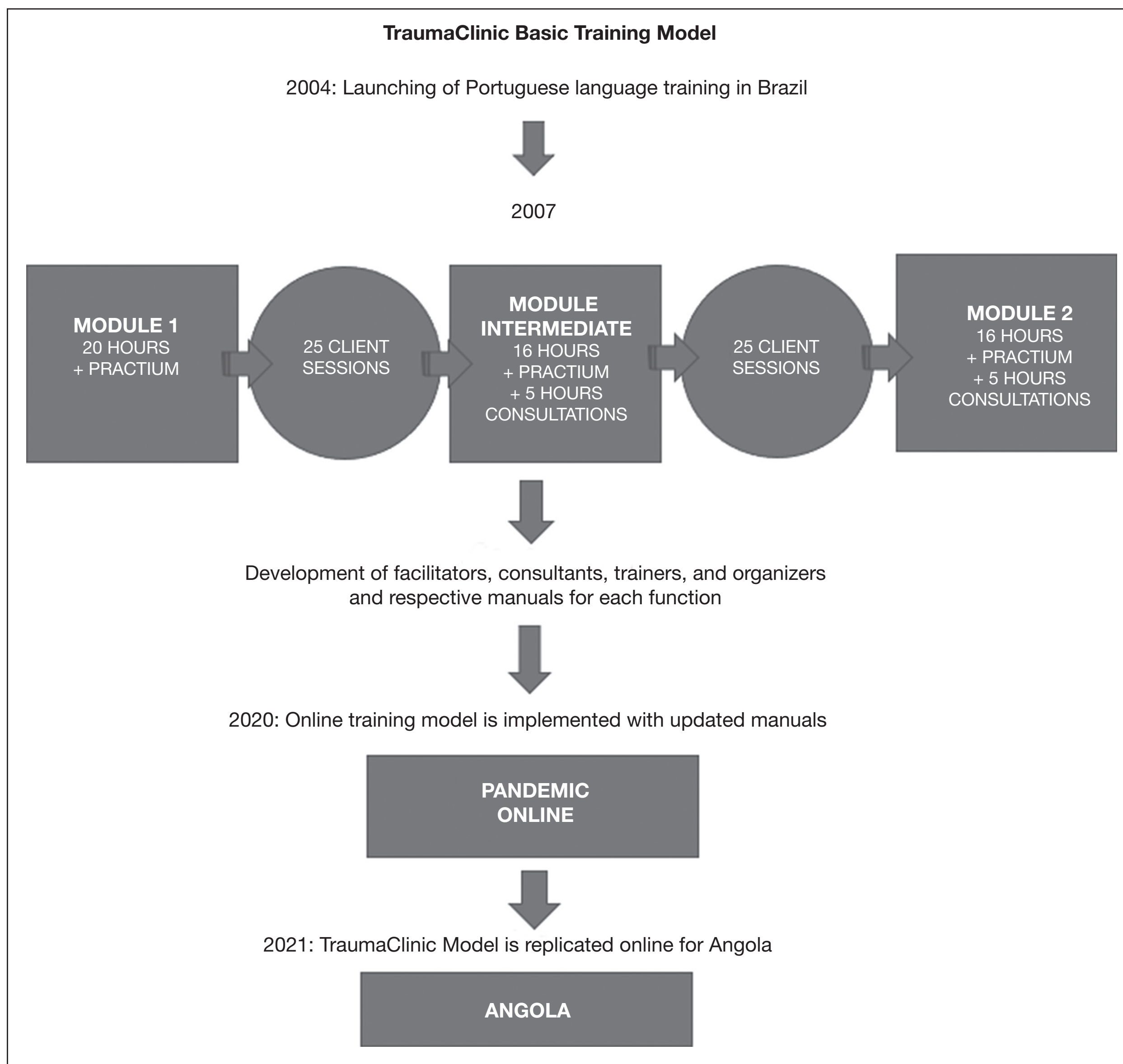

Figure 2. Prepandemic training needs addressed, implemented modifications, and observed results in TraumaClinic EMDR Basic Training Model.

EMDR therapy (Dias, 2017; Raboni, 2010; Silva, 2019) have been defended successfully in Brazilian universities and there has been an emerging body of national scientific peer-reviewed publications, which include literature reviews and case studies (Barbosa et al., 2014; Brunnet et al., 2014; Izotton et al., 2020). Today, there is a nationwide familiarity and acceptance of EMDR in the mental health field in Brazil.

The Impact of the Pandemic on This Basic Training Model

The COVID-19 pandemic and subsequent lockdown in Brazil began in March 2020. By then, an average of 18 training workshops (with three modules each) were being held annually, with 250–300 professionals finishing the entire EMDR training every year. Mindful of governmental requirements for social distancing, all EMDR training moved to virtual platforms. This required adjustments to the delivery of the EMDR training and, at the same time, integrating the adaptation of EMDR as videoconference psychotherapy. The teaching, learning, and consultation aspects of EMDR training were relatively straightforward to move online. However, the primary concern was how to undertake the practicum sessions—an inherent part of EMDR training—raising a critical question: How might an EMDR training participant transition from having no experience in the treatment approach at the start of training to feeling confident

enough to utilize new skills immediately after experience in their clinical practice?

