Client and Clinician Experiences of Eye Movement Desensitisation and Reprocessing (EMDR) Therapy

Study 1: Clinicians' Views and Experiences of Eye Movement Desensitisation and Reprocessing (EMDR) Therapy: A Mixed Method Systematic Review

Study 2: Clients' Experiences of Eye Movement Desensitisation and Reprocessing (EMDR) Therapy

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Declaration

This is to certify that the work I am submitting is my own and has not been submitted for another degree, either at University College Cork or elsewhere. All external references and sources are clearly acknowledged and identified within the contents. I have read and understood the regulations of University College Cork concerning plagiarism.

Signed: 

Date: 05/05/2022

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Finally, my deepest gratitude to the six participants who made this research study possible – it was a privilege to hear your stories.

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Abbreviations and Terminology

EMDR	Eye Movement Desensitisation and Reprocessing
IPA	Interpretative Phenomenological Analysis
PTSD	Post-traumatic stress disorder
NICE	The National Institute for Health and Care Excellence
MMAT	Mixed Methods Appraisal Tool
MDT	Multidisciplinary team
CBT	Cognitive Behavioural Therapy
JBI	Joanna Briggs Institute
RCT	Randomised controlled trials
TF-CBT	Trauma Focused-Cognitive Behavioural Therapy
AIP	Adaptive Information Processing
SUDS	Subjective Units of Disturbance scale
VOC	Validity of Cognition
PETS	Personal Experiential Themes
GETS	Group Experiential Themes

Chapter One: Introduction

Context and Overview

This thesis is comprised of two research papers exploring clients' and clinicians' experiences of EMDR. The first research paper is a mixed-methods systematic review synthesising fourteen studies exploring clinicians' views and experiences of EMDR therapy. The second research paper is an original empirical study employing Interpretative Phenomenological Analysis (IPA) to explore six clients' lived experiences of EMDR therapy and their sense making of this therapeutic approach.

Outline of Chapters

Chapter Two: Systematic Review

This chapter presents a mixed-methods systematic review on clinicians' views and experiences of EMDR, presented in the form of a journal article written for the *Journal of EMDR Practice and Research.* The relevant appendices are presented at the end of this thesis.

Chapter Three: Systematic Review Extended Methodology

This chapter presents additional information on the undertaking of the systematic review, including additional information on the methodological framework, the development of the review question, the search strategy, the inclusion and exclusion criteria, and the process of data extraction and synthesis.

Chapter Four: Major Research Project Literature Review

This chapter presents a literature review on EMDR, outlining the development of the approach, efficacy and treatment guidelines, mechanism of action, treatment protocol, and clients' experiences of EMDR.

Chapter Five: Major Research Project

This chapter presents the major research project, which utilised IPA to explore how six clients experienced EMDR therapy, presented in the form of a journal article written for the *Journal of EMDR Practice and Research*. The relevant appendices are presented at the end of this thesis.

Chapter Six: Major Research Project Extended Methodology

This chapter presents additional information in terms of the methodology for the major research project. Additional information is provided with regards to IPA, sampling, recruitment, data collection, data analysis, validity and quality, ethical considerations, reflexivity, and reflections regarding the impact of COVID-19 on research procedures.

Chapter Seven: Discussion and Conclusion

This chapter provides a summary of the findings of the systematic review and the major research project, and discusses the contribution, clinical implications, and limitations with regards to this thesis.

Chapter Two: Systematic Review

Clinicians' views and experiences of Eye Movement Desensitisation and Reprocessing (EMDR) therapy: a mixed methods systematic review

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Prepared in accordance with author guidelines for *Journal of EMDR Practice and Research* (Appendix A).

Abstract

This mixed methods systematic review aimed to provide insight into clinicians' views and experiences of EMDR. Eight electronic databases [PsychINFO, PUBMED, CINAHL, SCOPUS, Web of Science, EMBASE, Applied Social Sciences Index] and grey literature [ProQuest and Google Scholar] were searched systematically from inception to October 2021. Quality was assessed using the Mixed Methods Appraisal Tool (MMAT) and a convergent integrated approach was used to synthesise and integrate data. In total, 14 studies were included: seven qualitative, five mixed-methods and two quantitative, encompassing 1,065 participants. Thematic synthesis generated two overarching themes and seven subthemes. The first theme related to the facilitators and barriers clinicians experience in adopting and implementing EMDR, including the role of organisational support, clinician confidence, primary theoretical orientation, and client suitability and preparedness. The second theme related to perceived advantages of EMDR, including rapid results and positive outcomes, client empowerment, and getting to the root of the issue. This review provides a helpful insight into the factors which influence the dissemination and implementation of psychological therapeutic approaches.

Keywords: EMDR, Eye movement desensitization and reprocessing, systematic review, mixed method, clinicians

Introduction

Background

Eye movement desensitisation and reprocessing (EMDR) is a psychological therapeutic approach developed in the late 1980's by Francine Shapiro as a treatment for post-traumatic stress disorder (PTSD) (Shapiro, 1989). The theoretical underpinning of EMDR is that of the adaptive information processing (AIP) model, which was later developed by Shapiro to explain the mechanism of action underlying EMDR, and considers dysfunctionally stored memories as the primary basis of clinical psychopathology not otherwise explained by organic disease (Oren & Solomon, 2012). Indeed, according to this model, pathological presentations are believed to be associated with past disturbing experiences which have been dysfunctionally stored within memory and thus trigger dysfunctional patterns of emotional, behavioural and cognitive symptoms (Shapiro, 2001). EMDR aims to process the key traumatic memories within the client's life story that are hypothesised as being connected to current difficulties and symptoms (Balbo et al., 2019). EMDR follows a standardised protocol consisting of eight phases, one of which utilizes the signature component of bilateral sensory input.

Although initially met with considerable scepticism from the scientific community, EMDR is now recognised as an empirically supported psychotherapy for the treatment of PTSD, recommended by the National Institute for Health and Care Excellence (NICE) guidelines (Chen et al. , 2015; Cusack et al., 2016; Ehring et al., 2014; Moreno-Alcázar et al., 2017; NICE, 2019). Although not currently recommended by NICE guidelines for the treatment of other disorders, the application of EMDR has expanded to the treatment of a wide range of mental health conditions and comorbid presentations to PTSD, including depression (Wood & Rickets, 2013), bipolar disorder (Valiente-Gómez et al., 2019), and psychosis (de Bont et al., 2013). Indeed, in recent years EMDR has attained significant

popularity, with an increasing number of therapists being trained in the technique and thus a considerable increase in its clinical use.

To be trained in EMDR, it is a requirement that clinicians are qualified mental health professionals and thus EMDR is considered as a secondary psychotherapy training model. EMDR basic training consists of a training manual, theory-driven active teaching, behavioural role plays, and clinical supervision. The basic training structure involves at least 20 hours of didactic teaching and 20 hours of supervised practice from an accredited supervisor. Clinicians can then seek accreditation if basic training has been completed and they have worked with at least 25 clients and completed a minimum of 50 sessions (Farrell & Keenan, 2013). It was reported in 2015 that over 100,000 clinicians have attended training in EMDR internationally, but as with other therapeutic approaches, not all clinicians go on to integrate this approach into their clinical practice (Cook et al., 2009; Grimmet & Galvin, 2015). According to Farrell and Keenan (2013), within the United Kingdom and Ireland only 10%-12% of trainees who completed the EMDR basic training had become fully accredited in the therapy approach, though the numbers of clinicians working towards accreditation was not reported and is likely higher.

The decision to employ a particular therapeutic approach appears to be influenced by a range of factors, including clinician-related factors, client-related factors, the training itself, post-training skill development, and socioenvironmental influence (Becker et al., 2007; Grimmet & Galvin, 2015). Indeed, clinicians play a particularly important role in whether a treatment approach is adopted and implemented within clinical practice (Adams et al., 2016). There has been a small body of research conducted assessing factors influencing clinicians' practice. A study conducted by Cook and colleagues (2009) employed a web-based survey to investigate influences on psychotherapists' adoption and sustained use of new therapies in the United States and Canada. The most endorsed factors influencing current practice were

significant mentors, information gathered from books, and training received during graduate school. The least endorsed factors influencing current practice included training videos, treatment manuals and electronic Listservs. In terms of factors influencing willingness to learn a new therapeutic approach, the most endorsed factors were ability to integrate with the therapists' current approach, endorsement by respected therapists, and available training opportunities. The least endorsed factors included positive findings on the therapy reported in a research journal, endorsement by a professional organisation as being evidence-based, and clients' testimonials. In terms of continued use of a new therapy, psychotherapists reported that the most influential factors were their ability to conduct the therapy successfully and help clients, their own enjoyment using the therapeutic approach, and clients liking the therapy and reporting good effects. However, the majority of effect sizes in this study were small and thus further research is required in this area.

Clinicians are therefore in a position to provide helpful insight into the facilitators and barriers to adopting and implementing particular therapeutic approaches which can inform both the development of new approaches and the process of dissemination of therapies, including clinician training, implementation needs, and supervision needs. As proposed by Becker and colleagues (2004) it is important for research to be carried out with those who are directly involved in the implementation of a therapeutic approach to identify factors affecting clinical use or barriers within routine clinical practice.

Aim and Objectives

No systematic review has previously been conducted exploring the views of clinicians using EMDR. Thus, the aim of this review is to provide insight and understanding, through summary and synthesis of findings from studies that report on clinicians' views and experiences of EMDR therapy.

Secondary objectives to be addressed are:

(1) What are clinicians' experiences of the integration of EMDR into clinical practice?

(2) What barriers / difficulties might be experienced when integrating EMDR into their practice?

Methodology

Protocol Registration

The protocol for this systematic review was registered on PROSPERO (registration number: CRD42021277333).

Search Strategy

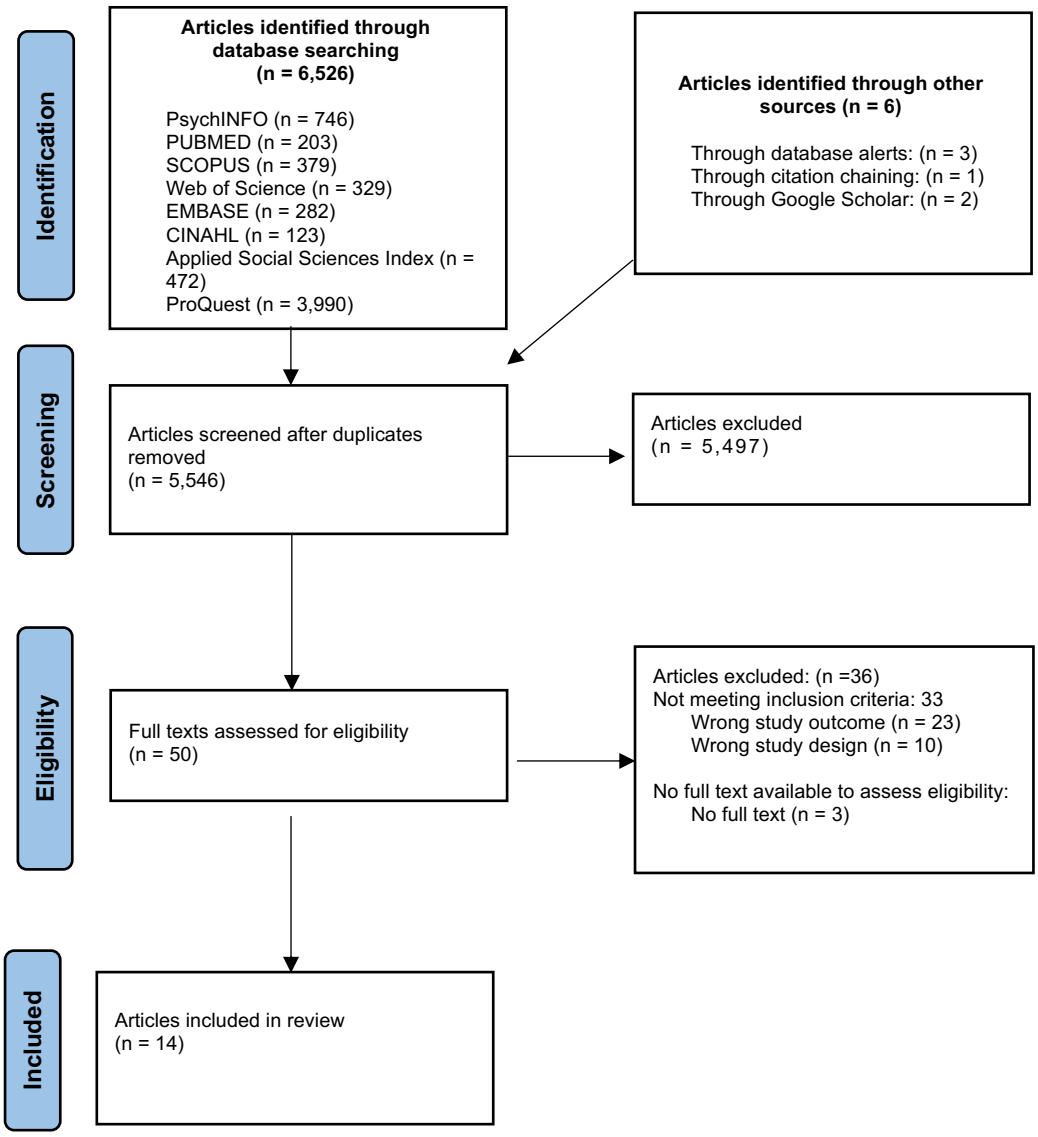
The following databases were searched from the inception of the database to October 2021: PsychINFO, PUBMED, CINAHL, SCOPUS, Web of Science, EMBASE, Applied Social Sciences Index and ProQuest. The search strategy included the following keywords: [("Eye Movement Desensitization Therapy" OR EMDR OR "eye movement desensitization") AND (clinician* OR professional* OR practitioner* OR psychologist* OR therapist* OR psychotherapist* OR psychoanalyst* OR counsellor* OR counselor* OR analyst* OR staff OR personnel OR training) AND (view* OR opinion* OR perception* OR perspective* OR belie* OR attitude* OR experience* OR qualitative OR viewpoint* OR standpoint* OR encounter* OR reaction* OR use* OR utility OR evaluation* OR account* OR narrativ* OR impression*)], with medical subject headings adapted and included for each database (See Appendix B). In order to assist in identifying relevant papers, the first 30 pages of Google Scholar were also searched and forward and backward citation chaining was conducted on included studies.

The inclusion criteria (See Appendix C) encompassed the following: qualitative, quantitative and mixed-methods studies, written in the English language, that focused on mental health clinicians' personal views and/or experiences of EMDR in terms of training or

delivery of the approach. Doctoral theses and non-peer reviewed studies were also included to reduce risk of publication bias. Studies were excluded based on the following criteria: the population were not mental health clinicians eligible/using EMDR; case studies, editorials, opinion pieces, books, reviews, and papers not reporting primary research findings; studies whereby clinicians' views and experiences of EMDR were not represented or analysed separately; studies reporting on their experience of a specifically adapted form of EMDR; studies that use 'EMDR clinicians' as a sampling strategy but investigating another phenomenon of interest. Following the search, all identified citations were collated and uploaded to the reference management software Zotero and duplicates were removed. The primary author firstly screened all citations for eligibility based on the title and abstracts and articles clearly not relevant to the research question were excluded at this stage. The second reviewer screened 10% of all citations based on the title and abstracts. The remaining full texts of potentially relevant articles were then reviewed by the primary author and the second reviewer. Where full text were not available, the authors were directly contacted or articles were requested through the university. Full texts were excluded at this stage if they did not meet the eligibility criteria and any discrepancies that arose between the reviewers were resolved through discussion. If a discrepancy could not be resolved, a third reviewer was contacted to assist with the decision. See Figure 1.1 For an outline of the PRISMA flow diagram.

Figure 1.1

PRISMA Flow Diagram



Quality Assurance

Eligible studies were subjected to a critical appraisal of methodological quality using the Mixed Methods Appraisal Tool (MMAT) version 2018 (Hong et al., 2018). The MMAT is a tool designed to allow for concurrent quality appraisal of qualitative, quantitative and mixed-methods research studies. This tool was chosen as it provides a standardised approach for screening a range of research designs and thus allows comparisons to be made across

studies of differing methodological designs (Crowe & Shepard, 2011). Each study was assigned a quality score, using asterisks to signify the quality appraisal, with possible scores ranging from (*) when one criterion is met to (*****) when all criteria are met (Hong et al., 2018). The most recent guidelines (Hong et al., 2018) recommended that one overall score should not be calculated from the ratings, and instead a more detailed presentation of the quality ratings should be provided to better inform the quality of the included studies (See Appendix D). Furthermore, as per Hong and colleagues (2018) studies of lower quality would not be excluded, but their potential impact on data synthesis would be discussed.

Data Extraction

The primary author identified all data to be extracted from the chosen articles for inclusion. Data extracted included: author, study location, research aim, study design, participant characteristics, sample, data, analysis, and an overview of findings.

Data Synthesis

Data synthesis was conducted in accordance with the guidelines published by the Joanna Briggs Institute (JBI) Mixed Methods Review Methodology Group (Lizarondo et al., 2020). As per the JBI guidelines, this review employed a *convergent integrated* approach as the review question could be addressed by both quantitative and qualitative research designs. Consistent with this approach, quantitative data was “qualitized” whereby data was extracted from quantitative studies and converted into textual descriptions to allow integration with qualitative data (Stern et al., 2020). Thematic synthesis was then employed as a means of synthesising the data in accordance with the steps outlined by Thomas and Harden (2008) which involves the coding of text 'line-by-line'; the development of 'descriptive themes'; and the generation of 'analytical themes'.

Results

A total of 6,526 studies were identified through database searching. Following removal of duplicates, 5,546 studies remained for title and abstract screening. The first author (MH) independently screened all titles and abstracts, while the third author (AG) independently screened 10% of all title and abstracts (n = 554). There was 98% agreement between reviewers at this stage of screening (Cohen's Kappa = 0.82). Fifty full-texts were assessed for eligibility. Thirty three articles were excluded as they did not meet the inclusion criteria (for further reasons please see Figure 1.1: PRISMA diagram). Three articles were excluded as no full texts were available to review. Fourteen articles were identified as eligible for inclusion in this systematic review, seven qualitative studies (Brendler, 2017; Cook et al., 2009; DiGiorgio et al., 2004; DiNardo et al., 2019, Hasandedic-Dapo, 2021; Jones-Smith, 2018; Phillips et al., 2021), five mixed-methods studies (Dunne & Farrell, 2011; Farrell et al., 2013; Farrell & Keenan, 2013; Hasanovic et al., 2021; Voung, 2019), and two quantitative studies (Edmond et al., 2016; Grimmett & Galvin, 2015). The included articles represented studies from the United States (57%), United Kingdom (29%), Turkey (7%) and Bosnia (7%). In total, 1,065 participants were included across studies. Gender was reported in nine of the fourteen studies, with 70 males and 198 females included within these studies.

Quality Appraisal

Overall, MMAT quality scores ranged from 2 stars (i.e. 40%) to 5 stars (i.e. 100%). Qualitative studies scored the highest for quality (6 of the 7 studies scoring 100%), followed by quantitative studies (ranging from 60 – 80%), and mixed methods studies (ranging from 40 – 80%). One study by Vuong (2019) failed to pass the screening questions as a clear research question was not provided and there was insufficient data presented and thus further appraisal was deemed not feasible or appropriate as per the MMAT scoring guidelines. See Appendix D for a breakdown of the quality scores.

Table 1.1

Characteristics of Included Studies

No.	Reference	Country	Research Aim	Study Design	Participants	Sample	Data	Analysis	Quality Rating	Overview of Key Findings
1.	Brendler (2017)	United States	How do experienced EMDR practitioners help their clients to develop resources required to tolerate EMDR desensitization?	Qualitative	**Age range:** 40 – 65 years **Gender:** 1 male, 4 females **EMDR Training Level:** Part 2 (n = 5) **Highest Level of Education:** Master's (n=4), Doctorate (n=1) **Years practicing EMDR:** At least 3	5 clinicians	Semi-structured interviews	Integrative Phenomenological Analysis (IPA)	*****	*Themes identified:* Therapist experience of working with their clients; Trauma conceptualization; Stabilization; All these tools used to resource clients.
2.	Cook et al. (2009)	United States	To provide an in-depth comparative case study of two attempts at diffusion of EMDR	Comparative Case Study	**Age range:** 30 – 62 **Gender:** 14 male, 15 female **Ethnicity:** White (n = 25), African American (n=1), American Indian (n=1), Mixed Ethnicity (n=2). **Qualification:** Majority (n = 23) were doctoral-level psychologists. **Setting:** Department of Veterans Affairs (VA) treatment setting	29 clinicians (n = 10) at first site, (n = 19 at second site).	Semi-structured interviews	Explanation building (Yin, 2003)	*****	*Themes identified:* EMDR adopted or thwarted based on influential staff members; It's (not) what we do here; Proof of value: experiencing is believing; Mechanism of therapeutic change; Perceived characteristics of EMDR; Different lens, different criteria; Aesthetics and comfort level using EMDR.
3.	DiGiorgio et al. (2004)	United States	This study examined how 3 therapists from differing theoretical orientations (psychodynamic, humanistic, and cognitive–behavioural) integrate eye movement desensitization and reprocessing (EMDR) into their work with clients.	Qualitative	**Age range:** 57 – 71 years **Gender:** 3 males **Theoretical orientation:** Psychodynamic (n=1), Humanistic (n-1), Cognitive-behavioural (n=1)	3 therapists	Semi-structured interviews	Consensual Qualitative Research (CQR) method	****	All therapists deviated from standard protocol to some degree, influenced by their primary theoretical orientation and clients.

