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Mental Health Practitioners' Trauma Knowledge and Self-Efficacy Post-EMDR Training

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Introduction

Studies on trauma-focused training interventions related to practitioners' knowledge of trauma and self-efficacy are limited (Allen et al., 2012; Sprang et al., 2008). However, the few studies conducted do show that practitioners maintain competency post-training, which produces better outcomes for clients (Allen et al., 2014; Decker et al., 2011; Will, 2021; Woody et al., 2015a; Woody et al., 2015b). In other words, practitioners' trauma knowledge and skills improve as a result of training in trauma-focused interventions. For example, Couineau and Forbes (2011) found that the most significant barrier to using a trauma-focused intervention was lack of confidence and skills (lower self-efficacy); however, training increased confidence and skills (higher self-efficacy; Weine et al., 2001). In addition, Laska et al. (2013) found that 12% of therapists' skills were attributed to the best outcome in clients. Liness et al. (2018) found that therapists obtained and maintained competence in cognitive behavioral therapy (CBT) for at least 12 months following their training. Simons et al. (2010) found, in the comparison of CBT and treatment as usual, that clients' depression and anxiety outcomes significantly improved after therapists (N=12) were trained in CBT. Similarly, Rauch et al. (2012), in their review of exposure therapy at the VA, found that "...trainings are effective in reducing attitudinal barriers to PE delivery and in increasing clinician self-efficacy for administration of the treatment" (p. 683). Thus, training influences practitioners' practice pattern and self-efficacy.

Knowledge and Self-Efficacy

Trauma knowledge and skill development increases self-efficacy, which is the belief in having capacity to perform a task well. To place this research in context, it is important to address the construct of self-efficacy. Albert Bandura (1977) proposed, developed, and studied the psychological concept of self-efficacy. Bandura's social-cognitive theory, which "analyzes

human self-development, adaptation, and change from an agentic perspective" (Bandura et al, 2001, p. 125; Bandura, 1986), is based on naturalistic settings where learning takes place through interactions between environment, personal factors, and behavior (Bandura, 1969, 1986). The perception of self is a widely understood concept of the structure of self in how one thinks and acts. This self-perception influences the construct of efficacy. Efficacy is the perception of one's ability to execute the required behavior successfully (Bandura, 1991). It involves self-appraisal, the belief in performance, which is influenced by self-observation, self-judgment, and self-reaction. There are four sources that contribute to efficacy beliefs: 1) mastery experiences—those in which the person has experienced success; 2) vicarious experiences—witnessing others model success and perseverance or demonstrating competence and use of effective strategies; 3) social persuasion—the by-product of others' encouragement and believing that the person possesses the capacity to succeed; and 4) physiological and emotional states—the reading of autonomic arousal and tension, and interpreting the somatic information correctly to reduce vulnerability and aversive physiological reactions (Bandura, 1986, 1991, 1995). These beliefs are reinforced through 1) direct reinforcement, 2) vicarious reinforcement, and 3) self-reinforcement (Bandura, 1986). In addition, self-efficacy performance is indirectly affected through cognitive, motivation, affective, and selection processes. The cognitive process is observed through a person constructing scenarios of success instead of failure. The motivation is based on the persistence of the person to continue at a task despite its difficulty (being intrinsically motivated). The affective component is the person reducing their anxiety, frustration, or even depressive symptoms. Finally, the selection process views a task as a challenge to be overcome rather than a challenge beyond one's ability, which reinforces one's motivation to seek out challenging tasks and thereby improves self-efficacy (Bandura, 1986).