The lived experience of providing EMDR training in Brazil using virtual platforms required a strong sense of collectivity within the training team. Initially, more experienced EMDR trainers led the initiative during the level 1 training programs before cascading to the rest of the team. Therefore, familiarizing the technical adjustments and adaptations required to deliver the teaching and learning material was imperative. In addition, a key aspect was training participants to use EMDR as a telehealth treatment intervention.

Learning Points

The ratio of facilitators to participants decreased from 1:9 (three trios) to 1:6 (two trios) for level 1 only. The original ratio for intermediate and level 2 was maintained. Using Zoom as the videoconference platform required facilitators to be familiar with the break-out room facility. This resource helped maximize the support for the training participants. During break-out room sessions, the primary trainer was available "on-call" should any need arise.

Again, the lived experiences of these adjustments were well integrated. Even before using videoconference platforms, training participants were instructed not to undergo EMDR self-experience with their worst memories and instead choose a childhood memory unrelated to the family of origin, with a subjective unit of disturbance (SUD) level of 5 or less for level 1, increasing to SUD 7 for level 2. Facilitators were instructed to be firm and clear with this directive. This reduced the scope of sensitive personal material that a participant might engage with and created a sense of safety.

EMDR consultation sessions were also altered for the online context. Groups of 6–7 training participants lasted 5 hours in the intermediate module and level 2. Training participants were required to actively participate and share their EMDR clinical cases during these sessions.

Advantages and Disadvantages of Working Online

There were distinct advantages in shifting EMDR therapy training to online delivery. First, for understandable reasons, there were benefits to not traveling in terms of time and expenses. Consequently, this allowed the training team more time with their own families—critical considering the realities of living through a global pandemic and the subsequent anxiety that goes with this. The economic benefits are also related to the training participants, with online training increasing the affordability, availability, and accessibility of EMDR training. In a developing country such as Brazil, these were significant barriers that were difficult to overcome with in-person training. Timekeeping also improved—a distinct advantage of online working as a training team and participants not caught up in traffic congestion or transportation difficulties. Most importantly, moving online showed a social commitment to not spreading the coronavirus, therefore not placing the training team and participants at any unnecessary risk and exposure.

Nonetheless, there were disadvantages to working online. First, not all training participants are comfortable with working online. Second, many were not able or willing to learn the technology necessary to participate, finding the challenge too daunting. Third, online training requires stable internet. Often the electricity in certain places of the country would go out which affected course transmission. Fourth, undertaking any training online is exhausting, so managing participants' energy and resource levels was often a challenge. Fifth, some participants struggled to access clients willing to work online. Finally, although the online courses fulfilled the government requirements of lockdown and COVID-19 protection, the participants acknowledged the lack of community and social engagement. The distinct advantage of in-person training relates to the possibility of community building; however, this was more challenging using virtual platforms.

Participation/Completion Rate Online

Moving to online training did not initially reduce the completion rate; however, a noticeable reduction was observed during the second wave of the COVID-19 pandemic (March/April 2021). Absences resulted because participants were ill or attending to family members hospitalized with the coronavirus. These participants were afforded flexibility and took longer to complete the training. Eventually, the 98%–99% completion rate stabilized.

Evaluations and Results

The course evaluations and pre-/postmodule quizzes had been part of the training program since moving to the online format. As a result, immediate feedback

was constantly available and integrated as part of the ongoing development. The results of the evaluations for all aspects of the training team are as follows: trainers, facilitators, consultants, and organizers achieved over 90% satisfaction levels from the training participants, of which over 900 participated. Specifically, 95% indicated an interest in additional training programs, and 97% of the respondents said they would recommend this course to a colleague. With further encouragement to us, 94% affirmed the importance of the 50 client sessions as an intrinsic component of the overall training, as supported by 93% of the training participant feedback.

Conclusion

Moving EMDR training online in Brazil made it possible to extend the reach of those who could not only be trained but also integrate their new skills and utilize them in clinical practice. Therefore, increasing the availability of trauma-informed care through EMDR is a priority. In addition, Brazil has an important economy, rich in diversity, so the potential for development in EMDR is extensive. Promoting access increases knowledge, availability, and resources to assist vulnerable and traumatized communities.

From the knowledge acquired in Brazil, the learning has migrated to the development of the country's first international humanitarian projects in Angola in 2021 and Mozambique in 2022. Team members, including trainers, facilitators, organizers, and consultants, volunteered toward this collaboration, successfully training $N = 17$ (2021) mental health professionals.

EMDR therapy training must adapt its pedagogies to the various populations and contexts as it expands worldwide. This country case study highlights the journey of the development of EMDR therapy in Brazil, by first providing insight into the process of adapting in-person EMDR therapy training to the Brazilian context. Second, this case illustrates potential ways of adapting EMDR training to online formats outside of North America and Europe. In both cases, the commitment to self-evaluation, awareness of trainee and community needs, and critical reflection produced an established EMDR training format that is successful, meaningful, and appropriate for the cultural context. It also illustrates how trainee feedback has been essential in shaping the next generation of EMDR therapy training in Brazil.

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