4.	DiNardo & Marotta-Walters (2019)	United States	To explore the question of how a sample of EMDR clinicians integrated the role of culture in EMDR therapy	Qualitative	**Age range:** 27 – 79 **Years practising EMDR:** 1 – 27	56 clinicians	Online survey	Interpretive and discourse analysis	*****	*Themes identified:* Reflections on universality, reflections on cultural influences on treatment, individual differences in cultural identity, clinician identity interacting with treatment, EMDR process, and implicit cultural aspects of treatment.
5.	Dunne & Farrell (2011)	United Kingdom	To explore if therapists from different theoretical backgrounds experience difficulties in incorporating EMDR into their clinical practice.	Mixed-methods	**Study Part 1** **Age range:** 32 – 78 **Gender:** 31 male, 43 female **Years practising EMDR:** 2 – 18 **Highest level education:** Diploma (n=10), Primary degree (n=10), Masters (n=38), Doctorate (n = 16) **EMDR training level:** Part 1 (n=1), Part 2 (n=22), Part 3 (n=51) **Therapeutic orientation:** Integrative (n = 26), Cognitive/behavioural (n = 25), Humanistic/experiential (n = 10), Analytic (n = 8), Other (n = 5) **Study Part 2** **Age range:** 36-68 **Gender:** 6 male, 3 female **Therapist years range**: 6 - 28 **EMDR years range:** 2 - 16 **Highest level education:** Diploma (n=1), Primary degree (n=0), Masters (n=5), Doctorate (n=3) **EMDR training level:** Part 1 (n=0), Part 2 (n=3), Part 3 (n=6) **Therapeutic orientation:** Integrative (n = 3, Cognitive/behavioural (n = 3), Humanistic/experiential (n = 2), Analytic (n = 2), Other (n = 0)	**Part 1** 74 clinicians **Part 2** 9 clinicians	**Part 1** Survey with one open ended question **Part 2** Semi-structured interviews	**Part 1** Descriptive statistics, ANOVAs and thematic analysis **Part 2** Content analysis	***	**Part 1** Thirty participants (41%) reported experiencing difficulties in incorporating EMDR into clinical practice. Five distinct themes emerged in relation to challenges in integrating EMDR into clinical practice: Time constraints; Anxiety/confidence, Workplace issues, Changes in EMDR therapists practice or theories, Client characteristics. **Part 2** *Themes identified:* Reported difficulties incorporating EMDR into practice; Specific changes in EMDR therapists practice or theories.
6.	Edmond et al. (2016)	United States	This study sought to determine the extent to which rape crisis centres use EMDR therapy, practitioners' perceptions of EMDR, and the provider characteristics that might support or	Quantitative, cross-sectional, web-based survey	**Age range:** 23 – 65 **Gender (n = 75):** 4 male, 71 female **Years of experience:** 0 – 28 **Ethnicity:** White (n=50), Latino (n=17), Black (n=3), Mixed-Race (n=3), American Indian (n=1), Native Hawaiian (n=1).	76 practitioners working within 47 rape crisis centres	Web-based survey	Descriptive statistics, chi-square analyses and t tests.	****	There is a low-use rate of EMDR (8%) in this setting. Perceptions of EMDR were predominately marked by uncertainty, reflecting a lack of familiarity with the model.

			hinder implementation of EMDR in this setting.		**Highest Level of Education:** No Bachelor's degree (n=18), Bachelor's degree (n=17), Advanced degree (n=41). **Setting:** Urban (n=45), Rural (n=31).					More than half of the practitioners indicated that they did not have a good understanding of the procedures and techniques involved in EMDR therapy (55.0%), and another 18.3% were uncertain about their understanding. There is strong interest in receiving training, particularly for those working in urban areas and those with advanced degrees.
7.	Farrell & Keenan (2013)	United Kingdom	To explore EMDR training participants' application of EMDR within their current clinical practice.	Mixed methods – survey	**Age:** Not reported **Gender:** Not reported **Core Profession:** Psychology (n=161), Psychotherapy (n=95), Counselling (n=83), Mental Health Nursing (n=71), Psychiatry (n=36), Social Work (n=14), Other (n=13), Medicine (n=12). **Main Psychotherapeutic Orientation:** CBT (n=211), Integrationist (n=127), Psychodynamic (n=60), Other (n=50), Humanistic (n=37).	485 clinicians	Postal survey	Descriptive statistics, ANOVA, qualitative analysis (type not reported)	**	Fewer than 10% of clinicians did not complete the full EMDR basic training for diverse range of reasons, including lack of funding, lack of EMDR clinical supervision and lack of confidence using EMDR. Most commonly cited reason for not using EMDR clinically was feeling that the training they received was insufficient in enabling them to feel suitably equipped and confident in using EMDR. 39.5% of overall clinicians had no supervision in place. EMDR is being used with a wide range of mental health problems, other than PTSD.

8.	Farrell et al., (2013)	United Kingdom	This article is an evaluation of eye movement desensitization and reprocessing (EMDR) Europe Humanitarian Assistance Program (HAP) facilitators' training in Pakistan based on a project set up in the aftermath of the 2005 earthquake.	Q-methodology	**Age range:** Not reported **Gender:** 4 male, 2 female **Job title:** Psychiatrists (n=5), GP/ Psychologist (n=1).	6 clinicians	Q-methodology	Factor analysis	****	*Two Factors:* Theory Practice Integration and Scientific Inquiry; Therapeutic relationship and Cultural Context
9.	Grimmett & Galvin (2015)	United States	This study investigated factors contributing to clinicians' use or discontinued use of eye movement desensitization and reprocessing (EMDR) as well as obtaining information pertaining to training experiences.	Quantitative, cross-sectional, web-based survey	**Age range:** Not reported **Gender:** Not reported **EMDR training level (n=238):** Part 1 (n=13), Part 2 (n=124), Certified (n=54), Approved Consultant (n=15), Facilitator (n=18), Trainer (n=10), Trainer of trainers (n=4).	239 clinicians	Web-based survey	Descriptive statistics, ANOVA/chi-square analyses	***	In total, 76% of respondents felt EMDR training had adequately prepared them. For those feeling un-prepared, ongoing training and consultation and more practice during trainings were sought. Most respondents (88%) reported positive reactions from colleagues regarding their EMDR use. Primary reasons for not using EMDR were preferring a previous modality, not feeling competent, client refusal, and discomfort suggesting it. Of those clinicians still using EMDR, 25% stated rapid results as the primary reason. Other reasons were feeling more effective as a clinician and an increase in referrals.
10.	Hasandedic-Dapo (2021)	Turkey	To investigate the thoughts and experiences of psychologists regarding EMDR	Qualitative	**Age range:** 25 - 50 **Gender:** Not reported **Qualification:** At least a master's degree in psychology (n=20)	20 psychologists	Online interviews - questionnaire consisted of open-ended questions	Phenomenological approach	*****	*Themes identified:* Positive personal or anecdotal experiences with EMDR; Perception that EMDR is primarily used for trauma;

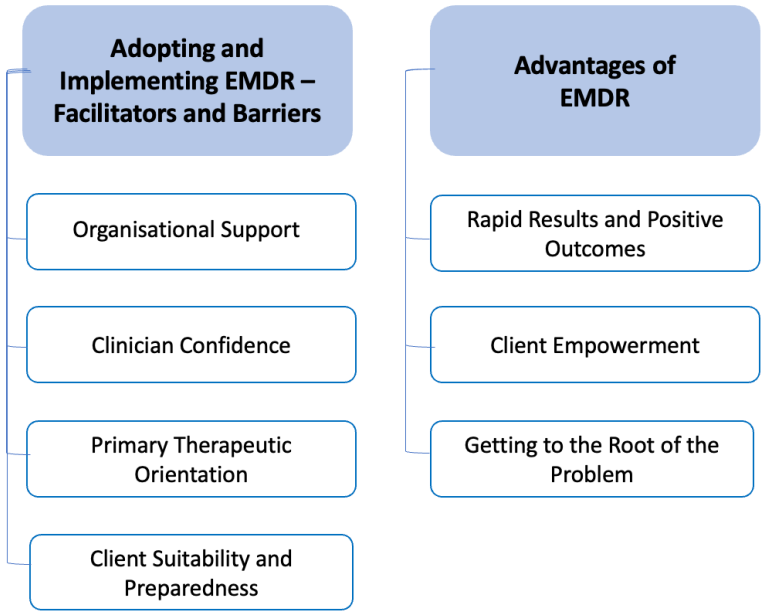
										EMDR is used as an adjunct therapy; Obstacles to EMDR training/certification; Limited knowledge and information about EMDR among psychologists and the general population
11.	Hasanovic et al. (2021)	Bosnia	To describe the experiences of education, clinical practice, and supervision of EMDR psychotherapy in the process of obtaining European accreditation of EMDR trainees from Bosnia and Herzegovina.	Mixed methods - cross-sectional, web-based survey	**Age:** Not reported **Gender:** 6 male, 30 female **Job title:** Psychologist (n=25), Specialist Psychiatrist (n=5), Specialist Educator (n=2), Medicine (n=3), Social Worker (n=1).	36 clinicians	Web-based survey	Descriptive statistics, qualitative analysis (type not reported)	**	*Themes identified:* Problems in practicing EMDR therapy; Experience in practicing EMDR therapy and experience with supervisors
12.	Jones-Smith (2018)	United States	To explore the perceptions of therapists about EMDR as a tool to assist adult women survivors of child sexual abuse.	Qualitative	**Age range:** Not reported **Gender:** 2 male, 8 female **Ethnicity:** White (n=4), Italian (n=1), African American (n=3), Russian (n=1), Puerto Rican (n=1) **Years using EMDR:** 3-13	10 therapists	Semi-structured interviews	Phenomenological	*****	*Themes identified:* Perceived effects of EMDR; Therapists perceived EMDR as more effective in treating child sexual abuse trauma than other treatment options; Perceived role of EMDR in a treatment program; The right time to introduce a client into EMDR; Strategies for implementing EMDR.
13.	Phillips et al. (2021)	United Kingdom	To explore therapists' experience of using EMDR with clients experiencing psychosis	Qualitative	**Age range:** Not reported **Gender:** 5 male, 25 female **Qualification:** Therapists formally trained in EMDR. **Job title**: Psychologist (n=13), Psychotherapist (n = 6)	20 therapists	Semi-structured interviews	Thematic analysis	*****	*Themes identified:* Familiarity with psychosis and EMDR; Acceptability of EMDR; The importance of systemic factors; Keeping key therapy principles in mind.
14.	Vuong (2019)	United States	The purpose of this study is to explore a clinician's viewpoint on the efficacy of EMDR treatment on victims of domestic violence.	Mixed-methods	Not reported	6 clinicians	Interviews	Not reported		*Themes identified:* Emotional responses; Daily Challenges with Trauma Symptoms; Clinicians' Perspectives; Helpfulness

Thematic Synthesis

Thematic synthesis generated two overall themes, with seven subthemes. See Figure 1.2 for an outline of findings.

Figure 1. 2

Diagram of Themes and Subthemes



Theme 1: Adopting and Implementing EMDR – Facilitators and Barriers

The theme "Adopting and Implementing EMDR" discussed the range of facilitators and barriers clinicians identified as influencing their experience of adopting EMDR as a therapeutic approach and implementing it into their clinical practice. This theme included four main subthemes: "Organisational Support", "Clinician Confidence", "Primary Therapeutic Orientation", and "Client Suitability and Preparedness".

Organisational Support

Clinicians across nine studies discussed the role of organisational support as both a facilitator and barrier to the adoption and implementation of EMDR in clinical practice (Brendler, 2017; Cook et al., 2009; Dunne & Farrell, 2011; Farrell et al., 2013; Farrell &

Keenan, 2013; Grimmett & Galvin, 2015; Hasandedic-Dapo, 2021; Hasanovic et al., 2021; Phillips et al., 2021). Organisational factors that supported clinicians to adopt the approach included the provision of on-site annual funded trainings, a felt expectation within the service to practice EMDR, and suggestions to use the approach from colleagues and supervisors (Cook et al., 2009; Grimmett & Galvin, 2015). Reflecting how EMDR was part of the organisational culture within the service, one clinician in the study conducted by Cook and colleagues (2009) stated:

> "This is the first setting that I've worked in where EMDR, is considered to be the treatment of choice ... where it's almost an expectation that you be trained in or versed in it. I mean it comes (up) in interviews, colleagues ask you do you do this, patients will ask are you going to be trained in EMDR; whereas in other settings where I've worked that's never been a part of the culture or climate." (Cook et al., 2009, p. 6)

Furthermore, the provision of supervision within the workplace was discussed as an important facilitator to the use of EMDR in clinical practice, providing clinicians with both emotional and practical support (Farrell et al., 2013; Grimmett & Galvin, 2015; Hasanovic et al., 2021; Phillips et al., 2021). Supervision was described by clinicians as an important support in supporting them in "consolidating the teaching and learning of EMDR" (Farrell et al., 2013, p. 180). Clinicians spoke about the benefit of receiving information and advice from their supervisor and other peers within their supervision group, obtaining advice from others when challenges arise, learning from other clinicians' cases, and being reminded of the frameworks and protocols (Hasanovic et al., 2021; Phillips et al., 2021). This is illustrated by one clinician who stated:

> "I also learn a lot from other members who, in every case, present a new, interesting experience, and from which I often learn how to be creative and relaxed with EMDR

and at the same time stick to the frameworks and protocols" (Hasanovic et al., 2021, p. 9).

However, it is of note this study conducted by Hasanovic and colleagues (2021) received a lower quality rating on the MMAT, achieving two stars. Furthermore, supervision was also discussed by clinicians as an important factor in building their confidence with the approach as well as mitigating against therapist stress (Phillips et al., 2021).

Moreover, clinicians also described a lack of organisational support as a barrier to the adoption and implementation of EMDR. In terms of organisational culture, EMDR was described by clinicians in the study conducted by Cook and colleagues (2009) as "not how we do trauma work" within the service and clinicians explained that there was a lack of encouragement or expectation to train in this approach which acted as a barrier to training (Cook et al., 2009, p. 6). Furthermore, the cost of EMDR training in terms of time, cost, and lack of funding within services were specifically reported as being barriers to adopting the approach in two studies (Farrell & Keenan, 2013; Hasandedic-Dapo, 2021). This was illustrated by one clinician who reported: "It's pretty expensive to get certified, and it took a lot of time, usually entire weekends to go through the trainings, which not many people can afford to devote." (Hasandedic-Dapo, 2021, p. 21). Clinicians across five studies reflected on a lack of support from colleagues within the workplace as a barrier to use of EMDR, which included colleagues lacking an understanding of EMDR (Dunne & Farrell, 2011; Hasandedic-Dapo, 2021), disagreements from colleagues which led to perceived bullying and cessation of referrals (Dunne & Farrell, 2011), a lack of recognition of the work (Phillips et al., 2021), and negative feedback and scepticism regarding the validity of the approach from colleagues (Brendler, 2017). Furthermore, a lack of ongoing supervision was also reported as a key barrier to implementation, particularly from an experienced supervisor (Dunne &

Farrell, 2011; Farrell & Keenan, 2013; Hasanovic et al., 2021; Phillips et al., 2021). In the study conducted by Farrell & Keenan (2013), 10% of clinicians who failed to complete Level 2 of EMDR training cited a lack of funding by their organisation and a lack of EMDR supervision provision as the top two reasons for discontinuation of the approach. In addition, this study also reported that 148 of the 485 participants reported practising without any clinical supervision. However, these findings should be considered in the context of the lower quality rating of the study conducted by Farrell and Keenan (2013), with this article scoring two stars on the MMAT. Lastly, logistical issues which included a lack of time and appropriate workplace conditions were also cited as barriers to implementation of EMDR (Dunne & Farrell, 2011; Hasanovic et al., 2021).

Clinician Confidence

Clinicians' confidence in EMDR as a credible and efficacious intervention as well as their confidence in their ability to implement the approach was discussed by clinicians in eight studies as an important factor influencing their experience of adopting and implementing the approach. For some clinicians, personally experiencing the effects of EMDR during the training process which involved experiential practice exercises increased their confidence in the approach and facilitated their adoption of the approach (Cook et al., 2009; DiGiorgio et al., 2004; Grimmett & Galvin, 2015; Hasandedic-Dapo, 2021). This was illustrated by one participant who reported:

> "I went to the first level of EMDR training… and I was the person they were demonstrating on, and while I didn't have very deep trauma, it helped with the memory that I had. So I feel pretty positive about it and I want to continue my education in EMDR." (Hasandedic-Dapo, 2021, p. 19).

Furthermore, some clinicians highlighted that it was the observability of the effects of EMDR in clients, either as observed by themselves or by colleagues, that positively

influenced their adoption of the approach and motivated them to continue their training and practice. This was outlined by one clinician who stated: "A client at the time had a cathartic experience using EMDR and that convinced me that there was something in this approach. That was what really sold it to me." (Dunne & Farrell, 2011, p. 185). Similarly, in the study conducted by Grimmett and Galvin (2015), the most common reason cited for pursuing training in EMDR was having heard about its positive effects from colleagues.

In terms of barriers to using EMDR, clinicians in the comparative study conducted by Cook and colleagues (2009) outlined a perception that EMDR lacks credibility as a barrier to adoption. EMDR was discussed as feeling more like a "social movement" or "money-making proposition" to the clinicians in this study (Cook et al. 2009, p. 5). In addition, clinicians in the site who chose not to adopt EMDR perceived the approach as lacking "theoretical soundness" and all reported that they would not use EMDR in large part because they did not understand the mechanism of change in comparison to other therapeutic approaches (Cook et al. 2009, p. 6). Several clinicians expressed concerns about the credibility of EMDR, equating it with invalid therapies and procedures and questioned its empirical basis. Speaking about their reaction to hearing about EMDR, one clinician stated: "It sounded like a far-fetched almost crazy idea that something that seemed so simple could treat PTSD. It seemed 'out there'", and further described it as "gimmicky" (Cook et al. 2009, p. 6). It is important to note that the majority of barriers to adopting EMDR identified were only reported in the study conducted by Cook and colleagues (2009), though the quality of this article was rated highly.

Furthermore, in six studies clinicians reported that their own "anxiety and confidence" (Dunne & Farrell, 2011, p. 184) impacted their ability to implement EMDR into their clinical practice. Some clinicians reported feeling worried about "retraumatising" the client or making things worse for them (Brendler, 2017, p. 75; Dunne & Farrell, 2017, p. 184), and spoke about the fear of what might happen if "EMDR goes wrong" (Phillips et al., 2021, p.

147). A lack of comfort and confidence in describing EMDR to clients due to clinicians' own feelings of discomfort and incompetence with the therapy approach was also reported as a barrier in two studies (Brendler, 2017; Grimmett & Galvin, 2015). Clinicians who were using EMDR infrequently for these reasons proposed wanting additional training to increase their level of skill and confidence (Cook et al., 2009). In addition, a third of clinicians not using EMDR in clinical practice in the study conducted by Keenan and Farrell (2013) considered that the EMDR training they received was insufficient in enabling them to feel suitably equipped and confident in using the approach. Furthermore, 24% of clinicians in the study conducted by Grimmet and Galvin (2015) reported that they felt unprepared following their EMDR training.

Primary Theoretical Orientation

In addition, clinicians' primary theoretical orientation was identified by clinicians as an important factor influencing their experience of implementing EMDR into clinical practice. Indeed, in the study conducted by Dunne and Farrell (2011), there was a statistically significant association, between orientation and experiencing difficulties in incorporating EMDR into clinical practice, with those of analytic (75%) or humanistic/experiential (70%) orientation experiencing more difficulties than those of behavioural/cognitive (32%) or integrative orientation (27%) who had fewer challenges. Difficulties with EMDR included being focused, structured and technique-oriented which was felt to be at odds with exploratory approaches in particular (Dunne & Farrell, 2011; DiGiorgio et al., 2004). Interestingly, in the study conducted by Grimmett and Galvin (2015), 57% of Gestalt therapists (n = 4) had discontinued use of EMDR and reported that this decision was due to the lack of emotional connection and depth offered by the therapeutic approach. This was in comparison to integrative therapists, whereby none of these clinicians had stopped using EMDR. Furthermore, the number one ranked negative experience using EMDR reported by

clinicians in the study conducted by Grimmett and Galvin (2015) was preferring another modality. Clinicians appeared to experience some discomfort in working in a manner that was at odds with their primary approach. This is illustrated by one clinician who reported: "I understood that when I start treatment with EMDR, I only apply EMDR, so it seems a shame/I am sorry to give up my previous knowledge and skills in which I have invested a lot both materially and mentally." (Hasanovic et al., 2021, p. 7).

Furthermore, reflecting the influence of primary theoretical orientation on implementing EMDR, the study conducted by Di Giorgio and colleagues (2004) identified that the three therapists included all deviated from the EMDR protocol at times, by either adding or subtracting from the standard protocol. Therapists were likely to adhere to aspects of the model that were more consistent with their primary theoretical orientation, and leave out aspects that were most at odds with their traditional way of working. For example, the psychodynamic and humanistic therapists in this study reported that they often leave out cognitions as part of the protocol as it feels artificial to them at times, whereas the cognitive-behavioural therapist did not leave out cognitions. Thus, the therapists' primary theoretical orientation appears to influence clinicians' experiences implementing the approach and adhering to the protocol.

Client Suitability and Preparedness

Clinicians across eight studies identified client suitability and preparedness as an important factor influencing their experience of adopting and implementing EMDR in clinical practice (Brendler, 2017; DiGorgio et al., 2004; Dunne & Farrell, 2011; Farrell et al., 2013; Grimmett & Galvin, 2015; Hasanovic, 2021; Jones-Smith, 2018; Phillips et al., 2021). In terms of facilitating use of EMDR, clinicians discussed the importance of ensuring the client is well-informed about EMDR in order to successfully implement the intervention (Brendler, 2017; Phillips et al., 2021), with one clinician stating: "I make sure they're super

educated about EMDR… just kind of hearing what their information about EMDR is and then making sure they understand, you know, usually checking in about EMDR, getting a history." (Brendler, 2017, p. 66). In addition, another key aspect of preparing the client was building a strong therapeutic alliance (Brendler, 2017; Farrell et al., 2013; Jones-Smith, 2018; Phillips et al., 2021). Clinicians within these studies spoke about the importance of building an alliance with their clients before embarking on EMDR and it was considered a key feature of successfully implementing the intervention, with one clinician stating: "It is the therapeutic relationship, I think, which plays an important role in successful outcome with EMDR" (Farrell et al., 2013, p. 180). In addition, systemic support was outlined as another facilitator to implementing EMDR, in terms of the client having a good network of support with the multidisciplinary team (MDT) as well as personal supports (Phillips et al., 2021). Furthermore, resourcing the client was the final aspect of preparation discussed by clinicians which involved spending time ensuring they had the appropriate resources and stabilisation techniques to provide them with the stability required to implement EMDR (Brendler, 2017; Phillips et al., 2021).

Moreover, in terms of barriers to use of EMDR, clinicians across five studies outlined several client presentations they deemed unsuitable for EMDR, due to the nature of the symptoms or aspects of the presentation that would make it difficult to successfully engage the clients. Client presentations mentioned were those actively self-harming or suicidal (Jones-Smith, 2018), clients with psychosis (Jones-Smith, 2018; Phillips et al., 2021), clients who were dissociative or chronically avoidant (DiGorgio et al., 2004; Dunne & Farrell, 2011), those with very low self-esteem or who were multiply traumatized (DiGorgio et al., 2004), or children with disabilities due to difficulty in adjusting the instructions to their level of understanding (Hasanovic et al., 2021). Client resistance or scepticism towards the therapy was also outlined as a potential barrier to implementation (DiGiorgio et al., 2004; Hasanovic

et al., 2021; Jones-Smith, 2018; Phillips et al., 2021), which was illustrated by one clinician who stated: “I quickly give up on this kind of approach if I see that the client is not particularly receptive to it. In that case, I choose an alternative approach" (Hasanovic et al., 2021, p. 7). In the study conducted by Grimmett and Galvin (2015), 10% of cognitive-behavioural therapists were no longer using EMDR on the basis of client refusal or lack of client interest in EMDR. In addition, participants outlined how perceiving clients as ‘not ready’ was an additional barrier to implementing EMDR and made them reluctant to process traumatic experiences with the client (Brendler, 2017; DiGiorgio, et al., 2004). Moreover, participants discussed how lack of stability within the client’s life in terms of ongoing stressors was an additional barrier to implementing EMDR. For example, one clinician outlined how if a client was experiencing an ongoing life stressor such as a divorce or illness within the family, then it would be an inappropriate time to open up a trauma (Jones-Smith, 2018). Similarly, it was reported that if the client was using substances to cope or did not have permanent shelter or housing, then implementing EMDR would not be suitable (Phillips et al., 2021).