Therefore, trauma training increases practitioners' self-efficacy to employ competent evidence-based intervention, as well as their knowledge of trauma. Bandura (1991) stated, "After their perceived coping efficacy is strengthened to the maximal level by mastery experiences, they manage the same stressors without experiencing any stress or autonomic arousal" (p. 240). It implies that mastery experiences increase the practitioners' ability to reduce perceive challenges and the stress along with those challenges. The practice experiences create anticipated self-reactions, which determine the perception of self-efficacy (Bandura, 1969). The experiences become internalized standards, guiding learned behaviors and future experiences, which are the practitioners' effect of efficiency and effectiveness (Bandura, 1991; Dewey, 1938; Palmer, 2001). Moreover, training adds to these experiences in which training is tested in practice and internalized based on the individual needs and desired outcome. An earlier meta-analysis on self-efficacy and work performance found a positive relationship between the two variables (Stajkovic & Luthans, 1998). Larson et al. (1992) developed and tested the Counseling Self-Estimate Inventory and found that training is positively associated with an increase in one's counseling self-efficacy beliefs. Similarly, Kozina et al.'s (2010) study examined changes in counselor self-efficacy perception in graduate students as they learned and began practicing with clients. They found that 75% of the participants had an increase in their total self-efficacy scores following the training. Sundborg (2019) examined what variables would predict commitment to trauma-informed care (TIC). These variables included foundational knowledge (referring to knowledge about trauma), principal support, self-efficacy, and beliefs about trauma. Sundborg found that knowledge and self-efficacy were indirectly correlated to trauma-informed care. This demonstrated that self-efficacy and beliefs about trauma, did have bearing on the participants' commitment to trauma-informed care. Berg-Poppe et al. (2022) had similar findings in their

study of pediatric providers; their TIC knowledge and self-efficacy increased after participating in the TIC curriculum training.

EMDR Therapy

Therefore, this study focuses on whether the trauma-focused intervention Eye Movement Desensitization and Reprocessing (EMDR) therapy training increases practitioners' knowledge of trauma and self-efficacy. Shapiro (2018) developed EMDR therapy as a trauma-focused therapy. She discovered the intervention as she was walking in the park. She noticed her eyes spontaneously rapidly moving and after this episode, the disturbing thoughts she had disappeared. She was fascinated by what she experienced and tried to bring those disturbing thoughts again. As she did, her eyes spontaneously moved back and forth diagonally upward. She began to experiment with this process and brought other disturbing thoughts and memories. She noticed the negative charge was greatly reduced after doing the eye movement.

EMDR therapy approaches trauma from a neurobiological approach (Saxe et al., 2007; Söndergaard & Elofsson, 2008), based on the adaptive information processing (AIP) model. The AIP model posits pathologies derive from earlier life experiences, which are linked in the nervous system in a specific state, either as maladaptive or adaptive in the neural system. Pathological experiences are usually linked in a dysfunctional, maladaptive manner. They are linked as a specific type of memory that is isolated from the rest of the adaptive memory network without having access to positive affect and cognition (Shapiro, 2018, 2007, 2009; Solomon & Heide, 2005). This pathology blocks the information processing system from reaching resolution. Shapiro asserted her model is aligned with the regenerative function of the body, in that the body is geared to heal itself when injured. Likewise, the mind has self-healing capabilities once the barriers are removed from the information processing system. Thus, the imbalance the trauma

created achieves homeostasis. EMDR facilitates the processing of negative experiences and their generalization to the adaptive associated memories. This process unblocks the information processing system leading to spontaneous appropriate behaviors (Shapiro, 2018). In other words, a link is created with the other adaptive memory networks and the fragmented memory.

The efficacy of EMDR in treating PTSD in children, adolescents, and adults has been well documented (Carbajal, 2018; Courtis et al., 2017; Laliotis et al., 2021; Shapiro, 2018; Wesson & Gould, 2009; Wood et al., 2018), and therapists adhering to the EMDR protocol show the best results (Maxfield & Hyer, 2002; Russell, 2008). However, efficacy validation of EMDR was difficult to ascertain at the beginning, and institutional approval was difficult to obtain. For example, the Institute of Medicine (IOM) report in 2008 stated that prolonged exposure therapy was the only intervention with sufficient empirical evidence to treat PTSD, and therefore it was the only recommended treatment for PTSD. Managed care companies did not begin to accept EMDR as treatment for PTSD until 2008 (e.g., Tricare accepted EMDR) as well. The World Health Organization (WHO) endorsed EMDR for trauma treatment in 2013 (Tol et al., 2014). One of the reasons for not accepting EMDR's efficacy was because many initial studies had design flaws, unreliable measures, non-blinded evaluations, and a lack of quality control for treatments, for example, not controlling for concurrent treatments (Bouderwyns & Hyer, 1996; Maxfield & Hyer, 2002; Russell, 2008). However, as these research weaknesses were identified, rigorous measures were taken, as Foa and Meadows (1997) recommended using the 7-Gold Standard for study design. Recently, de Jongh et al. (2019) identified more than 30 RCTs that confirmed EMDR's efficacy as a treatment for PTSD.

EMDR Training

The standard of EMDR therapy includes eight phases with the 3-prong approach to treatment, and the training consists of 40 hours of lecture and practicum and 10 hours of

consultation per EMDR International Association (EMDRIA; 2024) requirements in the US (EMDRIA is primarily the accrediting body for EMDR therapy). To qualify for the training, a practitioner must have a master's degree in a mental health-related field (e.g., psychology, social work, counseling, etc.) and be licensed to practice independently. Master-level students in their last semester are allowed to take the training under supervision as well (EMDRIA, 2024). Shapiro (1995) established the standard for training in making sure the basic standards are followed by all trainers.

Purpose of Study

Although EMDR is well validated and widely used (Courtis et al., 2017; de Jongh et al., 2019; WHO, 2013), there has been little research into the efficacy of the EMDR training itself since each trainer develops its own curriculum per EMDRIA guidelines or other accrediting body requirements. Only one study was found that investigated EMDR training in the United Kingdom and Ireland (Farrell & Keenan, 2013). Farrel and Keenan investigated the experience of participants to differentiate between EMDR-accredited and EMDR-nonaccredited therapists, finding that those who received EMDR-accredited training had better treatment outcomes. However, the focus of our study is to examine the level of trauma knowledge and trainees' self-efficacy before and after completing an EMDR training course. In essence, the investigation is into the training itself, not the efficacy of the therapy, to determine if the training has any effect on the practitioners' trauma knowledge and self-efficacy. The growing prevalence of EMDR and continuing demand for practitioners calls for more available training (Onofri, 2023), but competency and efficacy must be assured in all training since simply completing the required training does not automatically indicate that the practitioner is adequately competent to use the therapy with fidelity. That is why it is so important to have sufficient training and experience.

However, the relationship between a practitioner's prior knowledge and pre-training self-efficacy has not been investigated. This study seeks to understand how EMDR basic training affects trainees' knowledge of trauma and trauma treatment self-efficacy. It is important to understand the development of knowledge and self-efficacy to evaluate how training in EMDR therapy changes trainees' knowledge and self-efficacy in treating clients with trauma. With this study, we contribute to the literature by examining the effects of EMDR therapy training on trainees' self-efficacy and trauma knowledge.

Method

This retrospective data was collected for training evaluation purposes in 2018 to determine participants' (N=113) self-perceived trauma treatment efficacy and trauma knowledge base before and after an EMDR training, administered on the first and last days of training. The EMDR trainer collected the data to evaluate the program from six EMDR trainings conducted in Texas. The EMDR trainer provided the archival data to formally analyze it. An Institutional Review Board (IRB) approved this study.

Participants

The EMDR trainer is a licensed professional counselor (LPC) with over 15 years of experience providing EMDR-based trauma therapy to clients in Texas. He works with adults and older adolescents with histories of complex trauma and PTSD. He was in the last class of therapists trained by Francine Shapiro in 2005. He is EMDR certified, an approved EMDR consultant, and an EMDRIA-approved EMDR basic trainer, meeting the minimum requirements to conduct EMDR training. He has been providing EMDR basic trainings for over 10 years.

The trainer conducted the training across different cities in Texas (e.g., Conroe, Katy, Nacogdoches, and Plano) with approximately 20 trainees per location. The format of the training

was based on a two-weekend period: 20 hours each weekend with 10 hours of consultation. Table 1 presents practitioners' demographic information (N=113).