Theme 2: Advantages of EMDR

The theme “Advantages of EMDR” discussed the unique advantages clinicians perceived EMDR to possess. This theme included three main subthemes: “Rapid Results and Positive Outcomes”, “Client Empowerment” and “Getting to the Root of the Problem”.

Rapid Results and Positive Outcomes

A number of studies reported the quick rate of change EMDR provides as a unique advantage of the therapeutic approach (Grimmett & Galvin, 2015; Hasandedic-Dapo, 2021; Hasanovic et al., 2021; Jones-Smith, 2018; Phillips et al., 2021). EMDR was believed to resolve problems faster than other therapeutic approaches and lead to new insights emerging quickly for clients (Hasanovic et al., 2021), though this article received a lower quality rating

of two stars on the MMAT. In the study conducted by Phillips and colleagues (2021) one clinician stated: "what struck me with EMDR is, helping people to process the traumatic memories quickly, quicker than some other ways." (Phillips et al., 2021, p. 151). In the study conducted by Grimmett and Galvin (2015), rapid results were reported by 25% of clinicians as the main reason for using EMDR. Furthermore, clinicians in the study conducted by Jones-Smith (2018) also alluded to the long-term and lasting nature of the effects.

Indeed, many clinicians reported positive outcomes experienced by clients when utilising EMDR (Hasandedic-Dapo, 2021; Hasanovic et al., 2021; Jones-Smith, 2018; Phillips et al., 2021). In the study conducted by Grimmett and Galvin (2015), 80% of the clinicians surveyed (n = 239) reported positive treatment outcomes from their clients, with 7% reporting negative outcomes. In terms of trauma memories, clinicians described these memories no longer 'hijacking' the client, as outlined further by one clinician: "They don't go back there. They think, 'That thing happened to me and that was really awful. I wish it didn't happen.' They're able to think about it as a memory as opposed to re-experiencing it" (Jones-Smith, 2018, p. 80). Furthermore, clinicians also reported effective outcomes working with fears, leading to improvements in relationships, improvements in sleep, less shame and less feelings of defectiveness (Hasandedic-Dapo, 2021; Jones-Smith, 2018).

Client Empowerment

An additional benefit of EMDR according to clinicians was that of client empowerment. Clinicians spoke about clients having "a lot of control over the process" within EMDR (Phillips et al., 2021, p. 152). Clients were described as being "in the driver's seat" during the therapy, which was felt to be advantageous and assist them in getting their needs met (Jones-Smith, 2018, p. 7). Furthermore, the fact that EMDR does not require clients to talk about their traumatic experiences out loud was also discussed as an important

advantage of the therapy and an aspect of the process that empowers clients (Cook et al., 2009; Phillips et al., 2021). This was reflected by one clinician who stated:

> "You can be really upfront from the beginning that we can do the blind therapist protocol, you don't actually have to tell me any of the details of your experience…so the person doesn't have to go over and over again, telling me about the worst things that ever happened to them." (Phillips et al., 2021, p. 152)

This was also felt to be helpful for clients in allowing them to bypass shame (Cook et al., 2009) and helpful for therapists in providing less opportunity for vicarious trauma to occur (Phillips et al., 2021).

Getting to the Root of the Problem

Clinicians spoke about the benefits of EMDR as a therapeutic approach in the context of its holistic nature, "treating the mind, body and spirit" (Jones-Smith, 2018, p. 78) in comparison to other traditional talk therapies. Clinicians spoke about EMDR as a holistic and somatic approach which involved working with the client's body which was felt to be a unique advantage of the approach (Jones-Smith, 2018). In working at a deep level and "more thoroughly" (DiGiorgio et al., 2004, p. 243), clinicians also discussed the benefit of EMDR in that it allows the client to be taken back to the moment to process the trauma at a deep level, incorporating the physical sensations, which then allows for a change in "perspective and bodily sensations" (DiGiorgio et al., 2004, p. 242; Jones-Smith, 2018). EMDR was described as being an effective intervention for allowing clients to process their memories with greater emotional intensity and work at a deeper level (DiGiorgio et al., 2004).

Discussion

This mixed method systematic review was conducted to gain insight into clinicians' views and experiences of EMDR therapy. Fourteen studies were included in this review, which comprised of seven qualitative studies, four mixed method studies and two quantitative

studies. Two main themes and seven subthemes were identified within the data and will be discussed further below.

Clinicians identified a range of factors which either facilitated or impeded their adoption and implementation of EMDR as a therapeutic approach. These included factors related to the organisation, the therapist, the intervention and the client. Organisational support in terms of EMDR being part of the organisational culture, the provision of funded training opportunities, encouragement from colleagues to train in the approach, and the provision of supervision was identified as key factors facilitating the clinicians' adoption and implementation of EMDR as an approach. Indeed, this was paralleled with the barriers to EMDR that clinicians identified, which included EMDR not being part of the organisational culture, a lack of funding to train in the approach and a lack of available supervision for clinicians. This reflects the important role organisations play in terms of whether a therapeutic approach is adopted and implemented within a service. These findings are consistent with the work of Beidas and Kendall (2010) whom reviewed research focusing on the dissemination of evidence-based practice and put forth two key aspects of the integration process: (i) how training influences clinicians' knowledge and behaviour and (ii) how the workplace environment, including organisational support and clients, influence how clinicians adopt new practice. This is also consistent with the study conducted by Cook and colleagues (2009) who found endorsement by respected therapists and availability of training opportunities as key factors influencing willingness to adopt a new therapeutic approach. Thus, it is important that organisations ensure clinicians are provided with opportunities to train in evidence-based therapies to provide clients with the opportunity to avail of evidence-based interventions, as well as providing the supports required to facilitate the ongoing implementation of the approach.

The importance and availability of effective and supportive supervision and consultation was highlighted as paramount to clinicians' ability to implement EMDR within their practice. In accordance with the literature, clinical supervision is considered a core component of clinical practice within mental health and has been proposed as the most important factor in developing competencies within clinical practice (Falender et al., 2004, Stoltenberg, 2005). Furthermore, research has identified the importance of having ongoing clinical supervision in practice in order to assist with encouraging the use of the therapeutic approach post-training (Holloway & Neufeldt, 1995), as well as helping the clinician to maintain fidelity to the treatment approach (Bearman et al., 2017). Results of this systematic review also highlighted how ongoing and available supervision can be helpful in providing emotional support and assisting clinicians in gaining confidence working with EMDR. This may be an important factor to consider given that an identified barrier to using EMDR in practice was a lack of confidence and an anxiety regarding their ability to practice EMDR safely and effectively. Furthermore, supervision was also discussed as an important resource to assist with continued learning and education, including receiving information and advice on how to overcome challenges and stick to the protocol. Indeed, according to Bearman and colleagues (2017), initial training is a key aspect of educating the clinician about a therapeutic approach, but ongoing supervision is important in terms of actually implementing the therapy skilfully (Herschell et al., 2004). It is also possible that provision of regular and effective supervision may be an important protective factor to mitigate against some of the other identified barriers to implementing the therapy, such as a lack of therapist confidence in their skills, anxiety about EMDR potentially worsening the client, and difficulty implementing EMDR in the context of other theoretical orientations. Furthermore, it may be a supportive platform to discuss some of the workplace issues that may emerge, or client-related barriers that may be present.

In terms of clinicians' confidence in EMDR as an approach, it emerged that their experiences during training in terms of the experiential learning component was an important factor which influenced their adoption of the approach and motivated them to continue their training and implementation. Indeed, it has been argued that a training programme that encompasses an active rather than a passive learning approach is more likely to be successfully implemented into clinical practice post-training and thus this may be a strength of the EMDR training and increase clinicians' confidence in the approach (Cross et al., 2007). This finding is also consistent with the work of Beidas and Kendall (2010) who also identified how training influences clinicians' knowledge and behaviour, which then plays an important role in whether an intervention is integrated into practice.

The impact of theoretical orientation also emerged as an important factor to consider in terms of clinicians' experience of integrating the therapy into clinical practice. This review highlighted that some clinicians may choose to personalise or alter the protocol, which may be influenced by their own primary theoretical orientation. Indeed, EMDR is a secondary psychotherapeutic approach which means therapists training in EMDR have already been thoroughly trained in other primary approaches such as psychodynamic, humanistic and cognitive behavioural therapy (CBT) and may have developed their own personal style of treatment. Thus, results of this review raise the question of the importance of treatment fidelity in the implementation of EMDR. Studies have indicated that EMDR is a robust treatment in some ways, with effects and outcomes found to be unaffected by some changes to the protocol, such as variations in eye movements (Renfrey & Spates, 1994). However, studies have also identified that omitting aspects of the protocol can lead to poorer outcomes, for example in analysing procedures used in phobia studies utilising EMDR, it was found that studies which omitted more than half of the EMDR protocol achieved poorer outcomes than those who adhered to the full protocol (Shapiro, 1999). Furthermore, in a meta-analysis

conducted by Maxfield and Hyer (2002) which investigated the relationship between methodology (which involved treatment adherence) and efficacy in treatment outcome studies found that studies with fidelity assessed as adequate were more likely to achieve larger effects than those whereby fidelity was assessed as poor or variable. This reflects the potential importance of ensuring clinicians are highly trained and comfortable implementing all aspects of the standard protocol and understand the merits of each aspect of the protocol. It should be noted that this review excluded studies where there was a clear adaptation to the protocol, such as combining the therapy with another specific therapeutic intervention to create an adapted form of EMDR. Thus, this body of literature may be useful in gaining a deeper insight into additional deviations that clinicians make, the rationale for same, and the outcomes of these approaches.

In addition, a lack of client suitability and readiness was identified as a barrier to implementing EMDR in clinical practice. Within this subtheme, clinicians discussed lack of client interest or preference as a factor which prevents implementation of EMDR. This finding highlights the important consideration of client preferences as a factor influencing implementation of a therapeutic approach. Indeed, NICE guidelines make reference to this in terms of their guidance to consider EMDR for a diagnosis of PTSD or clinically important symptoms of PTSD "if the person has a preference for EMDR" (NICE, 2019). Furthermore, current guidelines for evidence-based practice indicate that treatment decisions should be made in the context of client preferences (APA Presidential Task Force on Evidence- Based Practice, 2006). Providing support for this recommendation, a meta-analysis of 35 studies conducted by Swift and colleagues (2011) found improved outcomes and decreased drop-out rates for clients whose preferences were accommodated compared to those were nonmatched to a preferred therapeutic approach. It is of interest that clinicians highlighted a number of presentations that they deemed unsuitable for EMDR, which appeared to vary within studies.

This highlights a need for further research to be conducted and for clear guidelines to be published regarding the use of EMDR for range of client presentations.

Strengths and Limitations

To our knowledge, this is the first systematic review of studies investigating clinicians' views and experiences of EMDR therapy. As outlined by Cook and colleagues (2009), clinicians are key stakeholders in terms of the adoption and continued use of a therapy as they not only determine their own probability of using the approach, but also may impact how receptive their clients are to undergoing the treatment approach. Thus, this review provided important insights into clinicians' experiences of adopting and integrating EMDR. The inclusion of quantitative, qualitative and mixed-methods studies strengthened the review in that it allowed for a more comprehensive insight into clinicians' views and experiences of EMDR which is a relatively new area. This review was also inclusive of grey literature which mitigated against publication bias. However, there are several limitations to this review that are important to highlight. The heterogeneity of the studies included in terms of research aims and study designs made it more difficult to collate the data and due to the variability across studies, a meta-analysis was not deemed suitable to analyse the quantitative data. Furthermore, due to the nature of the research, clinicians who chose not to adopt the approach or who discontinued the approach were underrepresented within the review. The study conducted by Cook and colleagues (2009) was a comparative case study between two sites, one of which adopted EMDR and one of which rejected its adoption and thus this study provided the greatest insight into the barriers to adoption. Additional research in this area would be of use to gain additional insight into the factors which may impede the decision to conduct training in EMDR. Studies were excluded if they were not written in the English language which therefore may have led to publication bias and exclusion of relevant studies

from different cultures. Finally, full texts were unavailable for three potentially relevant studies due to lack of response from authors or the failure to provide any contact information.

Conclusion

This mixed methods systematic review was undertaken to provide insight into clinicians' views and experiences of EMDR. The facilitators and barriers for adopting and implementing EMDR and well as clinicians' perceptions of the advantages of EMDR were identified, providing a helpful insight into the factors which influence the dissemination and implementation of psychological therapeutic approaches.

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Chapter Three: Systematic Review Extended Methodology

Systematic Reviews

According to the Cochrane Handbook, systematic reviews attempt to collate all empirical evidence that fits a pre-specified eligibility criteria to answer a specific research question (Antman et al., 1992; Oxman & Guyatt, 1993). Systematic reviews are considered the 'gold standard' way to synthesise results from a range of studies as they utilise explicit methodology which aims to minimise bias and provide reliable results from which subsequent decisions can be made and conclusions can be drawn (Antman et al., 1992; Boland et al., 2017; Oxman & Guyatt, 1993).

According to Gough and colleagues (2012) there are numerous reasons to conduct systematic reviews. Indeed, any individual primary research study may be fallible, either due to weak methodology or reporting or by chance, and can have limited relevance due to the specific scope and context in which they are set. In addition, systematic reviews can provide an important basis for planning future research and identifying appropriate gaps to explore within research to ensure this process is necessary and appropriate, as well as providing a context for interpreting new research results in an area (Gough et al., 2012).

Initially when the notion of evidence-based healthcare emerged in the 1990s, there was a dominant focus on undertaking meta-analyses of randomised controlled trails (RCTs) due to RCTs being considered as 'gold standard' in terms of research quality (Pearson et al., 2015). Indeed, RCTs are still considered the most appropriate approach in terms of determining evidence of effectiveness, though healthcare has shifted towards an interest in more than just cause-and-effect research questions, reflected in the diverse range of research approaches and designs used today including qualitative and mixed-method designs (Pearson et al., 2015)

Development of Systematic Review

Development of Research Question

Early scoping searches were conducted in order to identify potentially appropriate areas to focus the review on within EMDR. This involved researching existing published systematic reviews as well as PROSPERO, an international prospective register of systematic reviews, to identify potential gaps in the literature. I assessed the suitability of potential research questions and gauged whether there was enough literature in the area to generate a meaningful review. At this stage I generated a mind map of ideas to assist in focusing the research topic, which was discussed in supervision. The systematic review question was developed using a modified PICO table, presented below in Table 3.1. As per recommendations of the Joanna Briggs Institute (JBI), a broad review question was thus chosen that can be addressed by both quantitative studies and qualitative studies (Pearson et al., 2015).

Table 3.1

Modified PICO (JBI, 2014)

Population	Mental health clinicians
Context	Mental health clinicians eligible to use or using EMDR
Outcome	Clinicians' views and experiences of EMDR

Rationale for a Mixed-Methods Design

Indeed, based on the scoping searches, the research in this area appeared to be heterogeneous and thus it was decided that quantitative, qualitative, and mixed-methods studies that report on the views and experiences of clinicians would be included. This mixed-

methods systematic review is based on the PRISMA reporting guidelines (Moher et al., 2009). The design of the Joanna Briggs Institute (JBI) approach for conducting systematic reviews of both quantitative and qualitative research was also followed (Lizarondo et al., 2020). Mixed methods systematic reviews are an emerging field and the JBI approach was chosen as it allows a broad, inclusive approach to evidence and accommodates a range of research questions and study designs (Aromataris & Munn, 2020). The JBI approach provides authors with a comprehensive guide to conducting systematic reviews and describes in detail the process of planning, undertaking and writing up a systematic review (Lizarondo et al., 2020). A number of mixed methods systematic reviews adopting this approach have been published in recent times and were referred to in the design of this review (D'Souza et al., 2021; French et al., 2019; Hoang et al., 2018).

Development of Inclusion and Exclusion Criteria

In parallel, the inclusion and exclusion criteria were developed, informed by the above PICO table (Table 3.1). The full inclusion and exclusion criteria for this study are outlined in Appendix C and the decision making regarding the development of criteria will be discussed further. As previously mentioned, given the heterogeneity of study designs in this area, it was decided that quantitative, qualitative, and mixed-methods studies would be included. It was decided to include studies focusing on training and/or delivery of the approach to allow the views and perspectives of clinicians who had potentially attended training but not chosen to implement EMDR to be included. In addition, the criteria focused on clinicians' views and experiences of EMDR in relation to the traditional protocol only, as adapted forms of EMDR would be too heterogeneous to meaningfully analyse. Studies were excluded if they were case studies, clinical reports, editorials, opinion pieces, books, reviews, and papers not reporting primary research findings. This included clinical case studies written by clinicians focusing on the client's experience and outcomes which was not the focus of

this review. Furthermore, mixed outcome studies where data concerning EMDR could not be extracted separately were excluded. In addition, studies were excluded if they were not written in the English language as translation was not available due to time and cost reasons.

Developing a Systematic Review Protocol

A detailed systematic review protocol was developed and published on PROSPERO (registration number: CRD42021277333). PROSPERO records a comprehensive list of systematic review protocols in order to avoid duplication of effort, reduce reporting bias, and promote transparency in research (Schiavo, 2019).

Identifying Studies for Inclusion

Search Strategy

Studies for this review were located following a multi-step process. Firstly, computerised searches for literature were conducted on the following databases from their inception to October 2021: PsychINFO, PUBMED, CINAHL, SCOPUS, Web of Science, EMBASE, and Applied Social Sciences Index, based off similar systematic reviews in the area (Forbat et al., 2015). Keywords comprising the search string were chosen based on an examination of terminology used in existing systematic reviews that have investigated equivalent concepts, as well as use of a thesaurus in order to identify synonyms of the keywords (Forbat et al., 2015; Whitehouse, 2019). In addition, a workshop clinic with a subject librarian was attended to assist with the search strategy. Keywords were combined accordingly with index terms of each database to produce search strings personalised for each database (See Appendix B). The search for keywords and index items was performed across titles and abstracts. To reduce risk of publication bias threatening the validity of this systematic review, grey literature was also searched. This involved completing the search on

ProQuest which produced 3,990 articles to be screened, and searching the first 30 pages of Google Scholar for relevant articles (Haddaway et al., 2015). Furthermore, forward and backward citation chaining was conducted on included studies. No additional articles were found at this stage that were deemed relevant for inclusion. The remaining full texts of potentially relevant articles were then reviewed by the primary author and the second author. Where full texts were not available, the authors were contacted directly and articles were requested through the university. Two full texts articles were obtained through direct contact with authors, and three articles were excluded due to no full text being accessible.

Record Management

Search results were imported into Zotero 5.0.96.4 reference management software and duplicates were deleted. Rayyan software was used to screen titles, abstracts and full texts for suitability (Ouzzani et al., 2016).

Quality Appraisal

In accordance with PRISMA guidelines, the methodological quality of each article included in the systematic review was independently assessed by the first and second authors (Moher et al., 2009). The MMAT (Hong et al., 2018) was chosen to assess methodological quality as this tool allows researchers to concurrently assess of the quality of studies with diverse designs (Crowe & Sheppard, 2011). The MMAT has also been found to be a valid quality assessment tool and has been found to have good inter-rater reliability (Crowe & Sheppard, 2011). The MMAT provides a number of criteria to assess study quality specific for the different research designs. A scoring system was employed whereby a score of 5 stars (i.e. 100) indicated all criteria have been met. A second reviewer also conducted quality assessment on 25% of included studies (4 articles) and there was almost perfect agreement between reviewers on quality ratings (Cohen's Kappa = 0.85). It was decided that studies would not be excluded based on poor quality but any methodological issues identified would

be recorded and highlighted, as per MMAT recommendations (Hong et al., 2018). One study identified (Vuong, 2019) failed to pass the MMAT screening criteria due to lack of a clear research question and insufficient data presented. Thus, further quality appraisal was not deemed appropriate (Hong et al., 2018).

Synthesising Studies

Data Extraction

Data extraction was conducted as per guidelines recommended by the JBI (Lizarondo et al., 2020). In terms of quantitative descriptive data, data comprising an average or a percentage that profiled the sample was extracted. For analytic studies, data on all relationships relevant to the research question, both significant and non-significant results were extracted (Lizarondo et al., 2020). For qualitative studies, themes and subthemes relevant to the review, along with supporting illustrations were extracted. The data extracted also included specific details about the participants, study methods, phenomena of interest, context, data analysis, and outcomes (Lizarondo et al., 2020).

Data Synthesis

As per the JBI guidelines, since this review question could be addressed by both quantitative and qualitative research designs, a *convergent integrated* approach was followed for data synthesis. This method of data synthesis required data from quantitative and qualitative studies to be transformed into a mutually compatible format (Stern et al., 2020). Quantitative data was "qualitized" whereby data was extracted from quantitative studies and converted into textual descriptions to allow integration with qualitative data (Stern et al., 2020). For example, in the study conducted by Farrell and Keenan (2013), authors report quantitatively in a table that nine of 45 clinicians did not complete EMDR training due to lack of funding (Farrell & Keenan, 2013, pg. 7). Thus, this was transformed to read "20% of EMDR clinicians who did not complete their EMDR basic training reported this being due to

a lack of funding". Thus, all qualitized data from the quantitative studies were then assembled and pooled with the qualitative data extracted from the qualitative studies to prepare for synthesis. Thematic synthesis was employed as a means of synthesising the data as it can be used to synthesize the findings of heterogeneous studies, enables barriers and facilitators to be identified in the data, and has been argued to produce findings that directly inform practitioners, which would be of relevance to this study (Booth et al., 2016; Thomas & Harden, 2008). Thematic synthesis was conducted in accordance with the steps outlined by Thomas and Harden (2008) which are outlined below:

Step One

At first, I read and re-read the full texts of the 14 articles to be included in the review in order to immerse myself with the findings.

Step Two

At this stage I compiled all findings from each of the articles, including those that had been 'qualitized' as per the aforementioned JBI guidelines (Stern et al., 2020), into one word document in order to prepare the data for further analysis and coding.

Step Three

At this stage, I carried out line-by-line coding of the findings from each article included in the review, including original data as well as 'author interpretations' of the data. This involved reading each line of the results and discussion sections and carefully coding them according to their meaning and content. An inductive approach to coding was employed, whereby codes were derived from the data without pre-formulated assumptions as to how they should be defined. As each study was analysed, I added to the 'bank' of codes where necessary.

Step Four

At this stage, descriptive themes were developed by grouping and re-grouping codes based on similarities and differences in a hierarchical manner. During this process, I had the full texts on hand to review to allow me to refer back to the data to check context and detail and to ensure I was representing it appropriately. This resulted in 13 descriptive themes, which stayed close to the original findings in the included studies.