Table 1

Practitioners' Demographic Information

	n (%)
Gender	
Male	14 (12.4)
Female	71 (64.0)
Other	12 (10.6)
Age	
34 or younger	31 (27.9)
35-44	31 (27.9)
45-54	24 (21.6)
55-64	21 (18.9)
65 or older	3 (2.7)
Ethnicity	
Caucasian	69 (62.2)
African American	8 (7.2)
Hispanic/Latino	16 (14.4)
Asian American	11 (9.9)
Other	7 (6.3)
Licensure type	
LMSW	11 (9.7)
LCSW	17 (15.0)
LPC	53 (46.9)
LPC-I	21 (18.6)
LMFT	4 (3.5)
LP	2 (1.8)
Other	5 (4.4%)
Highest degree	
Masters	109 (96.5)
Doctoral	4 (3.5)

All the practitioners met EMDRIA's minimum requirements for the training and had to at least have a license in a mental health related field. Most practitioners were white (62%) and female (71%), and the majority were 44 years or younger (55.8%). Nearly all were licensed at the Masters-level (96.5%) and one-quarter were trained in social work as LMSW or LCSW (24.7%), and two-thirds were LPC or LPC-I (65.5%).

Measures

The trainer administered the background questionnaire to all six trainings that Carbajal developed in 2014 for another study (Carbajal, 2014). It included questions on therapists' level of education, licensure type, clinical experience, practice setting, and client trauma treatment. In addition, it included questions regarding therapists' use of these trauma-focused interventions: Cognitive Behavioral Therapy (CBT), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), and Eye Movement Desensitization and Reprocessing (EMDR). The background questionnaire also included demographic questions (e.g., years of experience, continuing education, formal training).

Furthermore, the trainer administered two scales before and after the training (the Trauma Treatment Self-Efficacy scale and the PTSD Knowledge Questionnaire; Carbajal, 2014). The Trauma Treatment Self-Efficacy scale is 8 items, scored on a 11-point Likert scale from 0 (cannot do at all) to 10 (highly certain can do); higher scores indicate higher self-efficacy in trauma treatment and skills. Carbajal's (2014) reliability test resulted in a .94 (N=283) alpha with social work master-level practitioners, and for this study, the reliability alpha was .91 (N=106).

The PTSD Knowledge Questionnaire was revised and validated by Carbajal in 2014 with social work master-level practitioners. The PTSD Knowledge Questionnaire is 18-items, scored on a 5-point Likert scale from 0 (strongly disagree) to 4 (strongly agree), and higher scores indicate higher knowledge about PTSD (trauma). Carbajal's (2014) reliability test resulted in a .81 (N=253), and for this study, the reliability alpha was .81 (N=101).

Analysis Plan

SPSS 29 statistical software was used to analyze the data. Univariate descriptive analyses (e.g., frequencies, means) were used to describe the study's sample and variables. This analysis

provided information about participants (e.g., practice location, demographic information, clinical experience, etc.). Correlation analyses were used to examine the relationship between years of working with clients who experienced trauma, percentage use of intervention, trauma knowledge, perceived self-efficacy, and training in CBT, TF-CBT, CPT, PE, and EMDR. Finally, a Paired Sample T-test was conducted on the pre- and post-tests.

Results

Descriptive Statistics

The data was assessed and verified to make sure missing data were addressed, removed cases with missing data and used a listwise deletion for other statistical procedures to reduce statistical analysis inaccuracies (standard errors).

Participants' Practice Characteristics

Table 2 presents practitioners' practice characteristics. Many practitioners were in private practice (56.6%); others worked in community settings (39.0%). Fewer practitioners reported working in outpatient/treatment centers (15.0%), inpatient facilities (10.6%), and VA/vet centers/medical centers (.9%). One hundred percent of practitioners reported treating a client with trauma, and over 50% reported having less than 10 years of experience treating clients with posttraumatic stress. Furthermore, 33% reported treating military members.

Practitioners reported using CBT (82.3%) as the primary intervention for trauma treatment, followed by TF-CBT (58.4%). The least common intervention practitioners reported using were CPT (37.2%), EMDR (19.5%), and PE (14.2%), respectively. Moreover, practitioners' knowledge of trauma on the PTSD Knowledge Questionnaire had a mean score was 3.38 (SD=.36, range from 0-4), and their trauma treatment self-efficacy mean score on the Trauma Treatment Self-Efficacy Scale was 5.76 (SD=1.97, range from 0-10).

Table 2

Practitioners' Practice Characteristics

Categories	n (%)
Clinical setting (Yes response only)	
Counseling/Community agency	44 (39.0)
Private Practice	64 (56.6)
Outpatient/treatment center	17 (15.0)
Inpatient	12 (10.6)
VA/Vet center/medical center	1 (.9)
Other settings	15 (13.3)
Years of trauma treatment	
0-9	75 (66.4)
10-19	31 (27.4)
20+	5 (4.4)
Intervention use (Yes response only)	
CBT	93 (82.3)
TF-CBT	66 (58.4)
CPT	42 (37.2)
PE	16 (14.2)
EMDR	22 (19.5)
Other	44 (38.9)
Knowledge	
Mean	3.38
SD	.36
Self-efficacy	
Mean	5.76
SD	1.98

CBT: Cognitive Behavioral Therapy, TF: Trauma-Focused Cognitive Behavioral Therapy, CPT: Cognitive Processing Therapy, PE: Prolonged Exposure, EMDR: Eye Movement Desensitization and Reprocessing

Correlation and Paired-T Test Statistics

A correlational analysis was conducted to assess practitioners' use of evidence-based interventions with age, years of treating clients with trauma, and training on trauma-focused intervention variables (a listwise selection was made to only include values entered across all the cases; N=78). Table 3 presents the correlations among the tested variables.

Practitioners' age was negatively associated with using CBT $r(78) = -.24$, $p < .05$; while years of experience were negatively associated with using CPT $r(78) = -.27$ $p < .05$; and

positively associated with using PE $r(78) = .34$, $p < .01$; and EMDR $r(78) = .39$, $p < .01$. Younger practitioners were more likely to use CBT, while practitioners with more experience were less likely to use CPT and more likely to use PE and EMDR. Age and years of experience were not significantly correlated to any other intervention use. Training on CBT and TF-CBT was not statistically significant with using CBT and TF-CBT. This indicates that training on these interventions does not influence how much they are used in the therapeutic setting.

Table 3

Evidence-Based Intervention Correlations

	Intervention Use				
N=78	CBT	TF-CBT	CPT	PE	EMDR
Age	-.24*	-.11	-.14	-.08	-.16
Years of trauma exp.	-.14	-.21	-.27*	.34**	.39**
Training					
CBT	-.16	-.02	-.15	-.07	-.15
TF-CBT	-.16	-.05	-.11	-.19	-.11
CPT	-.06	-.02	-.33**	-.24*	-.25*
PE	.30**	.02	.09	-.13	-.39**
EMDR	.47	-.07	-.11	-.17	-.17
Knowledge	.00	-.10	-.11	-.05	-.08
Efficacy	.01	.-15	-.00	-.12	-.21

*p <.05. **p <.01. ***p <.001. CBT: Cognitive Behavioral Therapy, TF: Trauma-Focused Cognitive Behavioral Therapy, CPT: Cognitive Processing Therapy, PE: Prolonged Exposure, EMDR: Eye Movement Desensitization and Reprocessing

Training on CPT was negatively associated with using CPT $r(78) = -.33$, $p < .01$; PE $r(78) = -.24$, $p < .01$; and EMDR $r(78) = -.25$, $p < .05$; while training on PE with using CBT $r(78) = .30$, $p < .01$ was positively associated, and using EMDR $r(78) = -.39$, $p < .01$ was negatively associated. CPT training appears to reduce the likelihood that practitioners will implement CPT, PE, and EMDR. However, training in PE increases the likelihood of using CBT while decreasing the likelihood of using EMDR. Finally, practitioners' knowledge about trauma was only positively associated with trauma experience in treating clients $r(78) = .23$, $p < .05$; while their

self-efficacy of treatment was positively associated with training in CBT $r(78) = .23$, $p < .01$; PE $r(78) = .35$, $p < .01$; EMDR $r(78) = .32$, $p < .01$, and experience in treating clients with trauma $r(78) = .39$, $p < .01$. Thus, practitioners' knowledge about trauma is highly correlated with trauma experience in treating clients. Self-efficacy of treatment is highly correlated with CBT, PE, and EMDR training, as well as more experience in treating clients with trauma.