Step Five

Finally, analytic themes were created which were able to 'go beyond' the initial findings of the primary studies and produce new concepts not visible in primary studies alone. During this process, I constructed a diagram of the 13 descriptive themes on Microsoft PowerPoint in order to consider the relationship between themes and assist with the development of higher-order themes. This lead to the development of two overall themes and seven subthemes which synthesized the findings across all of the included studies. At this stage, quotations were chosen to best illustrate each of the themes and a diagram was created presenting the themes and subthemes.

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Chapter Four: Major Research Project Literature Review

Eye Movement Desensitisation and Reprocessing (EMDR)

Eye Movement Desensitisation and Reprocessing (EMDR) is a therapeutic intervention first developed and introduced as EMD by Francine Shapiro in 1987 (Shapiro, 1989) as a treatment for post-traumatic stress disorder (PTSD), before developing into the EMDR therapy as it is known today. A core, signature component of EMDR therapy is dual attention, whereby the client attends to a traumatic memory whilst also engaging in a process of bilateral stimulation (Novo Navarro et al., 2018). The traditional form of bilateral stimulation in EMDR involves the rhythmic movement of the therapist's fingers to be followed by the eyes of the client, though this has been expanded in recent years to include other means of bilateral sensory input, including tactile motions, auditory tones and tapping using therapist's hands (Friedberg, 2004; Shapiro, 2001).

In keeping with Claude Bernard's (1865) claim that "it is always by chance that everything begins" and "science only comes after", EMDR was first developed by Shapiro based on an individual observation. Shapiro observed, whilst walking in a park, that alternating her eye movements from left to right appeared to decrease the negative emotion she experienced in association with a negative memory. She subsequently tested this hypothesis with veterans from the Vietnam war who met clinical criteria for PTSD and then developed a standard procedure for the approach. Over time, Shapiro further developed the treatment approach, incorporating feedback from clinicians and clients and later developed the theoretical model said to underly the approach, the Adaptive Information Processing (AIP) model (Shapiro, 2001), which is later described.

Since its inception, EMDR has been the subject of much debate and criticism from the scientific community, with its efficacy examined in dozens of randomised control trials

(RCTs). Several meta-analyses have demonstrated EMDR's efficacy in treating PTSD, reporting large effect sizes compared to control conditions and comparable effect sizes to cognitive-behavioural therapy (CBT) (Chen et al., 2015; Lee & Cuijers, 2013; Moreno-Alcazar et al., 2017). In terms of treatment guidelines for adults, EMDR has been recommended as an evidence-based treatment approach for PTSD by a number of clinical bodies (National Institute for Health Care and Care Excellence, 2019, World Health Organisation, 2013). Though, in clinical practice, EMDR is also applied to various other clinical presentations based on accumulating evidence supporting the link between trauma and past life events on the development of a range of psychological difficulties (Copeland et al., 2007; Kim & Lee, 2016; Ladin-Romero et al., 2018).

Valiente-Gomez and colleagues (2017) conducted a systematic review of RCTs investigating the efficacy of EMDR in mental health conditions beyond PTSD, concluding there is a relative scarcity of research in this area, though available studies did suggest EMDR improves trauma-associated symptoms in clients with comorbid psychiatric disorders and had a minor effect on primary disorders. In a more recent systematic review published by Cuijpers and colleagues (2020), EMDR was found to be effective for phobias and test anxiety, though the number of studies was small and risk of bias was high. In terms of other mental health problems, there were insufficient studies available to pool outcomes and although some studies indicated significant effects, the risk of bias was considered high for most studies. A number of limitations to the existing evidence base were highlighted by Cuijpers and colleagues (2020), including the heterogeneity in the studies in terms of a range of variables, small sample sizes, a lack of reporting of long-term outcomes, and the high risk of bias present in most studies. Thus, it was concluded that there is insufficient evidence to advise its use for mental health problems other than PTSD.

The mechanism of action underlying EMDR has also been subject to debate and controversy for many years. Shapiro thus developed the AIP model, which guides treatment procedures and provides an explanation for the basis of pathology (Shapiro, 2001; Shapiro, 2007). The AIP model proposes that humans have an internal information processing system that assimilates new information and integrates it into existing memory networks (Luber & Shapiro, 2009). Indeed, EMDR views the basis of psychopathology as memories of past disturbing experiences that have been incompletely processed by the brain's information processing system (Shapiro & Laliotis, 2011). It is proposed that in the context of traumatic memories which typically involve information which is overwhelming, threatening and dysregulating, the limbic system overrides the prefrontal system thus temporarily stopping it from being adaptively processed (Schore, 2003). Thus, the memory of the different components (emotional, sensory, cognitive and physiological) remain stored maladaptively in memory networks, unable to be fully processed and integrated (Montgomery, 2013; Schore, 2003). External stimulation similar to the original unprocessed adverse experience can then trigger sensations and images from the traumatic event (Landin-Romero et al., 2018). On this basis, Shapiro (2001) hypothesised that should memories be adequately processed, symptoms would be alleviated and proposed EMDR as an appropriate intervention to achieve same.

Shapiro (2001) also proposed that bilateral stimulation, such as eye movements, would facilitate this processing, by activating the information processing system to allow for an integration of the memory. Shapiro and Maxfield (2002) further proposed that eye movements decrease the vividness of the trauma image and related affect in the client's memory, which then reduces distress and related avoidance, and therefore facilitates processing (Shapiro & Maxfield, 2002). It has been argued that as the trauma image reduces in salience, the client is then able to access and attend to more adaptive information within their memory networks (Shapiro & Maxfield, 2002).

Based on this theoretical model, the exact mechanism of action underlying EMDR, particularly regarding the role of eye movements, has received much debate and criticism within the literature. Indeed, a particularly contentious debate within the area relates to the potential overlap of EMDR techniques with TF-CBT, most notably in relation to exposure to the trauma memories, arguing eye movements make no specific contribution (Salkovskis, 2002). However, a meta-analysis conducted by Lee and Cuijpers (2013) found evidence that eye movements do hold additional value in processing emotional memories during EMDR. There have been many models proposed seeking to understand the exact mechanism of action underlying EMDR from a scientific lens, with a recent systematic review conducted by Landin-Romero and colleagues (2018) classifying existing models into psychological, psychophysiological and neurobiological categories, with the main models outlined below.

The first psychological model is based on the orienting (or investigatory) response, described by Pavlov in 1972 (Rescorla & Wagner, 1972). This model argues that the eye movements activate an 'investigatory reflex' in which an alert response is activated along with associated autonomic responses, and then in the absence of actual danger this initial response is rapidly replaced with a feeling of relaxation (Landin-Romero et al., 2018). Thus, according to this model this relaxation response acts to desensitise a trauma memory. Indeed, Armstrong and Vaughan (1996) propose an extinction model whereby eye movements trigger the orienting reflex which both heightens alertness and access to trauma memories, as well as causes rapid extinction after no threat is detected. With repeated presentation of the same non-threatening stimulus during processing, the orienting response is said to habituate quickly, reducing a physiological response to that stimulus (Bradley, 2009).

The second and leading psychological model is that of the working memory hypothesis, based on Baddely and Hitch's (1974) multicomponent model of working memory. In this model, the central executive acts a supervisory system, integrating and

coordinating information from a number of subsystems, including the phenological loop (storing verbal and auditory information) and the visuospatial sketchpad (storing visuospatial information). It is proposed that during EMDR processing memories are being held in the visuospatial sketchpad. Thus, when the client is asked to attend to both the memory and eye movements, this taxes the visuospatial sketchpad and central executive systems, impairing the image and making the memory less emotional and vivid (Andrade et al., 1997). This process is also argued to provide clients with a sense of distance from the trauma event, consistent with the AIP model (Landin-Romero et al., 2020). According to this model, each recall of a memory is likely to modify the memory leading to it being re-consolidated into long term memory in this modified form (Haour et al., 2019). This model would then suggest that any task that divides attention and taxes the working memory system during the recall of a memory should reduce the emotional impact of the memory (Haour et al., 2019). This was supported by experimental studies whereby engaging in other demanding tasks during recall, such as mental calculation tasks, reduced the vividness and emotionality of negative memories (Engelhard et al., 2010). Of note, different modes of 'distraction' do not appear to produce the same level of effectiveness though, with eye movements appearing to be more effective than other types of stimulation in decreasing vividness and emotionality of distressing memories in healthy participants (van den Hout et al., 2011).

In terms of the rapid eye movement (REM) hypothesis, this states that repeated bilateral eye movements produces a brain state similar to that of REM sleep, leading to the same physiological changes (Novo Navarro et al., 2018; Stickgold 2002). Research has indicated that REM serves adaptive functions, including memory consolidation by integrating emotionally charged autobiographical memories into general sematic memory networks (Stickgold & Wehrwein, 2009). During REM, acetyl cholinergic mechanisms transfer weakly associative material to the hippocampus which is involved in forming long-term memories

(Haour et al., 2019). It is hypothesised that bilateral eye movements during EMDR produce acetylcholine and an orienting response, reorganising trauma memories by reducing the strength of the trauma memories and their associated negative emotions and integrating episodic memories into semantic memory (Haour et al., 2019; Landin-Romero et al., 2018). However, support for this model has only emerged indirectly, with one study finding improved sleep in PTSD clients following successful EMDR treatment (Raboni et al., 2014). Also, this model fails to account for effects of different types of bilateral stimulation.

Finally, it has been suggested that eye movements increase interhemispheric communication via the corpus callosum, thus facilitating the retrieval of episodic memories and associative memory processing (Landin-Romero et al., 2018). This was initially supported by a series of EEG studies which found horizontal saccadic eye movements to increase interhemispheric interaction and episodic memory retrieval (Bruyne et al., 2009; Propper et al., 2007). However, support for this hypothesis has been mixed and an EEG study conducted by Samara and colleagues (2011) found no evidence that eye movements enhanced interhemispheric coherence or that increased recall was associated with changes in coherence.

Thus, it is clear from the literature that there is still no agreed mechanism of action underlying EMDR and the role of bilateral stimulation. Given that EMDR is an eclectic psychotherapy approach, containing elements from many traditional psychological orientations, including psychodynamic, cognitive-behavioural, physiological, experiential and interpersonal therapies, there are likely a number of underlying processes contributing to EMDR's efficacy (Maxfield, 2003). Indeed, EMDR involves a range of core elements which along with bilateral stimulation, include free association, mindfulness, and multiple brief exposures (Maxfield, 2003). Due to this, some authors suggest that EMDR's efficacy can thus be attributed to the common effects of different therapies (Davidson & Parker, 2001). Although the debate regarding EMDR's mechanism of action has received significant

attention and focus in the literature, it is important to note that there are limited psychological treatments for which the exact mechanism of action have been confirmed, and thus EMDR is no exception (Cuijpers et al., 2020).

EMDR Treatment Components and Protocol

EMDR consists of a structured standard protocol of eight phases (Haour et al., 2019) The first phase of treatment consists of a detailed history taking and treatment planning to conceptualise the case and identify targets for treatment.

The second phase consists of the preparation/stabilisation phases whereby the EMDR model is explained and clients are prepared for therapy by establishing the mechanics of bilateral stimulation and learning regulation techniques such as the 'safe place', a guided visualisation technique in a place whereby the client feels safe. The clients also learn the 'stop signal' to maintain a sense of control during the processing.

The third phase consists of identifying and evaluating the distressing target memory for the particular session. The client is instructed to identify the most salient image associated with the memory and evaluate the distress caused by the event using the Subjective Units of Disturbance (SUDS) scale (Wolpe, 1969), an 11-point scale ranging from 0 "no disturbance" to 10 "worst possible". In addition, the client is assisted to elicit negative beliefs associated with the memory, for example "I am a bad person", "I am worthless" or "I am in danger". At this stage, a preferred contradictory positive belief is identified and its current validity is assessed in relation to the event using the Validity of the Cognition (VOC) scale (Shapiro, 1989), a 7-point scale ranging from 1 "completely false" to 7 "completely true". These initial scores on the SUDS and VOC scales serve as baseline measures prior to processing, and any associated physical or emotional reactions are noted.

The fourth stage is the desensitisation phase whereby the client is asked to bring to mind and focus on the traumatic memory, in terms of its many sensory elements (visual,

auditory, kinaesthetic, olfactory) as well as the associated emotions and beliefs. The therapist then initiates a series of bilateral stimulation which involves a series of alternating left and right eye movements, sounds or tactile stimulations. Bilateral stimulation is used to activate the client's inherent information processing system for 20 to 30 seconds intervals. During this process, clients are asked to have an open-mind and associations of ideas (i.e., free associations as per a psychoanalytic model) emerge and are said to be integrated into the client's memory network in an adaptive manner, in that theoretically they move from the amygdala to the pre-frontal cortex. Between each bilateral stimulation episode, clients are invited to take a deep breath and share any information that emerged during the stimulation. This phase is concerned with the desensitisation to negative emotion.

In the fifth phase, the installation phase, the therapist attempts to strengthen the preferred positive cognition to replace the negative one using bilateral stimulation. Examples of positive cognitions may include "I am a good person", or "I have value" or "I am safe now". Bilateral stimulation continues until the client accepts the full truth if the positive-self statement and the VOC reaches a score of 7 ("completely true").

In the sixth phase, the client engages in a body scan by closing their eyes and observing in their body if there is any remaining emotional distress or physical tensions related to the targeted memory. If present, the therapist further employs bilateral stimulation desensitisation processing to relieve them.

The seventh phase involves closure of the session, whereby regulation strategies are used to bring the client to a state of equilibrium should the reprocessing stage be incomplete within the session. Clients are notified on what to expect between sessions and to maintain a diary of any disturbances that may arise.

The eighth and final stage is the revaluation phase which reviews previous work and plans for additional targets.

Furthermore, in terms of the sequence of memories being processed, traditionally EMDR used a "three-pronged" approach, focusing on the past, present and future (Hase, 2021). Past trauma memories are processed initially, on the basis that they are believed to be driving current difficulties. Present triggers that remain active following the processing of past memories are then addressed. Finally, the 'Future Template' component of the treatment assists the client in visualising successfully managing a future event.

Client Experiences of EMDR

Whilst there has been a large literature base focusing on the efficacy of EMDR or trying to ascertain the mechanism of action underlying the approach, there has been significantly less focus on qualitative research and exploring client experiences. As argued by Hodgetts and Wright (2007), traditionally there has been less focus on clients' perspectives in research within the area of psychotherapy in general due to quantitative research being perceived as superior in nature. Indeed, as evidence-based, time-limited treatments have become even more popular in context of resource-limited healthcare systems, there has a been a strong focus on efficacy studies using outcome measures to measure symptomatology (Hodgetts & Wright, 2007). However, according to Hodgetts and Wright (2007), we cannot fully understand therapy or the process of change unless clients' experiences are explored.

In Elliott's (2008) review of six articles, which focused on client experiences of therapy in general, three main areas emerged- what clients find helpful or hindering about therapy, client's individualised perspectives on outcomes, and how clients deal with difficulties within the therapeutic process. Thus exploration of the client experience provides a helpful and important insight into the internal and external difficulties clients may experience within therapy which the therapists may not even be aware of, which can then inform future outcome studies. Further outlining the importance of focusing on the client experience of therapy, Bergin and Garfield (1994) proposed that it was the client, more so

than the therapist, who implements change process and outlined the importance of the client engaging, utilising and implementing aspects of therapy in order to achieve any meaningful impact.

There have been two recent systematic reviews in the area examining clients' perspectives of their experience with EMDR therapy. The first review published by Whitehouse (2019) included just five papers, with four superordinate themes identified. "EMDR changes a person" consisted of coming to terms with past trauma; cognitive and behavioural changes, which largely focused on ceasing substance misuse given the samples included in the studies; and a core 'transformational' change. In terms of "Necessary conditions for EMDR to effect change", this theme highlighted the importance of clients feeling safe during therapy, having doubts about EMDR overcome, and clients' self-care, attitudes and perceptions as important conditions for change. Interestingly, many clients spoke about the important role of the overall 'treatment facility' and staff for encouraging them to engage and instilling the belief they could recover, thus highlighting that the wider context in which EMDR is provided may impact clients experiences. The remaining two themes focused on the "EMDR method as the agent of change", and the "EMDR therapist as the agent of change", reflecting that clients may differ in their perception of the mechanism of action underlying EMDR therapy. It is of note that all studies included in the systematic review were USA-based studies, and three of five studies conducted were by the same author focusing on clients who completed EMDR in the context of an outpatient addiction treatment programme.

A more recent systematic review published by Shipley and colleagues (2022) expanded on the work conducted by Whitehouse (2019) to also include grey literature. This review included 13 studies, identifying four superordinate themes. The theme "EMDR as intervention" reflected clients' initial scepticism and the importance of early sessions for

clients to become familiar and comfortable with the approach. The theme "Mechanisms of change" consisted of clients recognising their past traumas, getting to the 'core' of the difficulties, experiencing within-session, between session as well as post-therapy changes. Other changes noted included reduced flashbacks and increased insight, though some clients reported feeling low after EMDR sessions and being more symptomatic following the intervention (Naccarato, 2008). "EMDR as transformative" reflected a profound level of change clients experienced due to EMDR. The final theme "Therapist factors" referred the important factors contributing to the formation of a strong therapeutic alliance, including connection, comfort, trust, as well as therapist flexibility and competence.

It was notable that all studies included were based in the USA (nine studies) or the UK (four studies), with no studies carried out within an Irish context. This review, along with the review by Whitehouse (2019) advocated for more qualitative research to be conducted across a range of populations, as well for any negative client experiences of EMDR to be explored and reported.

Rationale and Aims of the Present Study

Thus, there is the relative lack of qualitative research focusing on clients' experiences of EMDR within the literature, with no research in this area previously conducted within an Irish context. This is important to explore given the differences in the organisation of mental health services across countries, as well as the differences in terms of the wider culture. Furthermore, of the 13 studies included in the recent review conducted by Shipley and colleagues (2022), only five studies employed phenomenological methods, with only one of these studies employing Interpretative Phenomenological Analysis (IPA) (Brotherton, 2009). IPA can provide an important and useful insight into clients' unique phenomenological experience of EMDR within session and their meaning-making about this therapeutic approach. Thus, this present study aims to contribute to the literature by employing IPA to

gain an in-depth experiential account of the process of EMDR and explore how clients make sense of their experience with this psychological intervention by interviewing clients attending mental health services within an Irish context.

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Chapter Five: Major Research Project

Clients' experiences of Eye Movement Desensitisation and Reprocessing (EMDR) therapy

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Abstract

This study aimed to explore clients' unique phenomenological experiences of eye movement desensitisation and reprocessing (EMDR) and their meaning-making regarding this therapeutic approach within the context of an adult mental health service. Interpretative Phenomenological Analysis (IPA) was employed to collect and analyse data from six individual interviews with individuals who had completed an EMDR intervention. Three Group Experiential Themes were identified: "Trapped in trauma – self-disorganisation", "Being 'in' the process of processing" and "Moving on – adaptive resolution of trauma". The study provides an in-depth insight into client's experiences of EMDR in terms of the many processes and outcomes. The results are discussed in relation to clinical implications.

Keywords: Eye movement desensitisation and reprocessing (EMDR), clients' experiences, qualitative research, interpretative phenomenological analysis

Introduction

Eye Movement Desensitization and Reprocessing (EMDR) is a psychological therapeutic approach developed in the late 1980's by Francine Shapiro (Shapiro, 1989). EMDR is guided by the Adaptive Information Processing (AIP) model, which was developed by Shapiro to explain the mechanism of action underlying EMDR, proposing that dysfunctionally stored memories are the primary basis of clinical psychopathology not otherwise explained by organic disease (Oren & Solomon, 2012). EMDR thus aims to reprocess traumatic memories to reconsolidate and assimilate them within larger adaptive memory networks (Oren & Solomon, 2012). EMDR follows a standard protocol consisting of eight phases, one of which utilizes the signature component of bilateral sensory input. NICE guidelines recommend EMDR as a treatment of choice for PTSD (NICE, 2019), though its clinical application has expanded to other mental health conditions (Cuijpers, et al., 2020).

EMDR received considerable scepticism from the scientific community when first developed in the late 1980s, and thus its efficacy has been examined in dozens of randomized trials. Several meta-analyses demonstrate EMDR as an effective treatment approach for PTSD, achieving therapeutic effects equivalent to cognitive behavioural therapy (Chen, et al., 2015; Cusack et al., 2016; Ehring et al., 2014; Moreno-Alcázar et al., 2017). However, a recent meta-analysis criticized the poor quality of many studies in the area and thus highlighted the difficulty of drawing definite conclusions, particularly with regards to the efficacy of EMDR for disorders other than PTSD, and its long term efficacy (Cuijpers, et al., 2020). Furthermore, existing research in the area also largely focuses on investigating the mechanism of action underlying EMDR, with many researchers particularly interested in investigating the role of the eye movements within the intervention (Jeffries & Davis, 2013). In comparison, there is relatively little qualitative research focused on the personal experiences of clients who have actually undertaken EMDR.

As indicated by Gordon (2000), clients offer a unique and valuable perspective on what is helpful or unhelpful in therapy and it is important that this type of information is embraced and incorporated into the existing evidence base. It has been proposed that examination of clients' experiences in therapy is fundamentally important in order to advance our understanding of therapeutic processes, which in turn has implications for predicting engagement and outcome in therapy (Elliot, 2008). There are many important client in-session experiences within therapy that are often not typically reported in treatment trials, for example client dissatisfaction or in-session avoidance by the client, which would provide a helpful insight into client experiences and how therapists could work more effectively within session (Elliott, 2008).

A recent systematic review published by Shipley and colleagues (2022), expanded on the previous review published by Whitehouse (2019) to review literature on clients' experiences of EMDR therapy. The review published by Shipley and colleagues (2022) included 13 studies, identifying four superordinate themes. The theme "EMDR as intervention" reflected clients' initial scepticism, ranging from mild hesitation to outright fear, as well as the importance of early sessions in mitigating clients' fears through familiarisation with the approach and creating sense of safety. The theme "Mechanisms of change" consisted of clients recognising their past traumas, getting to the 'core' of the difficulties which was considered a key factor of positive change, experiencing within-session changes which were both positive and negative, and experiencing change between sessions and post-therapy, with some clients experiencing a 'domino effect' of positive changes following sessions. Other changes noted included reduced flashbacks and increased insight, though some clients reported feeling low after EMDR sessions and being more symptomatic following the intervention (Naccarato, 2008). "EMDR as transformative" reflected the profound level of change clients experienced due to EMDR; experiencing a

sense of freedom, a reduction in symptoms, and gaining a new perspective. The final theme "Therapist factors" referred to the important factors contributing to the formation of a strong therapeutic alliance, including connection, comfort, trust, which were considered important factors for a successful outcome. In one study, clients experienced an 'absence' of a therapeutic relationship, suggesting that the relationship may play a less critical role in EMDR than other therapeutic approaches (Edmond et al., 2004). This theme also reflected the importance of the therapist being competent and familiar with EMDR for clients, as well as the therapist being confident enough in order to utilise the protocols in a flexible, client-centred manner.