A Paired sample T-test was conducted, using the mean scores, to determine if the EMDR training changed the practitioners' scores for their knowledge about trauma and their trauma treatment self-efficacy perception. The practitioners' knowledge of trauma pre-test and posttest mean scores were 3.38 (SD=.36), and 3.53 (SD=.31), respectively, and the 95% confidence interval of the difference between means raged from -.24 to -.05; and their trauma treatment self-efficacy mean score were 5.76 (SD=1.98) and 7.77 (SD=1.25), respectively, and the 95% confidence interval of the difference between means raged from -2.44 to -1.57.

Table 4

Paired T-Test on Knowledge and Self-Efficacy

Pre-posttest	*M*	*SD*	95% Confidence Interval		*t*	*df*	*p*	Cohen's *d*
			Lower	Upper				
Knowledge	3.38	.36	-.24	-.05	-3.28	103	.001	.44
Efficacy	5.76	1.98	-2.44	-1.57	-9.21	103	.001	-1.21

The Paired T-test showed that participants' knowledge of trauma increased from pre-EMDR training (M = 3.38, SD = .36) to post-EMDR training (M = 3.53, SD = .31; t(103) = -3.28, <.001 with a Cohen's d medium effect size value of .44; and for their trauma treatment self-efficacy, it increased from pre-EMDR training (M = 5.76, SD = 1.98) to post-EMDR training (M = 7.77, SD = 1.25; t(103)= -9.21, <.001 with Cohen's d effect size of -1.21, indicating that EMDR training significantly changed participants' scores in both knowledge and self-efficacy. The negative effect size for trauma treatment self-efficacy indicates that

participants' perception changed in the opposite direction, with less confidence in implementing EMDR therapy after the training.

Discussion

This study investigated practitioners' associated variables with trauma-focused interventions and practitioners' self-efficacy and trauma knowledge before and after EMDR therapy training. This convenience sample shows 100% of practitioners are treating clients with trauma, and 33% treat military members and families, but 50% of the sample had less than 10 years of experience. This study found some interesting relationships between training in a treatment method and the use of that method. The most utilized treatment modality in this study was CBT. This finding could indicate that graduate programs place more emphasis on CBT than other treatment modalities (Leathers & Strand, 2018; Prock et al., 2022; Strand et al., 2014). Another interesting finding in this study is that training in CBT and TF-CBT was not associated with using CBT and TF-CBT. Previous studies have shown that training is positively related to using that intervention (Carbajal, 2023; Hamblen et al., 2010; Sprang et al., 2008; Steward et al., 2021). It could be a bias with the sample as all these practitioners were seeking EMDR training and possibly felt CBT and TF-CBT were not sufficient to treat their client population. Conducting a qualitative study regarding practitioners' decision not to use an intervention after training might provide some insights. Another interesting finding was that training in CPT was negatively associated with using CPT. Again, this could be related to practitioners' interest in EMDR and the thought that EMDR might be more effective in meeting their client population's needs. In this study, the training in PE was negatively associated with using EMDR but positively associated with using CBT. This is surprising because PE and EMDR are comparable trauma-focused interventions with similar theoretical frameworks, and PE is also more likely to

be utilized in VA settings (Carbajal, 2018; Shapiro, 2007; Rauch et al., 2012). The issue might be that more practitioners are trained in EMDR therapy as opposed to PE. It is also possible practitioners who seek EMDR therapy training have a bias towards EMDR therapy.

The Paired T-test results show that the pre- and post-tests were significantly different. The modest effect size of .44 for knowledge of trauma suggests that EMDR training specifically increases the practitioner's trauma comprehension. It is important to recognize EMDR training as a credible intervention to enhance a practitioner's trauma proficiency. While some post-secondary degrees do cover trauma knowledge, most clinicians receive much of their specialized training post-degree (Cook et al., 2017). We found that experience working with trauma is strongly correlated with knowledge of trauma, indicating that post-degree training is an important professional development to enhance one's skills. While most practitioners in this study showed a preference for using CBT to treat trauma, it is yet to be proven that specialized training in other intervention modalities (such as CBT, CPT, and PE) can accomplish the same. What this study also identifies is that training in CBT is not a significant indicator of using CBT in practice. However, training in CBT, PE, and EMDR is positively associated with overall experience in treating clients with trauma. The more trauma exposure practitioners had, the more likely they were to use either PE or EMDR as an intervention.