It was notable that all studies included were based in the USA (nine studies) or the UK (four studies), with no studies carried out within an Irish context which is important to consider given the variability in mental health services across countries. Furthermore, it was also highlighted by Shipley and colleagues (2022) that the included studies represented just 0.53% of the retrieved literature on EMDR (excluding duplicates), highlighting the relative lack of research in this area. This review, along with the review by Whitehouse (2019) advocated for more qualitative research to be conducted across a range of populations, as well for any negative client experiences of EMDR to be explored and reported.

Given the current lack of research on clients' experience of this therapy approach, the present study aims to gain an in-depth experiential account of the process of EMDR and explore how clients make sense of their experience with this psychological intervention, and thereby contribute further to the understanding of EMDR. As previously noted, clients experiences of therapy is an under-researched area that can provide importance insights into the field and inform the literature base as well as clinical practice.

Methods

Design

This qualitative study utilised a cross-sectional semi-structured interview design, employing an IPA approach to explore clients' unique phenomenological experience of EMDR and their meaning-making about this therapeutic approach. IPA was deemed the most appropriate methodology given the aforementioned aims. The three main theoretical underpinnings of IPA are phenomenology, idiography and hermeneutics. Phenomenology is concerned with the participant's subjective, lived experience of the event in question. The idiographic element of IPA means that each particular case is central to IPA research and thus IPA seeks to learn from each participant's unique story through an in-depth individualised analysis. The hermeneutics element of IPA relates to the interpretation of meaning. In IPA, the researcher is engaged in a process of 'double hermeneutics' as they attempt to make sense of how the participants made sense of their experiences (Smith et al., 2022).

Participants

Selection

Participants were recruited by clinical psychologists working in an adult mental health service within one catchment area in Ireland. This study utilised purposeful sampling to recruit clients who were at least 18 years old and had completed EMDR therapy. All clients were identified as suitable for EMDR in that they had underlying negative cognitions which were focused on during therapy, with the majority having experienced trauma (though may not have had a formal diagnosis of PTSD). Clinical psychologists in the service were asked to review their caseload and randomly identify 3-5 clients each who met the inclusion criteria and provide potential participants with an information sheet about the study.

Demographics

Six participants were recruited by three clinical psychologists and comprised four women and two men aged between 27 and 83. IPA typically requires a small sample size due

to its commitment to an idiographic approach. All participants were white Irish citizens who attended adult mental health services. Interview length ranged from 71 to 110 minutes (M = 86). All participants had completed an EMDR intervention with the self-reported approximate number of EMDR sessions completed ranging from 5 – 31. A description of participants is presented in Table 5.1.

Table 5.1

Demographic Details of Participants

Participant pseudonym	Gender	Age	Self-reported clinical presentation	Approx. no. EMDR sessions	Interview data collection method	Interview length (in mins.)
Jane	F	48	PTSD, depression, anxiety, history of psychosis	15	Online interview	110
Susan	F	42	Depression	15	Online interview	75
Luke	M	27	Social anxiety	7	Online interview	71
John	M	52	Depression	25	In-person interview	94
Nora	F	82	Anxiety and panic	5	Phone interview	80
Lorraine	F	45	Functional tremor, anxiety	31	In-person interview	86

Procedure

Recruitment

This research was granted ethical approval from the appropriate local university ethics board. Individuals who met the inclusion criteria were approached by a clinical psychologist known to them and provided with an information sheet providing details on the study to review. Those who were interested in taking part in the study were invited to contact the primary author directly to express interest and provide their informed consent.

Data Collection

The interview guide was developed in accordance with best practice IPA guidelines and the judgement of the third author as a clinical psychologist trained in EMDR (Smith et al., 2022). The interview guide was semi-structured and consisted of 10 questions and

prepared prompts. In accordance with IPA, this guide was used flexibly throughout the interviews to follow the concerns of the participant, as the expert on their experience. Questions were open and expansive to encourage participants to speak at length and in-depth and asked about previous experiences with therapy, personal experience of EMDR, helpful and unhelpful aspects of EMDR, engagement, and outcomes. In the context of COVID-19 and public health guidelines, three interviews were conducted online, two were conducted in-person, and one was conducted via phone interview. Interviews were audio recorded using a digital voice recorder and transcribed verbatim, whereby identifying information was removed and participants were assigned a pseudonym.

Data Analysis

Interviews were analysed using IPA and followed the seven-step guidelines set out by Smith and colleagues (2022). The first step involved each transcript being read and re-read repeatedly to immerse oneself in the data. Secondly, 'exploratory notes' were generated through close and detailed analysis of the semantic content and language use within the text. The third step involved generating 'experiential statements' from analysing the exploratory notes. The fourth step involved searching for connections across experiential statements within each transcript. The fifth step involved looking for clusters across experiential statements and labelling these connections as "Personal Experiential Themes" (PETs). The sixth step involved continuing the aforementioned five steps in analysing each case one by one. The final step involved searching for patterns of convergence and divergence across these PETs to develop a set of "Group Experiential Themes" (GETs) that highlighted the shared and unique features of the experience across the contributing participants.

Quality and Validity

Quality and validity were supported through use of research discussions with authors. The second author conducted a mini-audit as per guidelines from Smith and colleagues

(2022) and thus reviewed and commented on one interview transcript annotated with the first author's initial exploratory notes, experiential statements, and PETs to ensure analysis was conducted in a transparent manner and feedback was discussed and incorporated.

Reflexivity

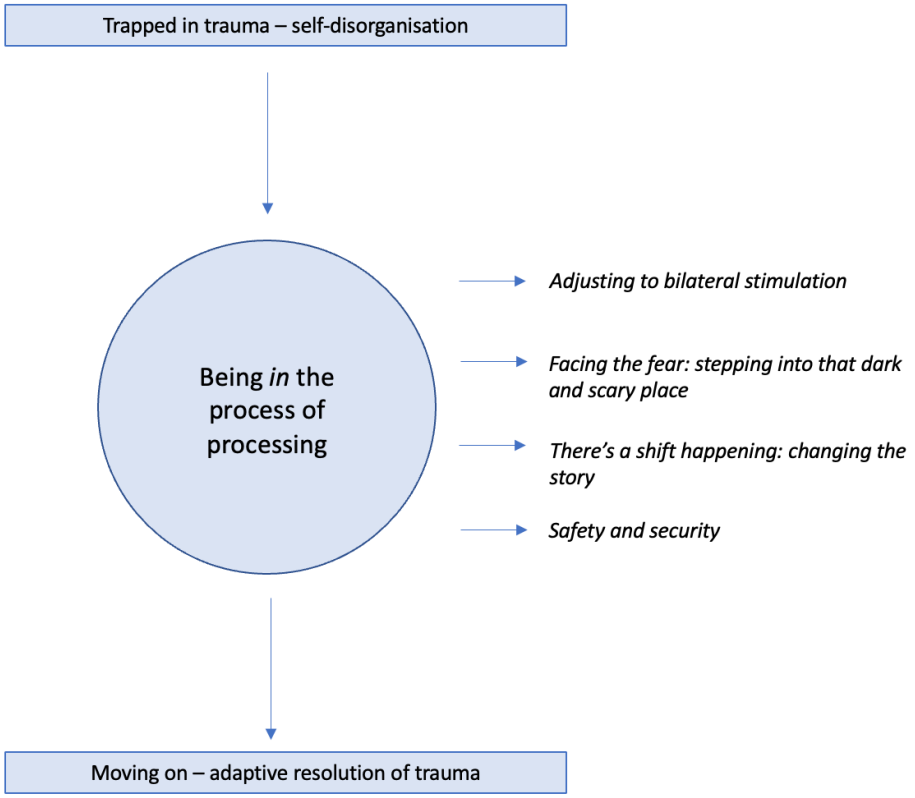
A reflexive journal was kept throughout the research process in order for the primary author to reflect on their own lived experiences and preconceptions, which are a key importance in terms of bracketing in accordance with Husserl's concept of phenomenological inquiry (Smith et al., 2022). The primary author was conducting doctoral training in clinical psychology at the time of this study and had completed a placement in an adult mental health service whereby EMDR was one therapeutic approach offered to suitable clients. Although having no training or direct clinical experience with the approach, the primary author was aware that some clinical psychologists in the area had positive perceptions of the approach. Thus, the primary author had to remain mindful of same during all aspects of the research process and remain open-minded to the participants' own experiences.

Results

Overall, three Group Experiential Themes were identified: "Trapped in trauma – Self-disorganisation", "Being 'in' the Process of Processing", and "Moving on – Adaptive Resolution of Trauma". The middle theme encompassed four subthemes related to various aspects of participants' experiences of the EMDR process. Themes are presented chronologically in Figure 5.1.

Figure 5.1

Chronological Presentation of the Themes



Trapped in Trauma – Self-Disorganisation

This Group Experiential Theme illustrates participants' lived experience prior to EMDR therapy, in terms of clinical symptomatology, a disorganised self, and a sense of desperation. Three participants directly reflected on their experience of being preoccupied by memories of their trauma and their language conveyed a sense of entrapment. "I feel before the EMDR I was kind of stuck in the trauma aspect of it and my brain was still replaying the trauma and it was never ended" (Luke, p.15). Luke's use of the phrase "still replaying" located his trauma memories as an active and perpetual part of his present day life prior to EMDR, and his sense of being "stuck" in this process reflects a sense of loss of agency and a

powerlessness. This was echoed by Jane who further reflected on the impact of the recurrent memories stating: “ugh it just wore me out, it wore me out, it stopped me from living” (Jane, p. 21). Jane’s excerpt indicates a loss of functioning and agency within the world. For two participants, Lorraine and Nora, they described a divergent experience of an avoidant and dissociative presentation in which the psychological pain underlying their difficulties was outside of awareness, with Lorraine noting “I still didn't think one of the main issues was the main issue, you know what I mean, so I was very lost in why I was like that” (Lorraine, p. 73). Here, Lorraine described being “lost” which reflected a sense of a lack of a present self, and her experience of dissociation may be understood in the context of her life and personality, whereby she described herself as someone who would always ‘block out’ and avoid difficulties.

Participants all reflected on the wider impact the trauma experience had in terms of their life and self-organisation, which included affect dysregulation, negative self-concept, and interpersonal difficulties. Luke made sense of his experience with anxiety, expressing “being trapped in that traumatic experience, subconsciously was keeping me heightened constantly” (Luke, p. 74). Luke alludes to his trauma experience being located within his subconscious and having an underlying and ubiquitous influence on his daily functioning, keeping him hypervigilant to threat. This alludes to a fear of a repetition of trauma and a sense of vulnerability within the world.

Similarly, five participants reflected on the negative self-concept they had, including negative beliefs about themselves, self-blame, and feeling worthless:

> “My opinion of myself, it was just- it was awful you know. Ehm, I was abused when I was younger… so I ended up believing that I had done really bad things… I never ever fixed that, I always had that fundamental belief” (John, p. 10-11).

John's excerpt depicts the impact his abuse had in terms of developing negative core beliefs about himself, including self-blame for what had occurred and a felt sense of responsibility for the event. John further puts responsibility on himself, by reflecting that he had never "fixed" that – depicting a broken self. Four participants also reflected on interpersonal difficulties, in terms of isolating themselves from others, blaming others, and disconnection.

Reflecting on these difficulties, participants described different therapeutic interventions they attempted and/or completed, with all participants having prior experience of intervention including CBT, compassion-focused therapy (CFT), dialectical behavioural therapy (DBT) and mindfulness. Participants identified positive aspects of the treatments, though the general consensus was that they had not found a resolution to their trauma, with John describing his completion of both individual and group-based CBT as "interesting" but conveyed that "none of it really stuck, it kind of wore off very, very quickly and I kinda ended up back where I was'' (John, p. 11). This sense of being stuck and struggling to make lasting progress was echoed by a number of participants and provided context to their introduction to EMDR. Many participants recalled reaching a particular 'stage' of hopelessness and/or desperation to find a solution to their difficulties prior to commencing EMDR. This appeared to influence participants approach to EMDR, with all participants in the study going on to subsequently describe a 'willingness' to commence EMDR, with Susan reflecting: "I think I probably got to a point where I'm willing to try anything you see if it will help" (Susan, p. 30). For participants, this willingness appeared to emerge from a sense of desperation to find a solution for their trauma memories, motivation for change, and a trust in their therapist.

Being 'in' the Process of Processing

This Group Experiential Theme describes participants' immersive experience of being 'in' the process of processing during EMDR, touching on various aspects of the process.

Adjusting to Bilateral Stimulation

All participants reflected on their experiences of adjusting to the process of bilateral stimulation and allowing the mind to wander freely. For Luke and Nora, they interpretated the equipment as safe and acceptable.

> **"**I think it wasn't as if someone was putting a helmet on my head… it was just hold two things and look at them and I was like 'right, I can do that!' and I'm not gonna get electrocuted so we'll try it like" (Luke, p. 13)

For Luke who had a history of difficult experiences within a medical context, he perceived the equipment as acceptable and non-threatening due to its perceived non-invasiveness. This was echoed by Nora who assumed she must have observed the equipment before given her acceptance of same and described the process as "completely painless" (Nora, p. 47), also describing it using medicalised language. For Jane, she described initial hesitation: "when she pulled out this, these wires and these flashes I said 'Oh sweet God! What are we doing now!" (Jane, p. 19). Jane's exclamation reflects a shock and sense of anticipation, but her use of the first person plural pronoun locates her and the therapist as a collaborative dynamic which provides a sense of safety and control.

Three participants initially began bilateral stimulation with use of finger movements, with their therapist transitioning to the use of equipment during their intervention. Susan spoke of experiencing this transition as difficult, leading her to disengage from the process in-session:

> "One thing I did notice was that I found it was a lot more effective with the finger movement versus the other… the sound and the vibration sensations they kind of more distracted me and took me out of the process." (Susan, p. 17)

For Susan, she later described the tone as "harsh" and "disturbing" which distracted her from the process. For John, he also described an adjustment period when he commenced with the equipment, initially distracted by the vibrations: "For a while it was kind of a bit off-putting because the buzzing of the thing in your hand is like the phone, so you're kind of going 'phone, phone, phone!'" (John, p. 31). John's description both reflects a familiarity with the sensation and thus an acceptability, as well as a difficulty 'letting go' and relaxing into the process.

For John, he also initially experienced difficulty relinquishing control to allow his mind to wander, instead counting the number of finger movements his therapist completed in a controlled manner. This was also echoed in his description of finding it difficult to accept that there were "no right answers" (John, p. 20) when providing feedback to the therapist, worrying he was conducting the process incorrectly. This can be understood in the context of John's rigid beliefs that there were always correct and incorrect answers, and his tendency to be self-critical. He later described that although it took some time to "settle in" (John, p. 28) to the process, he was able to achieve so. This sentiment was also reflected by Lorraine who experienced difficulties in terms of adjusting to the pace of the horizontal saccadic eye movements: "It was weird now at first [laughs] tryna with the eyes… it's just the speed of the lights you know… I used to be up in a heap now but I just went bit slower… you can adapt it." (Lorraine, p. 14). Lorraine's description reflects her anxiety regarding maintaining the pace of the eye movements and she later attributed the blame to herself, but recounts an ability to adapt same with the assistance of the therapist.

Facing the Fear- Stepping into that Dark and Scary Place

This subtheme uses metaphor to illustrate participants' experience of activating the trauma memories during the desensitization phase of therapy, with Susan describing activating the images as "facing your fear, stepping into that dark and scary place" (Susan p.

21). This evocative statement reflects the immersive experience of this process, a felt sense of directly facing the trauma, and the fear evoked by this process, which was echoed by most participants. In making sense of the fear, Susan indicated EMDR was activating memories she would usually try to avoid. Luke also made sense of his fear stating "I suppose I was always fearful doing it, maybe am I gonna get stuck in this thing now?… is this thing gonna get my brain stuck in it… the brain is powerful" (Luke, p. 55). Luke reflects apprehension and fear in terms of the mechanisms of EMDR which may be interpreted in the context of his hypervigilance to threat, and his reference to the brain as a "powerful" entity indicates a fear of vulnerability and powerlessness in the process. For three participants, they reflected that their initial fear led them to avoid discussing particular traumas until they had gained courage during therapy.

All participants described the multi-sensory nature of activating the trauma, with Jane stating "It was like something was wakening up, wakening in my stomach and it was just gurgling and gurgling and I just, I just couldn't stop it you know" (Jane, p. 13). The metaphor of wakening her trauma within her body illustrates Jane's interpretation of her physical reaction as her trauma being activated from within, which was out of her control. Many described this process as 'overwhelming' in nature as they described many sudden reactions they experienced that felt out of their control.

> "I could always find myself out of nowhere you're just doing it and eh used to get overwhelming of emotions out of nowhere… you're kinda in a trance with it and you're going through it and out of nowhere then it's just eh swell up so eh." (Luke, p. 18)

Luke's repetition of "out of nowhere" captures the suddenness with which he experienced these emotions and also may reflect his discomfort at the lack of control he had in this process. This led Luke to disengage at times: "I just threw the things on the floor and

said 'no I'm not doing it!'… I think the emotion process was too much" (Luke, p. 19). Luke's description of the emotional activation as "too much" can be understood in the context of his personality, as someone "wouldn't be a person to show emotions" (Luke, p. 23) and thus he was experiencing social embarrassment. Luke explained his experience of processing as overriding his typical coping mechanism of repression which he used in everyday life and talk therapy stating: "before I could just supress it… but there was no suppression of this" (Luke, p. 45). Thus, the activation of emotion appeared to evoke shame and override typical defence mechanisms used to suppress emotion.

For Susan, this unlocking of emotions and overriding of her typical defences was experienced in a positive manner. Susan described her experience of EMDR as "less kind of in the intellectual place and gets down more into the emotions" and as someone who usually has difficulties "tuning into emotions" during talk therapy, EMDR was interpreted as more effective (Susan, p. 34). Susan also reflected on the multi-faceted nature of the process, which included "visual things, music, physical sensations", interpreting this as the "whole body is responding to the process" (Susan, p. 16). Susan made sense of her processing experience as EMDR allowing her to "work more with the unconscious side" (Susan, p. 34) compared to traditional talk therapy. All participants recalled feeling that their trauma was being activated at a 'deep' level, and although this posed challenges for some, reliving the trauma was framed by all as a necessary part of the process in order to resolve their trauma.

There's a Shift Happening: Changing the Story

All participants spoke of the extensive range of changes and 'shifts' they noticed during the process of EMDR, both within session and across sessions.

In terms of in-session changes, three participants recalled their experience of reducing the distress evoked by the trauma memory and becoming more physiologically relaxed as the session progressed. This was prominent in Jane's interview who spoke of her chest pain

easing during the session: "the more I went on with the stimulation or whatever it would ease… it would pass, and I could breathe" (Jane, p. 14*)*. Jane's sense of being able to breathe appeared particularly significant to her, repeatedly mentioned throughout her interview, depicting a sense of newfound freedom. This experience increased the acceptability of the approach and motivation to continue with EMDR.

Most participants also recounted experiencing change in terms of the content or their interpretation of their identified memory. This was illustrated by Susan:

> "I suppose after time you'd start to feel some changes, some shifts, where images might start to get more positive, thoughts might start to get more positive, songs would come into my head… starting to change the story in my head" (Susan, p. 27)

Susan describes multi-sensory experience of her memory becoming a more positively experienced event from a visual, cognitive and auditory manner, appearing to change her narrative regarding the experience. This process was further illustrated by John who reported:

> "you'd kind of start off with a really emm, maybe dark or bad thought or experience… but you'd tip away at it until eventually you kind of went 'actually that wasn't my fault you know', this wasn't my fault, and eventu- it took me a while for the roulette wheel to stop on that and say 'this where you are now'' (John, p. 43).

For John who had a history of childhood abuse whereby he held a core belief of being a bad person, he describes gaining new insights and interpretations of the memory, and the impact this had on his sense of self. His use of the word "actually" reflects that sudden emergence of insight, and use of repetition of "wasn't my fault" may reflect the process of having to repeat this new message which is at odds with his longstanding core beliefs to become his new accepted belief. His description also reflects a felt sense of changing his experience of the memory at a deep and core level to almost end up in a new location. Furthermore, John also depicted experiencing a "breakthrough" of positive emotions during

sessions including happiness and pride, which took time to make sense of in the context of his emotional blunting. Thus, this unlocking of emotions and change in cognitions depicted a core shift experienced by John.

All participants reflected on their memorable experience of noticing shifts between and across sessions and how they interpreted this as EMDR 'working'. Luke reflected on a moment of surprise whereby he reflected on the session whilst driving, without becoming dysregulated:

> "When I was thinking about and doing the EMDR I got quite emotional and shut down, but then when I was doing it d'you know driving I was like there's no reaction or emotion coming now like so, what we spoke about the process, it must be working cause I'm driving the car like [laughs]." (Luke, p. 63).

Luke exclaimed this in a humorous manner reflecting his surprise in the moment of realisation that EMDR must be 'working' given his ability to bring up the memory without becoming dysregulated. Like Luke, all participants recalled personal moments of realisation of something internally shifting which was interpreted as EMDR being effective. Lorraine described her experience of resolving her first traumatic memory as a "turning point" (Lorraine, p. 79) in therapy which increased her openness and comfort with the approach. Indeed, this was echoed by many participants who recalled that first successful reprocessing of a memory instilled hope, belief and confidence in the approach. This is in stark contrast to the sense of hopelessness that pervaded the participants prior to EMDR.

Safety and Security

A subtheme which emerged throughout all participants narratives was safety and security during EMDR, particularly with regards to the therapeutic relationship and regulation techniques. Individuals spoke at length about the many positive qualities and attributes the psychologist possessed; including being an attuned presence, making them feel

understood, being a protective support who 'defended' them, and being a safe and secure base. Participants felt the trust within their relationship was a key facilitator to engaging with the process and feeling comfortable sharing their vulnerabilities and emotions in sessions.

Furthermore, participants described the therapist as a secure guide who they felt would observe and monitor them:

> "If you're not able to let yourself go, you won't get the best thing out of it, but the thing you need is to know is when you do let yourself go that you will be safe, that the therapist will keep you safe and that you won't end up in trouble… I knew there was somebody there to keep an eye on me and keep me safe and help me if I needed it." (John, p. 81).

For John, the felt sense the therapist was "keeping an eye" on him reflects the therapist as a secure base which allowed him to explore his trauma memories with the trust that he would be kept safe. All participants discussed the importance of 'letting go' during the processing and attributed this to the trust within the therapeutic relationship.

In addition, participants also discussed the importance of flexibility and choice, in that EMDR felt client-led and provided them with a sense of control. For example, Nora outlined how each session the therapist would give her an option to do EMDR and the decision to do so was in her hands. This was also echoed by other participants who at times took breaks from EMDR due to feeling fatigued from previous sessions or not feeling in correct frame of mind to engage, which Luke described as providing a sense of "ownership" (Luke, p. 38) to the client. Most participants described EMDR as client-focused and that session content was based on what emerged from within them. Luke and John discussed the sense of control they felt within the process.

> "If you look at it the other therapies are therapist-driven, so the therapist kind of holds the reins on the session and directs… but in EMDR it's you that are in charge, the

> therapist is there to support you on your journey but em, but basically you're coming out with the answers, you're coming out with the questions, there's- it's all yourself so it's a way of digging deep" (John, p. 34).