Self-efficacy is a measure of confidence in the practitioner's ability to treat trauma symptoms. Low self-efficacy will keep a practitioner from providing much needed services to clients (Wolfe, 2022). Research shows that practitioner trauma knowledge and self-efficacy in trauma treatments are associated with increased treatment success and a lower likelihood of practitioner burnout and turnover (Becker-Haimes et al., 2022). It is in the interest of the profession to increase practitioner self-efficacy, and we know that self-efficacy is positively

associated with training and experience. It is curious, but not surprising, that this study found that self-efficacy decreased after EMDR training. It can be argued that an increase in knowledge is functionally useless without appropriate application and developing skills competency. The findings of our study confirm that knowledge does not necessarily translate to skill. A 2011 study of VA staff found that "the more clinicians implemented a model, the more helpful they found it" (Najavits et al., 2011, p. 145). Therefore, skill development happens in post-training opportunities (Grimmett & Galvin, 2015). Thus, lower self-efficacy after the EMDR training indicates practitioners' awareness that they lack the skills to effectively provide EMDR therapy, as this is the completion of the basic training. In other words, they do not have the advanced skills that come with practice and experience, but they do have the knowledge on how to begin developing those skills.

Recommendations

In this study, the participants were largely Caucasian females with an advanced degree in psychology. The majority had a private practice background. This is important to note, as EMDR is more likely to be practiced (and continued) in a private practice setting (Grimmett & Galvin, 2015). Alternative theoretical orientations and treatment modality preferences are significantly associated with a practitioner's decision to not use EMDR in their practice. CBT continues to be the most prevalent intervention choice for practitioners. Age was negatively associated with using CBT while experience was positively associated with CPT, PE, and EMDR. There is indication that younger practitioners feel more affinity to CBT when they are newer in their careers (Cook et al., 2009). Perhaps older practitioners have more training or confidence in adding alternative interventions beyond CBT.

Post-training practice and skill development is critical in a practitioner's use of an intervention, particularly as it relates to treatments for trauma. Many practitioners feel that the current training they receive is too much information in too little time, leading to a lack of overall competence (Grimmett & Galvin, 2015). Two-thirds of our sample indicated less than 10 years' experience working in trauma. It is recommended that this study include an additional post-test on self-efficacy after a specific period of practice, such as six to twelve months. There are also some strong indicators that EMDR training would be appropriate for students near graduation, to add to their knowledge base.

Conclusion

EMDR therapy is a well-researched trauma treatment modality, and this research adds to our knowledge base regarding how EMDR training contributes to practitioner trauma knowledge and trauma treatment self-efficacy (Becker-Haimes et al., 2022; Edmond et al., 2016; Grimmett & Galvin, 2015; Williams et al., 2015; Wolfe, 2022). Training on trauma interventions is a specialization that benefits treatment-seeking clients who experience trauma. In Gifford et al.'s (2012) study of clinicians implementing evidence-based treatment, they suggested that due to clinicians' inability to implement such treatment, training was necessary to reduce the use of ineffective and inefficient practices and reduce harm to clients. Thus, this study adds to the professional knowledge base on this topic because research on the relationship between practitioners' trauma knowledge and self-efficacy in trauma-focused training interventions is limited (Decker et al., 2011; Woody et al., 2015a; Woody et al., 2015b). All trauma interventions require some initial training to provide the intervention, but there is not much follow up research on the training's impact on practitioner knowledge, competence, and confidence, particularly in the aftermath and long-term follow-up, to the training (Grimmett & Galvin, 2015; Wolfe, 2022).

As noted in this study, EMDR training does increase the practitioner's trauma knowledge. It is unclear whether this is unique to EMDR or applies to other types of trauma-focused training. Furthermore, recognizing trauma-focused training as having a positive influence on practitioner self-efficacy has significant implications for lowering overall burnout and practitioner attrition (Becker-Haimes et al., 2022). This dual focus, of increasing knowledge and self-efficacy, can impact future growth for students, recent graduates, and seasoned practitioners alike. It is vital to continue investigating the relationship between the type of trauma training and practitioner experience, knowledge, treatment fidelity, self-efficacy, and longevity in practice.

Declaration of Conflict of Interest

The third author is an EMDRIA-approved trainer and has been an EMDRIA board member.

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