John reflects his sense that EMDR allowed him to be in control of the therapy relative to other approaches he had experienced, with the therapist acting as a supportive guide. His repetitive use of the second person pronoun in reference to the client emphasises his sense of control. This was also echoed by Luke and appeared particularly salient for both due to their reported discomfort with authority. For Luke, he discussed feeling safer in the EMDR process as he could maintain a "high level of focus" (Luke, p. 68) whereby he was permitted to just be "solely focused on two hands", with the therapist taking a more back-seat role guiding him along and maintaining his safety. He contrasted this experience to his experience of talk therapy, whereby he would feel too hypervigilant of his surroundings to fully focus and engage.

A sense of choice and control in the process was also echoed by Jane who spoke of her ability to reconnect with her trauma memories internally without feeling pressure to verbalise her experience:

> "Ok I was re-living these images, but I wasn't having to talk about them… I was experiencing it, I could visualise it and I was, internally I was feeling it but, she [therapist] was, guiding and being supportive you know… I felt no pressure to say anything that I didn't want to say, or do anything". (Jane, p. 16)

The repetitive use of 'I' in Jane's excerpt powerfully depicts her sense of being the focus of the session and the control she had within this space, with the therapist taking a more guiding and supportive role. In terms of the role of the therapist, some participants had a diverging viewpoint such as Nora who perceived the therapist as being the leader within the

session, though this was perceived as being a safe dynamic for her and she still acknowledged having a choice on whether to partake in EMDR and controlling the content of the session.

When discussing safety and security during EMDR, all participants also referred to the use of regulation strategies as being important to their experience, including the safe place, voo breathing technique, stop signal, and use of the pulsars.

Moving on – Adaptive Resolution of Trauma

This final Group Experiential Theme captures the impact participants felt EMDR had on their lives following completion of therapy. All participants stated that although their trauma memories still existed, they had achieved a 'resolution' in terms of the memories no longer evoking distress and having power over their lives.

> "I suppose I've put into a box – it's not gone- I've put into a box the fear that I had from being a child, that's in a box now and it's off to the side, it doesn't influence my decisions or the way I live anymore" (John, p. 104)

John uses metaphor to also describe his sense that his trauma has been 'relocated' to a place whereby it no longer influences his decision making and provides a sense of gained control and personal agency. The resolution of the trauma memory was discussed in terms of the impact on the self and a felt sense of freedom, with Jane stating:

> "It's like a load has been lifted! It's like a freedom, it's that cord has been broken or detached from all that stuff that happened. It's just- it's just gone, its over there and that's where its staying.". (Jane, p. 55)

Jane's evocative account and use of imagery reflects many of the sentiments relayed by all participants in the study. Jane depicts a newfound sense of freedom and detachment from her past, with the use of the imagery of a cord being broken reflecting a detachment of the self from her trauma memories and an emergence as a separate being. Her use of

metaphor of load being lifted also evokes a sense of freedom, which strongly juxtaposes the heavy burden of being trapped within her trauma previously described.

Participants also reflected that the gains achieved had sustained following completion of therapy, with Susan stating "It's been a while since I've had my EMDR and I'm still getting the benefit, that these things aren't coming back and haunting me" (Susan, p. 18). Susan's use of "still" reflects a sense of ongoing and lasting benefits from EMDR. In making sense of the longevity of the gains, John stated: "I suppose yes because the changes were from the inside out whereas with CBT it's from the outside in… but yeah, so they were from the inside out, very different to anything else!" (John, p. 119). John's excerpt reflects a sense of change occurring internally within the self, comparing it to talk therapies whereby he felt the effects had not sustained.

In terms of additional benefits, both Jane, Lorraine and Luke discussed feeling more present and aware, which they felt was a result of no longer being preoccupied by their trauma memories, with Jane stating "I'm not so focused on the past you see- that it's like I'm more aware of what's going on now, you know… what's going on around me and within me." (Jane, p. 70). Jane links her newfound ability to be more aware of her own emotional experiences as well as connect with others as resulting from the resolution of her trauma and preoccupation with the past. This was echoed by Lorraine who described feeling more regulated, clear-headed and aware which she attributed to EMDR removing the "chaos" (Lorraine, p. 93) from her mind.

In terms of additional intrapersonal outcomes, participants spoke of changes in terms of increased self-compassion, improved emotional regulation, reduced guilt and self-blame, becoming more assertive of their needs, changing core beliefs about themselves, and feeling they had developed helpful coping strategies. In terms of interpersonal outcomes, participants spoke about improving their relationships and increased empathy to towards others, with

John stating "I have a lot more empathy now for other people and for their story, whereas I used to be kind of selfish because it was my story and it really wasn't anybody else's story to be told" (John, p. 104). John's statement reflects a newfound ability to empathise with others, no longer trapped in his own trauma narrative. In addition, three participants described developing a more hopeful and optimistic outlook on life with Susan outlining: "I suppose I felt more positive. I can be quite negative and pessimistic so feeling optimistic was a big shift" (Susan, p. 48). Luke attributed his hope and optimism to being comforted by the fact he has found an effective therapeutic approach for him should anything else happen to him in future.

Discussion

This study explored six clients' unique phenomenological experience of EMDR and their meaning making in relation to this therapy. IPA analysis generated three overarching Group Experiential Themes: "Trapped in Trauma – Self-Disorganisation", "Being 'in' the Process of Processing", and "Moving on – Adaptive Resolution of Trauma".

All participants within this study provided a context of their life prior to commencing EMDR, discussing the impact of their trauma memories and adverse life experiences in terms of preoccupation with trauma memories, dissociation, self-disorganisation, and feelings of desperation. Overall, there was a sense of participants feeling 'stuck' in the past, unable to find a resolution to their difficulties and move forward. Indeed, our understanding of trauma today acknowledges the impact adverse life experiences can have in terms of a difficulty with remaining present and grounded, with the individual somewhat trapped in past experiences (Spiers, 2015). All participants in this study had previous experience with psychological interventions, and although they identified positive aspects of these therapies, there was a general consensus that participants felt they had failed to resolve their trauma memories. All participants discussed reaching a state of 'willingness' to commence EMDR. Indeed, client

motivation and willingness has been identified across psychotherapeutic approaches as being predictive of treatment effectiveness (Ryan et al., 2011). Motivation appears to be important not only upon commencement of therapy but throughout the process in order to sustain engagement and overcome obstacles, which appeared to be true for participants in this study (Ryan et al., 2011). Participants made sense of their willingness in context of being desperate to find a solution following their experience of previous therapies, a personal attribute, and trust in their therapist. Thus, it is unclear from this sample whether individuals who had no previous therapy experience would be willing to try EMDR as a first-line treatment.

Participants had mixed experiences with adjusting to the process of bilateral stimulation, with some interpreting the equipment as safe and acceptable, and others finding it difficult to adjust to pace of the eye movements and perceiving the auditory tone as aversive. Clients' personal in-session experience of adjusting to the process of bilateral stimulation appears to be under-researched in the literature and thus this finding provides an interesting and important contribution to the area. Indeed, findings from this study highlight how client preferences may vary in terms of the mode of bilateral stimulation utilised in session, with research in the area of insomnia indicating that clients' preferences are largely determined by acceptability factors rather than efficacy (Sidani et al., 2009). A study conducted by van den Hout and colleagues (2012) found use of auditory tones as an inferior method of bilateral stimulation compared to eye movements, despite the majority of participants reporting a preference for auditory tones, describing the eye movements as tiring and distracting. This area warrants further research, given the importance of acceptability in fostering engagement whilst also considering the effectiveness of the modality. Indeed, according to Lee and colleagues (2006), a positive experience with bilateral stimulation during the first few processing sessions appears to be associated with a favourable outcome

for clients, and thus clients' may require practice with a range of stimulation methods to ensure comfort.

Participants in this study interpreted EMDR as working at a 'deeper' level than talk therapy. This idea was reflected in the systematic review published by Shipley and colleagues (2022), who reported that clients often used analogies to describe how EMDR allowed them to get to the 'core' or 'root' of their difficulties, often citing this as one of the key mechanisms facilitating positive change. Furthermore, in the systematic review conducted by Whitehouse (2019) EMDR was also described as leading to core 'transformational' change in clients, who described it as occurring at a 'cellular' level. In this present study, participants described a wide-range of multi-sensory experiences felt during processing, which they interpreted this as the trauma being activated in its raw form and EMDR working at a deeper level. As opposed to traditional top-down talk therapies such as CBT, EMDR's combination of top-down (cognitive) and bottom-up (affect/body) processing in resolving trauma may reflect participants' sense of working at a deeper level (Soloman & Heide, 2005). This is in line with Shapiro's model of AIP, whereby the various multi-sensory components of the unprocessed memory are believed to behave as dysfunctional, maladaptive information until reconnected and integrated (Shapiro, 2001; van der Kolk, 1994).

Participants felt EMDR had an ability to 'unlock' emotions and uncover core aspects of the trauma memory, which some participants felt was outside of their control. Two participants spoke of their typical defences of intellectualising or supressing emotions being overcome during EMDR. To the best of our knowledge, this finding has not been previously documented in the literature on clients' experiences of EMDR and thus advances our knowledge of how some clients may experience the therapy process. Indeed, dissociation is a core symptom of trauma and considered a potentially protective defence mechanism in which affect is dampened on confrontation of distressing events or upon triggering of related

memories (van der Kolk et al., 1996). These protective strategies are believed to interfere with engagement in psychotherapy, particularly in the context of exposure-based treatments whereby emotional engagement with trauma-related information is considered a key aspect of the process for successful treatment (Foa & Kozak, 1986). Neuroimaging research in the area of PTSD has identified increased activation in the prefrontal cortex in individuals with dissociative symptoms suggesting an inhibition of limbic system and an overmodulation of emotions (Lanius et al., 2010). A study conducted by Herkt and colleagues (2014) investigated the role of bilateral stimulation as a specific element in facilitating access to negative emotional material whilst creating new associative links. The study demonstrated an increase in limbic activation during the processing of negative emotional stimuli, along with decreased activation in the prefrontal regions associated with cognitive control. This study suggests that EMDR may thus facilitate access to emotions which may be particularly useful and salient for clients whom have difficulty overcoming psychological defences.

Participants reflected on their experience of in-session and across session changes, interpreting them as evidence EMDR was 'working'. Participants interpreted these moments of realisation as significant in terms of instilling hope and belief, increasing motivation to engage, and increasing confidence to face memories previously avoided. As discussed by Shapiro (2001), the development of self-belief is a key aspect of recovery. Indeed, she argues that the relative rapidity of progress clients can experience in EMDR, compared to longer term traditional psychoanalytic treatments, can allow clients to develop a sense of hope regarding their ability to heal. Furthermore, the installation of adaptive cognitions throughout the process may allow for ego strengthening and development of positive and adaptive self-beliefs to occur which may also foster hope and engagement (Shapiro, 2001).

Participants all described and made sense of a broad range of outcomes they experienced as a result of engaging in EMDR, which included resolving their trauma

memories. This is consistent to findings reported by Edmond and colleagues (2004) who in a mixed-methods study examined the effectiveness of EMDR and eclectic therapy from the perspective of 38 adult female survivors of sexual abuse. Those who had completed EMDR spoke of achieving a greater 'resolution' of their trauma memories, reporting outcomes ranging from complete cessation of trauma-related distress to major changes in their perception of self. Notably, a sense of resolution was not reported in those who completed eclectic therapy, who instead focused more on the coping strategies they had learned from their therapist.

Participants also reported that resolving traumatic memories led to improvements in terms of chronic long-term associated difficulties; including emotion regulation, self-concept and interpersonal relationships. Indeed, the role of trauma and adverse life experiences as a predisposing, precipitating and perpetuating factor in mental health difficulties is well established, with studies indicating that traumatic stress can increase the severity of mental health disorders (Spitzer et al., 2007). Indeed, as observed by Ehlers and Clarke (2002), traumatic events can develop maladaptive core beliefs in relation to the self, and thus through resolution of same perhaps this leads to generalised improvements in wellbeing. In a study conducted by Guahar (2016) on the efficacy of EMDR for depression, a generalisation effect was found for negative cognitions, with the number and strength of negative cognitive beliefs significantly decreased at posttreatment, even for those not targeted by the intervention. Indeed, the generalisability of EMDR's positive outcomes to untargeted cognitions has been previously documented (Shapiro, 2014). Furthermore, in making sense of this change, many participants in this study spoke of a newfound ability to stay present and move forward in their lives. This is in keeping with van de Kolk's (2014) position that ultimately the key goal of trauma treatment is to assist people to integrate their past into the present so they are able to become more present in their lives and move forward.

It was notable that all participants also highlighted the enduring nature of the gains they had made, noting that although time had passed since completing their intervention, the traumatic memories were still no longer possessing the power they previously had over them. However, it is important to note that exact time since cessation of their intervention had not been captured, though some participants spoke of completing the intervention approximately one to two years prior to the interview. As highlighted by Cuijpers and colleagues (2020), there is a lack of research assessing the long-term impact of EMDR, though a study conducted by Edmond and Rubin (2004) provided preliminary evidence that therapeutic benefits maintained over an 18-month period, though this study had a small sample size. This raises the question regarding the cost-effectiveness of EMDR as an intervention, with recent research in the area finding EDMR to be the most cost-effective intervention for adults with PTSD (Mavranezouli et al., 2020). Though, authors concluded that there is a need for more high quality studies to be conducted in this area, investigating long term costs and effects.

Moreover, it is important to note that participants were careful to clarify that EMDR had not been a panacea in that they still experienced ongoing difficulties with their mental health. Thus, clients may still need to avail of further supports and interventions post-EMDR. Though, in making sense of their remaining difficulties, participants appeared more confident in their ability to manage remaining difficulties with use of coping strategies, some of which included techniques learned during EMDR. Thus, this may be reflective of EMDR's focus on installing adaptive cognitions and enhancing the self, as well as the inclusion of the 'Future Template' component of the treatment, assisting clients in visualising successfully managing future events.

All participants emphasised the significant role of safety and security played in their experience of EMDR, which is consistent with the previous studies conducted in the area (Shipley, 2022; Whitehouse, 2019). Participants reflected on the many positive qualities and

attributes demonstrated in the therapeutic alliance, including attunement, unconditional positive regard, acceptance and empathy, and the role this played in facilitating their ability to engage in EMDR. These qualities are consistent with Roger's (1957) core components of the therapeutic alliance which facilitates therapeutic change. Indeed, the therapeutic alliance has long been recognised as a key factor influencing success in therapy regardless of approach (Flückiger et al., 2018). Although the therapeutic alliance receives less focus in the EMDR literature, EMDR requires a high level of trust and safety in both the therapist and the process order to facilitate clients' engagement in venturing into emotionally charged past traumas memories that are typically avoided and feared (Hase, 2021). In the EMDR literature, there is a significant emphasis on fidelity to protocols and procedures, which is also supported by studies in the area which have found fidelity to the model to be associated with more positive outcomes (Maxfield & Hyer, 2002). However, in her writings, Shapiro (2001) did acknowledge the importance of the therapeutic alliance within EMDR, describing the implementation of EMDR as an interaction between the client, the method, and the clinician, and highlighted the need for the therapist to provide safety, unconditional regard and flexibility. Participants in this study discussed the flexibility and choice offered by therapists provided them with a sense of control and agency which appeared to maintain engagement in therapy and are considered key components of a trauma-informed approach.

Contributions and Clinical Implications

This original empirical paper makes a unique contribution to the literature, being the first study exploring clients' experiences of EMDR in an Irish context and further advancing our understanding of this therapeutic approach utilising an IPA approach. In addition, this study highlighted a number of clinically relevant findings. In terms of bilateral stimulation, participants appeared to require time to adjust to the process and differed in terms of their preferred mode of stimulation. This is a unique finding in the literature and thus highlights a

need to assess client preference in this area. In addition, participants felt EMDR allowed them to work at a 'deeper' level than talk therapy, allowing them to overcome psychological defences and unlock emotions, uncover core beliefs, and access memories outside of awareness. Previous research in the area has indicated that overall clients appear to consistently perceive EMDR as working at a deeper level than alternative approaches (Shipley, 2022; Whitehouse, 2019) and thus this study further supports this idea. However, clients' experience of overcoming their psychological defences during EMDR processing appears to be a unique finding not previously documented in the existing literature and thus adds to our current understanding of the process of EMDR and how clients make sense of this. This experience was both experienced by participants in a positive and fearful manner, further emphasising the need for safety and a strong therapeutic alliance in EMDR which appeared to be a key factor in overcoming any fear and ambivalence. Indeed, the importance of safety factors in supporting clients in the process of EMDR is consistent with previous research in the area (Shipley, 2022; Whitehouse, 2019). Participants varied in terms of their perception of the therapist's role, either interpreting them as a supportive guide in the background, or as the leader in the process. For those who experienced EMDR as more client-led, this appeared to be a significant factor in allowing them to feel in control and have agency and appeared particularly useful for those who had difficulties engaging in more therapist-led treatments. Thus, EMDR may be useful for clients who tend to intellectualise during talk therapy and find it hard to work at an emotional level which further advances our understanding of the approach. Furthermore, participants all felt EMDR allowed them to resolve their trauma memories and achieve a wide-range of additional benefits which appeared to sustain over time.

Limitations

This study employed a purposeful sampling strategy and although participants were homogeneous in relation to the completion of an EMDR intervention, participants differed in terms of number of EMDR sessions completed, length of time since completion, self-reported clinical presentations, age range, and previous therapeutic approaches experienced. These factors may have influenced participants' experiences of EMDR and recall of events in question. All participants spoke of a willingness to engage in EMDR and thus this may be considered a selection bias, with those less willing not represented. In addition, findings only represent experiences from those who had successfully completed the intervention and do not provide insight from those who may have dropped out. Furthermore, due to COVID-19, modes of data collection in this study varied and the use of remote methods of interviewing may have impacted the quality of the data collected. However, the data collected remotely did not appear to differ greatly in terms of length of interview or depth of data collected. According to Smith and colleagues (2022), the use of remote means of interviewing can also be an effective way to remove barriers to engaging in IPA. In this study, the choice of remote interviewing allowed two participants to be included who otherwise would not have been comfortable taking part.

Conclusion

This study provided an important insight into the lived experiences of individuals who have completed an EMDR intervention within an adult mental health setting. This study provided greater awareness into the experiences of clients in relation to bilateral stimulation, the process of desensitisation and re-processing, the experience of changes and shifts, the experience of safety and security, outcomes post-therapy, and how they made sense of these experiences.

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Chapter Six: Major Research Project Extended Methodology

Research Design

Interpretative Phenomenological Analysis (IPA)

Interpretative Phenomenological Analysis (IPA) (Smith et al., 2022) is a qualitative research approach which aims to examine how individuals make sense of their life experiences. IPA is grounded in the principles of phenomenology, idiography and hermeneutics. Phenomenology is the philosophical approach to the study of experience and is concerned about understanding what an experience is *like* for individuals. For Husserl, a major phenomenological philosopher, phenomenological inquiry focuses on what is experienced in the individual's consciousness (Smith et al., 2022). Based on this principle, thoughtful focus and examination on the way in which participants experience the phenomenon of interest is essential to IPA (Finlay, 2011). Husserl argued that in order to achieve this, we need to be able to consciously 'bracket' or 'put to one side' our preconceptions, prior understandings, and biases about the world (Finlay, 2011). However, critiques of Husserl's work argue that the ability to truly bracket pre-conceived knowledge is unattainable (Tuffour, 2017). Furthermore, capturing pure experience is deemed inaccessible given that experience is usually witnessed after the original event has already happened (Smith et al., 2022). Heidegger questioned the possibility of obtaining knowledge outside of an interpretative stance, given that we all exist in a culturally and historically conditioned environment from which we cannot easily bracket (Smith et al., 2022). Thus, based on this premise, IPA also identifies strongly with the principle of hermeneutics.

Hermeneutics is the second major theoretical underpinning of IPA and is the theory of interpretation or meaning (Smith et al., 2022). Analysis in IPA is an interpretative endeavour said to be a joint product of the participant and the analyst (Smith et al., 2022). Indeed,

although the primary aim of IPA is the lived experience of the participant and how they make sense of their experience, the end result of the analysis and interpretation is always based on how the analyst makes sense of how the participant makes sense, and thus this is the double hermeneutic (Smith et al., 2022). Furthermore, IPA involves the researcher navigating between different layers of interpretation, in which the double hermeneutic can also be invoked (Eatough & Smith, 2017). Ricoeur (1970) distinguished between two interpretative positions – the hermeneutic of empathy or affirmation and a hermeneutic of suspicion or questioning. For IPA, Smith and colleagues (2022) suggest that IPA takes a centre-ground position, combining a hermeneutic of empathy and a hermeneutic of 'questioning'. Both stances are employed to encourage the researcher to both adopt an 'insider perspective' and imagine what it is like to stand in the shoes of the participant, whilst also being more questioning of the data, probing for meaning in ways which may be outside of the participant's awareness or for which they are unwilling to share (Eatough & Smith, 2017). It is important to note, the hermeneutic of questioning in context of IPA is based upon what is in the data itself, rather than importation of external theory (Smith et al., 2022). IPA analysis also involves the hermeneutic circle, whereby the researcher works with the data in a dynamic, iterative manner, examining the whole in light of its parts, and the parts in light of the whole, being open to shifting ways of thinking and interpreting the data (Eatough & Smith, 2017).

Idiography is the final major principle underlying the IPA approach and is concerned with the particular (Smith et al., 2022). IPA is committed to understanding how a particular phenomenon is experienced by particular people in a particular context (Smith et al., 2022). This contrasts from the 'nomothetic' approach that is popular within psychology in its aim to make claims and generate laws at a group or population level. Therefore, IPA values smaller homogenous samples, which for some may be considered a limitation of the approach

(Pringle et al., 2011). However, IPA's idiographic approach takes care to pay great attention to each case, analysing it thoroughly before moving on to the next case, thus allowing for a richer depth of analysis than may be possible with a larger sample. At the level of analysis, IPA is also concerned with providing a detailed analysis of the convergence and divergences between the individual's experiences and thus not losing sight of the particulars (Tuffour, 2017).

Rationale for Methodology

In terms of my own epistemological position, I align most with a constructivist position, which ascertains that there is no single "true" account of reality, and instead all knowledge is local, socially constructed and situation dependent (Madill et al., 2000). Thus, the research question was formed on the basis of this position, seeking to understand the subjective experiences of clients who have completed EMDR within their own life context and the personal meanings they attach to this experience.

In terms of choosing a methodological approach for this research project, IPA was deemed the most appropriate approach given that this study was primarily interested in generating in-depth accounts from clients regarding their experience of EMDR and their meaning-making regarding this approach. IPA allowed me to consider the clients' unique phenomenological experience of EMDR, whilst also considering their interpretative processes, as well as the researcher's interpretation (Smith et al., 2022). Compared to reflexive thematic analysis, IPA is more idiographic in nature, allowing an exploration of convergences and divergences across participants (Braun & Clarke, 2021), which was in keeping with this study's aims.

Sampling

In keeping with an IPA approach, a purposeful sampling strategy was employed given the focus of this study was on gaining insight into a particular experience of completing

EMDR therapy. Purposeful sampling is a widely used non-random sampling technique within qualitative research that utilizes a specific criteria or purpose to select a sample who are knowledgeable or have an experience with a particular phenomenon of interest (Cresswell & Plano Clark, 2011). As IPA is an idiographic approach and is committed to gaining a detailed case-by-case analysis of each participant, a small sample size is recommended (Smith et al., 2022). Although no exact number is recommended in terms of sample size, Smith and colleagues (2022) recommend a sample size of between six and ten participants for a doctoral level research study. This study recruited a sample of six participants which allowed for an in-depth analysis of each case to be conducted, as well as a cross-case analysis to assess for similarities and differences across participants.

In terms of sampling, IPA also aims to obtain a fairly homogeneous sample, which can be defined as a sample whereby participants are deemed as similar according to important variables (Pietkiewicz & Smith, 2014). The authors outline that the aim for obtaining a homogeneous sample must be balanced with the practicalities of recruitment and the topic of inquiry. The inclusion criteria for this study included the following: participants must have been 18 years or older, must have completed their EMDR intervention, and must have received the intervention from a clinical psychologist trained in the approach. Participants were recruited from eight clinical psychologists within a region in Ireland who had attended EMDR training and were working towards attaining their full accreditation which required completing EMDR with 25 clients each. At the time, it was estimated that there was a potential sample of approximately 80-100 clients who had been offered EMDR on the clinical psychologists' caseload, however not all clients had fully completed their intervention which thus limited the actual sample meeting criteria for inclusion with the exact number unknown. It was initially considered whether to limit the sample in terms of a specific diagnosis to assist with homogeneity. However, through consultation with the third

author (clinical psychologist trained in EMDR), it was outlined that clinically the decision to offer EMDR to clients was not solely based on a diagnostic label. Therefore, it was decided not to exclude potential participants on this basis. However, all clients would have been similar in that they were offered and deemed suitable for EMDR due to the presence of underlying negative cognitions which are focused on during therapy, with the majority having experienced trauma. Due to the potentially limited pool of participants available, a decision was made to not place any further pre-defined criteria for inclusion in the study in order to maximise recruitment.

Recruitment

Once ethical approval for this research study was obtained from Clinical Psychology Research Ethics Committee (CPREC) University College Cork (UCC) (See Appendix E), the recruitment of potential participants commenced. Recruitment followed a protocol developed by the research team which was guided by ethical principles. The first author sent out a recruitment email to the eight psychologists trained in EMDR explaining the study and asking the psychologists to each approach and invite approximately 3-5 clients from their caseloads who met the inclusion criteria. Psychologists were asked to randomly identify a sample from the eligible participants listed on Microsoft Excel to reduce the potential bias of the psychologist potentially choosing clients who they felt had achieved a successful outcome in EMDR. However, as this process was not conducted by the researcher, there is still a risk that this process was biased. Psychologists provided potential participants with an information sheet (See Appendix F) outlining details of the study and an accompanying consent form (Appendix G) to review. Potential participants were asked to contact the first author directly to express their interest in the study.

Data Collection

Method

In accordance with IPA's aim to obtain a rich, detailed, first-person account of personal experiences, Smith and colleagues (2022) recommend that data collection methods chosen allow for detailed thoughts, feelings and stories to be elicited from the participants, as well as granting them an opportunity to speak freely and at length to develop and reflect on their concerns. Semi-structured, one-to-one interviews were therefore chosen as the most suitable data collection method for this study.

Interview Schedule

A semi-structured interview guide (See Appendix H) was developed by the first author through consultation with the literature and discussions with the research team, which included a clinical psychologist trained in EMDR. The interview guide comprised of 10 open-ended questions on a range of areas including previous experience of therapeutic approaches, the experience of processing memories in-session, the therapeutic relationship, helpful and unhelpful aspects of the therapy, engagement, and changes and/or outcomes. The interview questions served as a guide and thus were used flexibility to allow for any unanticipated areas that emerged to be explored. Prompts were also utilised to further explore participants experiences.

Setting

During the period of initial recruitment and data collection (October 2021) this study did not have approval from UCC to conduct interviews in-person in light of COVID-19 public health measures, and thus remote interviews were only available. Participants who expressed interest at this time were informed of this and two chose to wait to see if in-person interviews would become available. Approval was granted for in-person interviews in November 2021 and thus participants were provided with a choice of their preferred mode of data collection – in-person, online, or by phone. Three participants chose online interviews, two participants chose in-person interviews, and one participant chose a phone interview.

Procedure

Firstly rapport was established with participants through initial phone calls when organising the interviews and at the beginning of the interview. I then spent time discussing the information sheet with participants and obtaining informed consent. I provided background information about myself, explaining my role as a Psychologist in Clinical Training and the development of the research study. I provided participants with an outline of the interview process, encouraging them to speak freely about whatever they felt was most relevant in as much detail as they felt comfortable. As participants would have completed EMDR in the context of difficult memories, participants were reminded that they could break or stop at any time and did not have to answer any questions if they were uncomfortable to do so. Prior to the start of interviews, I collected demographics, which included date of birth, approximate number of EDMR sessions completed, type of bilateral stimulation used, and self-reported clinical presentation. The interviews ranged in duration from 71 to 110 minutes (M = 86). The interviews were audio-recorded using a digital voice recorder and later transcribed verbatim. I also took time after each interview to write in my reflective journal, noting down my experiences of the interview and if I had any particular thoughts, interests or feelings on anything that had been discussed in order to bracket these.

Data Analysis

Data was analysed as per the seven-step process outlined by Smith and colleagues (2022) in an iterative manner.

Step One

At first, I immersed myself in the original data through the reading and re-reading of the transcripts. At this stage, I noted my first impressions and bracketed those upon re-reading of the transcripts, allowing all aspects of the transcript to be provided full attention.

Step Two

At this stage, I engaged in the process of exploratory noting whereby I maintained an open mind when reading through the transcripts and noted anything of interest within the transcript in the column to the right hand side of the page. At this stage, I engaged in detailed line-by-line analysis developing a core set of comments which had a phenomenological focus and thus stayed close to the participant's meaning in terms of important objects of concern for the participant and how they made sense of them. Alongside these comments, I also engaged in more interpretative exploratory notes whereby I attempted to understand the participant's concerns and make sense of them by consideration of their language use, the context of their lived world, and consideration of any relevant concepts which may assist in making sense of their accounts. Indeed, at this level my comments encompassed different layers of interpretation. Descriptive comments stayed close to what the participant explicitly said and highlighted any key concerns, phrases, explanations or objects of note. Linguistic comments explored the specific use of language from the participant to further gain insight into the participant's experience and the meaning they made of the event in question. This included comments on pronoun use, repetition, degree of fluency, tone, laughter, use of pause and silences, imagery and metaphor use. Conceptual comments took an interrogative and interpretative approach and involved 'questioning' the data in terms of possible meanings and noting any key concepts I felt may have been emerging in the data. These questions were preliminary in nature and it was understood at this point that some of these questions may remain unanswered, though some may lead to further analysis and reflections about the data. An example for Participant 1 (Jane) is presented in Appendix I.

Step Three

At this stage, experiential statements were developed and documented in the left hand side margin of the transcript. As per Smith and colleagues (2022), experiential statements involve the analyst making statements that are experiential in nature, relating to the

participant's *experiences* of the phenomenon of interest or their experience of making sense of these events. Experiential statements were constructed through analysis of the exploratory notes previously generated and involved generation of a concise statement which reflected a balance of the participant's original experiences and my analytic interpretations. I developed experiential statements by examining discrete sections of the transcript while simultaneously recalling what I had learned during the analysis of the full transcript, reflecting the *hermeneutic circle* within IPA (Smith et al., 2022). Close attention was also paid to the particulars of the data, particularly when generating experiential statements which may have been focused on an issue that had emerged multiple times within the transcript.

Step Four

This step involved searching for connections across experiential statements within the transcript. At this stage, I began using NVivo to assist with the clustering of experiential statements due to the large volume of data within each of my transcripts, which is provided as an accepted option by Smith and colleagues (2022). This involved uploading the transcripts to Nvivo, adding in each experiential statement and linking them to particular quotes within the text. At this stage, this also gave me another opportunity to review and update my experiential statements as by re-reading the transcripts online further provided me with additional insights and consideration of local parts in terms of the whole, as per the hermeneutic circle. At this stage I searched for patterns in my list of experiential statements by allocating statements to preliminary folders on NVivo. To assist with this process I used the Diagram function on NVivo and used my research journal to draw mind-maps and make notes to assist with the process and overcome any restrictions that working with a two-dimensional space may involve. I was careful to be flexible, open-minded and dynamic in the process and continuously consider a statement's allocation to a folder, ensuring each statement was given equal importance and consideration, and that created subfolders were

open to change and development. In terms of organising the statements, I considered patterns of similarity whereby experiential statements were clustered together based on being highly-related. Statements were also clustered in terms of polarization, whereby conflicting statements were brought together to highlight contradictory aspects of the process. In addition, contextual or narrative organisation of the experiential statements was also incorporated, whereby experiential statements were considered in the context of the particular temporal moments for which they related to. This was relevant in the context of EMDR, whereby participants reflected on key moments across the process. These clusters were used to form the Personal Experiential Themes (PETS).

Step Five

This step involved naming the Personal Experiential Themes (PETS) for the participant and presenting them in a Microsoft Word document. This involved presenting the PET as the highest level of organisation, with a list of subthemes where relevant. The list of experiential statements which formed the PETS and subthemes were listed, with their accompanying quote from the transcript including page number. This provided an evidence trail whereby the quote and associated exploratory notes and experiential statement could be reviewed to provide evidence as to how they were created. See Appendix J for an example, based on Participant 1 (Jane).

Step Six

At this stage, I analysed the remaining five transcripts using the aforementioned steps. In keeping with the idiographic approach in IPA, I ensured each participant's transcript was analysed in its own terms to allow for any unique or personal features to emerge. I attempted as much as possible to bracket ideas that emerged from the first transcript to assist with this process. For each participant, I generated a document presenting their PETS, subthemes, experiential statements and supporting quotes.

Step Seven

The final stage involved the generation of Group Experiential Themes (GETs) through cross-case analysis of the previously developed PETS. This stage is described by Smith and colleagues (2022) as a creative process which involves looking for patterns of similarity and differences across the PETS. At this stage I made sure to not present a 'group norm', and instead ensured participants shared as well as unique experiences were considered, in keeping with an idiographic approach. To assist with this process I drew a diagram presenting each participant's PETs and subthemes on an individual A4 page. I then put the six A4 pages on a large surface area to consider possible convergences and divergences across the PETS. During this process, I also had my original transcripts and individual PET word documents on hand to consult to allow me to refer back to the data to check context and detail and to ensure I was representing it appropriately, holding multiple lenses in mind. I generated GETs based on higher-order concepts evident across participants, whilst making sure to also reflect the unique way this was evidenced in each individual participant's account, considering points of convergence and divergence. GETs were then presented in a table, with relevant subthemes were necessary. Within the table of GETs relevant experiential statements and quotations were included for every participant under the themes and subthemes and the decision was made to defer which quotations would be included until the writing stage, which is outlined as an option by Smith and colleagues (2022) (See Appendix K for a table of GETs). A figure was constructed (See Figure 5.1) to present the GETs in a chronological order, displaying the interconnections.

Ethical Considerations

Ethical Approval

This research was granted ethical approval from the UCC Clinical Psychology Research Ethics Committee (CPREC).

Informed Consent

Informed consent to participate in this study was ensured through provision of an information sheet (Appendix F) which outlined clearly the purpose of the study, what the study would involve, what would happen to the data, and the possible benefits and risks to partaking. Participants' choice to partake was also clearly outlined to ensure that they did not feel obligated to take part and understood that participation would not impact any future treatment. Participants were invited to contact the researcher with any questions or concerns when deliberating whether to partake. Participants were also offered an opportunity to ask questions during the phone call organising the interview, and prior to the interview beginning. Written informed consent was obtained from all participants.

Confidentiality

Participants were fully informed about confidentiality and its limits. They were aware that although quotations would be used for the write up of the research study, all identifying information would be removed from the transcript. To maintain confidentiality and respect participants' right to anonymity, participants were also aware that audio recordings would be transferred onto an encrypted laptop and password protected and then removed from the recording device, before being deleted post-transcription. As a mandated person under the Children First Act, participants were also informed about the limits to confidentiality in that I would be legally required to formally report any disclosures of child abuse and neglect to Tusla, the Child and Family Agency (Department of Children and Youth Affairs, 2017). Furthermore, participants were aware that if I had concerns regarding an immediate risk to themselves or others, I would contact their mental health team or emergency services as appropriate.

Minimising Harm

In terms of minimising the potential for harm by participating in this study, a number of measures were put into place. Firstly, the study and topic of interest was explained to participants from the outset in the information sheet and before the interview commenced. Participants were also informed that they could stop the interview at any time, take a break, refuse to answer questions, or withdraw their participation at any time without providing an explanation. Given that participants were clients of an adult mental health service it was understood that there was a risk that participants could experience psychological distress or could disclose such during the interview process. As a Psychologist in Clinical Training, I have clinical experience providing psychological support to individuals in distress and responding to risk. During the interviews, I monitored participants' emotional states and provided them with an opportunity to debrief with myself about their experience of the study. It was prepared that if a participant did become distressed I would utilise my clinical skills and training to manage same and conduct a risk assessment if warranted. However, no participant left the interview distressed. Participants were also reminded to contact their adult mental health team if they experienced any distress after the interview.

In addition, it was proposed that only including participants who have completed their EMDR intervention reduced the risk of clients feeling obligated to take part in the research to please their current therapist. In addition, it also reduced risk of participants having to discuss memories that they may not have had the opportunity to resolve.

Due to COVID-19, further ethical considerations had to be considered. In terms of in-person interviews, an application (COVID-19 Response Plan – Research at Interface with Society) was submitted and approved by UCC to ensure the necessary COVID-19 guidance measures and safety protocols were in place to conduct in-person interviews in a safe and ethical manner. Measures included completing a COVID-19 symptom screening checklist, conducting interviews in a well ventilated room, wearing face masks, social distancing and

use of a Perspex screen, and use of sanitiser. Participants were informed of the aforementioned measures prior to attending the interview and were aware of their choice to conduct the interview remotely if preferred.

In terms of online interviews, additional concerns had to be considered. For example, for participants who chose to complete remote interviews I advised them to choose a time and place whereby they would feel most comfortable and free to talk without their confidentiality being compromised. Two participants chose to conduct the interview from their home and one chose to conduct the interview from his parked car to ensure confidentiality was maintained.

Validity and Quality

As per recommendation from Smith and colleagues (2022), Levitt and colleagues (2018) criteria for reporting qualitative research provides a helpful outline to advise the write up of qualitative research to allow its validity to be gauged. This criteria informed the write up of the journal article to allow for validity to be established.

The validity and quality of this research study was supported through use of consultation with my research team. The first author attended organised workshops on IPA with the primary academic supervisor (second author) and two peers to discuss IPA as a methodology and to practice data analysis to ensure it was being conducted in accordance with the guidelines. This involved bringing excerpts of transcripts, practicing generating exploratory notes and experiential statements, and obtaining feedback from the group. Furthermore, as per recommendation of Smith and colleagues (2022) and Yin (1989), a mini-audit was conducted by the second author who reviewed one participant's fully analysed transcript, which included exploratory notes, experiential statements, clusters and the development of PETs. The second author was able to then assess the validity of the research, ensuring my data analysis was credible and provide any additional notes they felt were

relevant. Given the interpretative element of IPA, the aim of this audit was not to reach a 'consensus' or uncover the 'truth', but rather to assess to check if the analysis was conducted in a transparent manner.

Furthermore, the guidance of Nizza and colleagues (2021), who outlined four quality indicators of a high quality IPA paper, was also followed in the analysis and write up of this paper. The first quality indicator involves constructing a compelling, unfolding narrative through appropriate use of participant quotations with accompanying analytic interpretation, and attempting to provide a sense of progression throughout the narrative. The second quality indicator involves developing a vigorous experiential and/or existential account and ensuring the author pays attention to participants sense-making regarding events. The third indicator involves a close analytic reading of participant's words to provide interpretation and explore its significance. The final quality indicator involves attending to both convergence and divergence in the data.

Reflexivity

Reflexivity is an integral part of phenomenology and hermeneutic inquiry. Husserl's work on the phenomenological method outlined the importance of being able to bracket one's own pre-conceptions in order to understand the person's lived experience (Smith et al., 2022). Indeed, according to Fook and Gardner (2007), reflexivity is the ability to recognise that ourselves and the context in which we live influence the way in which we research. Indeed, it's important for researchers to reflect on their background, assumptions, values, and beliefs and how they may impact all aspects of the research process, including study design, analysis and write-up (Finlay & Evans 2009). However, Heidegger questioned the possibility of obtaining any knowledge outside of an interpretative stance, given that we all exist in a culturally and historically conditioned environment from which we cannot easily bracket

(Smith et al., 2022). Though, I reflect on some of the steps I undertook in order to practice reflexivity and bracket as best as best as I could within this study.

Throughout this study, I kept a reflexive journal from early in the research process to document my thoughts and feelings throughout the process and utilised supervision as an additional resource to assist in identifying my presuppositions. As a Psychologist in Clinical Training, I have gained experience working in adult mental health services with clients presenting with a range of clinical presentations, and although I had never worked with EMDR directly, I was aware from the outset that I had worked with colleagues who had spoken positively about the intervention. Given that I had also undertook a systematic review on clinicians' views and experiences of EMDR I was also conscious of how this experience had potentially impacted my own curiosities and perceptions, though I still remained curious and open-minded regarding EMDR.

Prior to and during the interviews, I attempted to bracket any perceptions I had and follow the lead of the participants. This involved personal self-reflection during the interview and noting my own thoughts, feelings, urges, and curiosities which allowed me to make a conscious choice in terms of my questioning. This is in keeping with my clinical work whereby I have to be attentive to both myself and the clients, paying attention to my own reactions in order to be aware of transference and countertransference processes emerging. One aspect I found challenging was disentangling the role of researcher from that of psychologist, particular in terms of interviewing participants whom had trauma histories and thus were reflecting on negative experiences from their lives. This is evidence in an excerpt from my reflective journal following my first completed interview:

> "This participant came across as a warm, reflective, yet vulnerable and anxious individual with a significant trauma history and was extremely open in sharing her experiences. Given the topic, I noticed that it was hard to distinguish my role as the

> researcher versus psychologist, feeling an urge to validate her experience, make interpretations, and provide support during moments of difficulty. This was unexpected but an important consideration going forward. I made sure to take time at the end of the interview to have a debrief and provide her with support and time to reflect on the process". (Reflective Journal)

In addition, I used my reflexive journal to reflect on my experience of each interview and any initial reactions to the process, particularly in terms of my own curiosities and feelings about the therapy. This was also reflected in my diary following the first interview:

> "I am noticing my own surprise at level of impact EMDR seemed to have on this person's life. Need to now bracket this off so that it does not impact my interviewing style for other participants. Was surprised by the level of change the participant experienced and her ability to express this. I did feel my curiosity expand about the approach and need to be mindful of being biased regarding its impact." (Reflective Journal)

With each interview elapsing, I also found it even more important to bracket in terms of noticing similarities or differences that were emerging across interviews and noticing any urges to act on these as reflected in my diary after the fourth interview:

> "Obtained another interesting perspective on EMDR. I am now noticing patterns in answers and thus making an effort to bracket these and pay as much attention to new ideas or contrasting ideas which can emerge during the interviews, ensuring to follow the client's lead. Noticing that I have to make more effort with this now that I have completed a few interviews." (Reflective Journal)

Thus, engaging in reflexivity throughout the interviewing process was fundamentally important to allow me to adhere to the IPA principles and allow the participant's own lived experience to emerge.

Reflexivity was also employed during the process of data analysis, reflecting on and bracketing my own thoughts, feelings, beliefs and expectations and how it was impacting the process. During data analysis, and in trying to balance the hermeneutic of empathy and hermeneutic of suspicion, I noticed my anxiety regarding representing the participants' experiences incorrectly which particularly emerged during the initial development of experiential statements, as reflected in my journal:

> "I am finding it difficult to create experiential statements and move beyond the participant's words at times, fuelled by anxiety of being an 'outsider' and thus mis-representing the client's experiences. Feel my own values regarding empowering the client and listening to their voice is influencing this. Hoping I do the data justice." (Reflective Journal)

During this process, I was aware of how my knowledge, experiences, and beliefs regarding psychological concepts and interventions may influence my interpretation of the data and development of themes and thus made sure to engage in active reflection regarding my interpretations, ensuring they were grounded in the data rather than importing external theories. I also reflected on my interactions with, and responses to the data, noticing any biases I may be experiencing in terms of relating to particular participant's experiences for example. Indeed, I noticed in myself a particular affiliation to two particular participants, and thus ensured I reflected on this process in order to bracket this potential influence on data analysis. This was important to ensure all participants' transcripts were provided with same level of attention. Furthermore, as I immersed myself further within the analysis, I also noticed my own beliefs and perceptions of EMDR changing and my curiosity regarding the approach growing even further, and thus had to bracket these to ensure they did not impede on the process. The use of my reflective journal as well as supervision was of great assistance during this process.

Reflexive Statement

This statement aims to offer transparency in terms of my personal reflexive stance. I conducted this research study as a white, Irish, 27 year old female Psychologist in Clinical Training. I have a Bachelor of Science degree in Psychology and a Master's degree in Psychological Science. I conducted this research study for my Doctorate of Clinical Psychology. My original interest in this topic was developed in context of my longstanding interest in mental health and wellbeing from a psychological, trauma-informed perspective.

In context of my position as a Psychologist in Clinical Training, I have worked in Adult Mental Health and thus gained experience working with clients presenting with range of mental health presentations. I have worked clinically with providing intervention for one client with a formal diagnosis of PTSD using a TF-CBT model, though have worked with a range of clients who have experienced adverse life events which have predisposed and perpetuated their difficulties. As a mental health professional, I am aware of my own interest in finding effective and acceptable interventions for individuals with mental health difficulties, and I am particularly interested in trauma-informed approaches. Thus, I was aware of my own curiosities in terms of being a trainee and open to learning new models of intervention to improve client experiences. In addition, my position as a Psychologist in Clinical Training, who has formal training in therapeutic skills and an interest in wellbeing of others, this undoubtedly influenced my experience of the interview process, evoking feelings such as empathy, sadness, and curiosity for the participants which had to be managed and bracketed. I identify as an integrative clinician, with my work integrating a number of psychological paradigms, including psychodynamic, cognitive, behavioural, and humanistic approaches. Thus, I have a pre-existing knowledge of psychological theories which may have impacted my approach to data analysis and my interpretations in terms of the double hermeneutic. In this study, I was also aware of my "outsider" position, in that I had not

received EMDR as an intervention or been a client of the adult mental health service. Thus, I was aware of my position of power in terms of the research process and wondered if participants would either relate to me as a therapist in the interaction, or assume I was knowledgeable on the intervention given my training and thus would share less ideas or experiences. Thus, in interviewing the participants I provided background information on myself and emphasised that they were the expert in this interaction and I was only interested in their personal experience. Furthermore, I noticed in myself a felt sense of responsibility as a researcher to do "justice" to the experiences of the participants I interviewed.

Overall, I feel my clinical training was a strength in terms of data collection and harnessed me with the skills to build a strong rapport with the participants I interviewed, provide a safe and secure space from which they felt comfortable sharing their personal experiences, and ultimately led to the collection of rich data.

Reflections on Conducting Research during COVID-19

As aforementioned, this research study took place in the context of the COVID-19 pandemic which influenced aspects of the research process, particularly data collection. Traditionally, face-to-face interviews are deemed gold standard of qualitative research (Novick, 2008). This is due to the fact it provides a more naturalistic setting compared to other approaches, allowing for researchers to build rapport with participants in context of physical proximity and to analyse and assess participants non-verbal behaviours (Holt, 2010). However, due to legal restrictions and safety measures put into place during COVID-19, remote means of interviewing had to be introduced as an option for this study. As per Smith and colleagues (2022), IPA is a flexible approach which fortunately allows for the use of a range of data collection methods, including online methods. In this study, the choice to conduct the interviews remotely involved consideration of both advantages and

disadvantages. In terms of advantages, remote interviewing allowed for the inclusion of participants who may otherwise have been restricted due to geographically-related time or cost barriers (Self, 2021). In-person interviewing also provided a sense of safety for researcher and participant in context of COVID-19 and allowed medically vulnerable participants to feel more comfortable partaking. In this study, it allowed two participants to take part who otherwise would not have been able to participate due to geographical and health-related reasons. Furthermore, the provision of an option to conduct the interview remotely provided more flexibility to participants regarding the date and time of the interview, which increased accessibility of the study (Self, 2021).

In terms of disadvantages, remote interviewing via online and phone can also have drawbacks in that there can be a potential lack of privacy, distractions, or background noises (Self, 2021). Fortunately, these difficulties did not emerge for interviews conducted online in this study and participants were recommended to schedule the interview at a time and location whereby they would have privacy. In addition technological issues can emerge such as poor signal or poor sound/video quality. To control for this, participants in this study were sent the link to the online interview two days prior to allow them practice joining the meeting. Furthermore, concerns have been expressed in terms of accessibility of technology, or lack of competence and comfort for some people in terms of utilising online modes of communicating. Although in context of COVID-19, online means of communicating have become more commonplace, and thus participants are more likely to have had some experience communicating in this manner (Self, 2021). In this research study, three participants chose to conduct their interview online, reporting comfort with the approach. For one participant, their mode of interviewing changed from online to phone interview due to lack of comfort with the online means. In addition, remote methods of data collection can

also have ethical implications in terms of privacy and confidentiality concerns which were previously outlined.

In terms of the my own reflections, the use of multiple modes of data collections was overall advantageous in increasing accessibility of the study for research participants and providing them with a sense of choice. Overall, the depth in data collected across interviewed did not differ in a noticeable manner, with all types of data collection methods producing detailed and in-depth accounts. Rapport was easily established across all means of data collection, perhaps increased by both my own and the participants' increased familiarity and experience with the use of technology throughout the pandemic. I had also made sure to conduct phone calls with participants prior to the remote interviews in order to assist with the development of rapport and familiarity which appeared effective. As expected, face-to-face interviewing did offer a greater ability to read body language which I found helpful. This was more limited online and impossible during the phone interview. However in the context of social distancing measures and the use of face makes during face-to-face interviewing, this did hamper my ability to read facial expressions during in-person interviews which was an unexpected experience and something that I found more challenging.

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Chapter Seven: Discussion and Conclusion

Summary of Findings

The overall aim of this thesis was to explore client and clinician experiences of EMDR therapy. The mixed-methods systematic review presented in Chapter Two aimed to synthesise research on clinicians views and experiences of EMDR therapy. Fourteen studies were included in this review, generating two over-arching themes and seven subthemes. The first theme outlined the range of factors identified by clinicians as acting as facilitators or barriers to adopting and implementing EMDR. Organisational factors identified included the organisational culture, support from colleagues, provision of funding, and provision of supervision. Clinicians' confidence in the approach was also identified as an important factor, both in terms of their belief in the efficacy and credibility of the approach as well as their own confidence in implementing EMDR into practice. Clinicians' primary theoretical orientation influenced their experience of integrating EMDR, with those who preferred working from an exploratory orientation experiencing greatest difficulty. Furthermore, client-related factors influencing clinicians' experience of implementing EMDR included client suitability, client preferences, and client preparedness. Finally, perceived advantages of EMDR included rapid results and positive outcomes for clients, client empowerment and control in session, and perceiving EMDR as getting to the root of the problem.

The major research project presented in Chapter Five aimed to explore clients' experiences of EMDR therapy. Interpretative Phenomenological Analysis (IPA) was employed to collect and analyse data from six individual semi-structure interviews with individuals who had completed EMDR, identifying three overarching themes. Clients described and made sense of the impact trauma had on their lives before commencing EMDR; in terms of trauma-related clinical symptomatology, having a negative-self-concept, experiencing interpersonal difficulties, and hopelessness. All participants had prior

experience of talk therapies, and there was a general consensus that although they identified positive aspects of these therapies, their trauma had not been resolved. Participants approached EMDR with a willingness, which appeared to emerge from a desperation to identify a solution and/or a strong therapeutic alliance. Participants also reflected on their experience of processing during EMDR, indicated mixed experiences in terms of adjusting to bilateral stimulation. Participants all spoke of the multi-sensory nature of their experience whilst processing trauma memories, with some participants speaking of an unlocking of emotions which felt out of their control. In making sense of their experience, participants all spoke of EMDR allowing them to work at a 'deeper' level than previous talk therapies, which they felt allowed them to get to the 'root' of their difficulties. In addition, participants all spoke of experiencing shifts within and across sessions in terms of their experience of the trauma memories, interpreting these changes as EMDR working and thus increasing hope and motivation. The provision of a safe and secure environment was discussed as an important aspect of the process, which included having a strong, trusting therapeutic alliance, the use of regulation strategies, and having control and flexibility in the process. Furthermore, participants also spoke of their experience post-EMDR, describing their trauma memories as resolved and no longer exerting power over their lives. Resolution of the trauma had also led to a wide-range of additional benefits for participants in terms of both intrapersonal and interpersonal changes.

Limitations

There are several limitations of this thesis that must be considered. In terms of the systematic review, the mixed methods approach allowed findings from a wide range of study designs to be synthesised, thus maximising findings. However, the studies were heterogeneous in nature, which made it more difficult to collate the data and due to the variability across studies a meta-analysis was not deemed possible for the quantitative data.

Furthermore, due to the nature of the literature in the area, clinicians who chose not to train in EMDR or discontinued the approach were underrepresented within the review, though one study reported clinician experiences from a site who chose not to adopt EMDR which made a valuable contribution. Finally, studies were excluded if they were not written in the English language which therefore may have led to publication bias and the exclusion of relevant studies from different cultures.

In terms of the major research project, this study aimed to recruit a homogeneous sample, though participants did differ on number of variables including number of EMDR sessions they completed, length of time since completion of the intervention, self-reported clinical presentations, age, and previous therapeutic approaches experienced. These factors may have influenced experiences of EMDR and recall of the events in question. In addition, findings from this study only represent experiences from those who had successfully completed the intervention and do not provide insight from those who may have decided to drop out of EMDR. Furthermore, the use of remote means of data collection may have impacted the quality of the data collected, though this did not appear to be the case.

Contributions and Clinical Implications

The mixed-methods systematic review makes an original contribution to the literature base, as it is the first known study to synthesise studies investigating the views and experiences of clinicians in relation of EMDR therapy. As clinicians play a particularly important role in whether a treatment approach is adopted and implemented within clinical practice and thus which treatment options are available to clients, this study provided important insights into the range of factors influencing decisions to adopt and/or implement EMDR (Adams et al., 2016).

In terms of clinical implications, this study highlighted the key role the organisational culture has in terms of clinicians' decisions to adopt EMDR. For some clinicians, the organisation appeared sceptical of EMDR as an evidence-based approach reflecting the importance of high quality research on the efficacy of EMDR being disseminated to organisations to ensure clients get access to evidence-based treatments. In addition, it appeared that the availability of effective and supportive supervision and consultation was paramount to clinicians' ability to implement EMDR within their practice. However, it appeared not all clinicians had access to EMDR supervision which raises concerns given that supervision is considered a core component of clinical practice and an important factor influencing adherence to the model, prevention burn out, providing support, and building confidence. Indeed, supervision may be an important factor in ensuring therapist's feel confident in their implementation of EMDR, which is important given that from clients' perspectives in the major research project, clinicians ability to provide a safe, secure and containing presence as well as being perceived as competent enough to utilise EMDR flexibly were considered key factors facilitating clients' engagement in EMDR. Given that many aspects of EMDR are unfamiliar and novel to individuals in comparison to traditional talk therapies, this may raise scepticism from clients if not properly acknowledged and contained, and thus it is important clinicians are in a position to feel confident in order to support clients (Whitehouse, 2019).

Furthermore, as outlined in the systematic review, clinicians reported that a lack of client suitability and readiness was a barrier to implementing EMDR in practice. It is of interest that clinicians highlighted a number of presentations they felt were unsuitable for EMDR, including those who were dissociative, chronically avoidant, had multiple traumas, had psychosis, were self-harming or those with disabilities, which appeared to be based on clinical judgement. Given that EMDR is offered to clients with a range of presentations,

despite only being an evidence-based treatment for PTSD, there is a need for additional high quality research on the efficacy of EMDR for a range of mental health conditions in order to provide clear evidence-based guidance regarding the appropriate use of this therapeutic approach. Furthermore, client preference emerged as an important factor influencing clinicians use of EMDR in practice, which is in keeping with a client-centred approach. It was of interest that in the major research project, all clients were willing to pursue EMDR which appeared to motivate their engagement, reflecting the importance of ensuring client preferences are taken into consideration.

In addition, an interesting finding that emerged was the role primary therapeutic orientation had on clinicians' experiences of implementing EMDR, with clinicians who identified with more exploratory therapeutic approaches experiencing the most difficulty in implementing EMDR. Indeed, clinicians spoke of making adaptions to the protocol which appeared to be influenced by their primary orientation. Given that protocol fidelity has been associated with more positive outcomes (Maxfield & Hyer, 2002), this may raise clinical implications for clients in terms of not receiving evidence-based treatment. Thus, it is perhaps important for both future research as well as EMDR training to focus on further exploring the key aspects of the approach that are important for efficacy, as well as providing space in training and supervision to discuss any difficulties clinicians have with particular aspects of the approach and how to implement EMDR effectively into practice.

In terms of the major research project, this original empirical paper makes a unique contribution to the literature, being the first study exploring clients' experiences of EMDR in an Irish context. Indeed, as previously noted, clients experiences of therapy is an under-researched area that can provide important insights into the field and inform the literature base as well as clinical practice. Indeed, in terms of clinical implications, clients discussed variable experiences in terms of bilateral stimulation, with some clients finding the mode of

stimulation (i.e., auditory tones, flashing lights) aversive or difficult to adjust to, or finding it difficult to allow the mind to wander in a free manner. This reflects the importance of clinicians preparing clients and taking their preferences into consideration in order to enhance their ability to engage effectively. In addition, clients spoke of experiencing an unlocking of emotions during the processing of memories, which appeared to be outside of their control. This aspect of the process appeared to assist clients in accessing emotions, overriding their typical defences. Thus, EMDR may be useful for clients who tend to intellectualise during talk therapy and find it hard to work at an emotional level.

Furthermore, clients identified important safety factors which facilitated their engagement in EMDR, including a strong therapeutic alliance. This finding reflects how although EMDR is a structured protocol-led therapy, clinicians should still ensure a strong therapeutic alliance is built before commencing the intervention with clients. Additionally, EMDR was described as being a more client-led therapy, reducing the need to verbalise their trauma in detail and allowing clients to feel a sense of control and agency. This was a finding also by clinicians in the systematic review, who also felt EMDR empowered clients and provided them with a sense of control, describing this as a unique advantage of EMDR.

In terms of outcomes, clients reported that EMDR had successfully resolved their trauma memories, with effects appearing to sustain over time, which was also echoed by clinicians in the systematic review as a unique advantage of the approach. This suggests EMDR may be a cost-effective intervention, particularly given that both clients and clinicians spoke of additional benefits clients experience post-intervention, including improvements in interpersonal relationships, the relationship with self, hope and optimism, and a reduction in clinical symptomatology.

Conclusion

The aim of this thesis was to explore how clients and clinicians experience EMDR therapy. A systematic review and an original, empirical research study generated important insights into the adoption, implementation and experience of EMDR processing from both the clinician and client perspective – the two key stakeholders within therapy. This thesis highlighted important clinical implications for organisations and professionals working clinically providing EMDR to clients.

References

Adams, Z. W., McCauley, J. L., Back, S. E., Flanagan, J. C., Hanson, R. F., Killeen, T. K., & Danielson, C. K. (2016). Clinician Perspectives on Treating Adolescents with Co-occurring Post-Traumatic Stress Disorder, Substance Use, and Other Problems. *Journal of Child & Adolescent Substance Abuse*, *25*(6), 575–583.

Maxfield, L., & Hyer, L. (2002). The relationship between efficacy and methodology in studies investigating EMDR treatment of PTSD. *Journal of Clinical Psychology*, *58*(1), 23–41. https://doi.org/10.1002/jclp.1127

Whitehouse, J. (2019). What do clients say about their experiences of EMDR in the research literature? A systematic review and thematic synthesis of qualitative research papers. *European Journal of Trauma & Dissociation*, 100104. https://doi.org/10.1016/j.ejtd.2019.03.002

Appendix A

Journal of EMDR Practice and Research Author Guidelines

INSTRUCTIONS FOR AUTHORS The Journal of EMDR Practice and Research is a quarterly, peer-reviewed publication devoted to integrative, state-of-the-art papers about Eye Movement Desensitization and Reprocessing. It is a broadly conceived interdisciplinary journal that stimulates and communicates research and theory about EMDR, and their application to clinical practice. The journal publishes experimental studies; theoretical, review, and methodological articles; case studies; brief reports; and book reviews. Examples of research areas include: randomized clinical trials; treatment outcomes with specific populations; investigation of treatment processes; evaluation of the role of eye movements and bilateral stimulation; and contribution of individual factors and personality variables to treatment outcome and/or process. Articles address theoretical issues and clinical challenges to broaden clinicians' understanding and skills; they discuss such complex issues as: strengths and weaknesses in the literature; impact of ethnicity and culture; and evaluation of client readiness for treatment.

Manuscript Submission
Submit manuscripts, in English, in MS Word format electronically at https://mc.manuscriptcentral.com/emdr. Manuscripts will be acknowledged on receipt. Following preliminary review by the Editors, to ensure compliance with required elements, manuscripts will be peer-reviewed by members of the Editorial Board.

Manuscript Style
The following are guidelines for developing and submitting a manuscript. Manuscripts that do not conform to these guidelines will be returned to the author without review, and with recommendations for changes needed to complete the submission process.

1. Manuscripts must be professionally prepared in accordance with the most recent edition of the Publication Manual of the American Psychological Association.

2. Manuscripts are generally expected to be 20-35 pages in length and double-spaced throughout; however, longer manuscripts may be considered. Brief reports will be 10-15 pages in length. Word count for qualitative research is 10,000 as per correspondence with journal, with tables counted as 300 words.

3. The title page must include authors' names, positions, titles, affiliations, full contact information (address, phone, fax, and e-mail). This information should not be included elsewhere in the manuscript, to ensure blind review.

4. The second page should contain the title of the paper and an abstract of no more than 125 words as well as 3 to 5 key words listed below the abstract. Key words should express the precise content of the manuscript, as they are used for indexing purposes.

5. All articles must contain a comprehensive literature review. For example, a manuscript describing EMDR treatment of a certain disorder would summarize the literature about the nature of that disorder, review research studies that investigated outcomes of other treatments, as well as studies that evaluated EMDR treatment of that disorder.

6. Articles that recommend a clinical approach that differs from EMDR's standard protocol or its foundational Adaptive Information Processing model (Shapiro, 2001) should explain these differences.

7. In order to promote critical thinking and an unbiased approach for the dissemination of ideas, recent advances, and current research, all articles must take an objective, scientific stance, and a respectful tone.

8. It is recommended that Case Studies comply with the following format: (1) Literature review, (2) Introduction of the case, (3) Presenting problems, (4) Client history, (5) Assessment, (6) Case conceptualization, (7) Course of treatment, including assessment of progress and outcome, (8) Discussion of treatment implications, (9) Recommendations, and (10) References.

9. Photos and line art figures should be sent as tiff (300ppi) or eps (800ppi) files.

10.Contributors are responsible for obtaining written permission from copyright owners for illustrations, adaptations, or quotes of more than 300 words.

Types of Articles

The following descriptions summarize the types of articles published by the Journal of EMDR Practice and Research. Authors are encouraged to use this information to assist them in writing their article, and to ensure that their manuscript meets requirements. We recognize that sometimes authors' manuscripts have dual purposes and may fall into more than one category; in such cases, the authors should ensure that their paper meets all requirements for each relevant category. A summary chart can be found on the last page of this document.

Review Articles

Purpose:
• Provides a summary of a specific body of literature with the purpose of integrating and synthesizing the findings

Treatment provided in the study:
• None

Data collected in the study:
• Examines the findings in published material

• A meta-analysis or other statistical analysis could be conducted

Style:

• Organization of the review article is determined by content.

Other Research Studies

Purpose**:**
• Collects information to answer specific questions
• Uses scientific methodology to explore areas such as: Experiences of EMDR clients; Experiences of participants in EMDR trainings; Experiences of EMDR clinicians;

Data collected in the study:
Survey data, qualitative data. Other data (e.g., behavioral, psychometric) may also be collected.
Appropriate statistical analysis should be conducted.

Results:
• Claims for evidence arising must be framed according to standard scientific procedures.

Style:
• The paper should be written up as a research study: (1) Literature review, (2) Method (with subsections on participants, measures, procedure, etc), (3) Results, (4) Discussion, and (5) References.

Some Examples of Other Research Studies:
Dunne, T., & Ferrell, D. (2011). An investigation into clinicians' experiences of integrating EMDR into their clinical practice. Journal of EMDR Practice and Research, 5(4), 177 – 188.

Farrell, D., Dworkin, M., Keenan, P., & Spierings, S. (2010). Using EMDR with survivors of sexual abuse perpetrated by Roman Catholic priests. Journal of EMDR Practice and Research, 4(3), 124-133.

Ricci, R. J., & Clayton, C. A. (2008). Trauma resolution treatment as an adjunct to standard treatment for child molesters: A qualitative study. Journal of EMDR Practice and Research, 2(1), 41-50.

Appendix B

Search Strategy for Each Database

1. **Psychinfo -** ***746 results***

(DE "Eye Movement Desensitization Therapy" OR EMDR OR "eye movement desensitization") AND (DE "Mental Health Personnel" OR DE "Clinical Psychologists" OR DE "Psychotherapists" OR DE "Counselors" OR DE "Clinicians" OR clinician* OR professional* OR practitioner* OR psychologist* OR therapist* OR psychotherapist* OR psychoanalyst* OR counsellor* OR analyst* OR staff OR personnel OR training) AND (DE "Attitudes" OR DE "Experiences (Events)" OR DE "Narratives" OR view* OR opinion* OR perception* OR perspective* OR belie* OR attitude* OR experience* OR qualitative OR viewpoint* OR standpoint* OR encounter* OR reaction* OR use* OR utility OR evaluation* OR account* narrative* OR impression*)

Limiter: English

Years: 1991 – 2021

2. **PUBMED –** ***203 results***

("Eye Movement Desensitization Reprocessing"[Mesh] OR "eye movement desensitization" OR EMDR) AND ("Counselors"[Mesh] OR "Psychotherapists"[Mesh] OR clinician* OR professional* OR practitioner* OR psychologist* OR therapist* OR psychotherapist* OR psychoanalyst* OR counsellor* OR narrative* OR analyst* OR staff OR personnel OR training) AND ("Personal Narratives as Topic"[Mesh] OR "Personal Narrative" [Publication Type] OR "Narration"[Mesh] OR "Attitude of Health Personnel"[Mesh] OR "Attitude" [Mesh] OR view* OR opinion* OR perception* OR perspective* OR belie* OR attitude* OR

experience* OR qualitative OR viewpoint* OR standpoint* OR encounter* OR reaction* OR use* OR utility OR evaluation* OR account* OR narrative* OR impression*)

Limiter: English

1992 – 2021

3. **CINAHL – *123 results***

(MH "Eye Movement Desensitization and Reprogramming" OR EMDR or "eye movement desensitization") AND (MH "Psychotherapists" OR "psychotherapist*" OR MH "Psychologists" OR "psychologist*" OR MH "Counselors" OR counsellor* OR clinician* OR professional* OR practitioner* OR psychologist* OR therapist* OR psychotherapist* OR psychoanalyst* OR analyst* OR personnel OR staff OR training) AND (MH "Psychotherapist Attitudes") OR (MH "Qualitative Studies+") OR (MH "Narratives") OR (MH "Interviews") OR view* OR opinion* OR perception* OR perspective* OR belie* OR attitude* OR experience* OR qualitative OR viewpoint* OR standpoint* OR encounter* OR reaction* OR use* OR utility OR evaluation* OR account* OR narrative* OR impression*

Limiter: English

1994 – 2021

4. **SCOPUS – *379 results***

("Eye Movement Desensitization Therapy" OR EMDR OR "eye movement desensitization") AND (clinician* OR professional* OR practitioner* OR psychologist* OR therapist* OR psychotherapist* OR psychoanalyst* OR counsellor* OR analyst* OR staff OR personnel OR training) AND (view* OR opinion* OR perception* OR perspective* OR belie* OR

attitude* OR experience* OR qualitative OR viewpoint* OR standpoint* OR encounter* OR reaction* OR use* OR utility OR evaluation* OR account* OR narrative* OR impression*)

Limiter: English

1994 – 2021

5. **WEB OF SCIENCE – *329 results***

("Eye Movement Desensitization Therapy" OR EMDR OR "eye movement desensitization") AND (clinician* OR professional* OR practitioner* OR psychologist* OR therapist* OR psychotherapist* OR psychoanalyst* OR counsellor* OR analyst* OR staff OR personnel OR training) AND (view* OR opinion* OR perception* OR perspective* OR belie* OR attitude* OR experience* OR qualitative OR viewpoint* OR standpoint* OR encounter* OR reaction* OR use* OR utility OR evaluation OR account* OR narrative* OR impression*)

Limiter: English

1994 – 2021

6. **EMBASE – *283 results***

('eye movement desensitization and reprocessing'/de OR EMDR OR 'eye movement desensitisation') AND ('psychotherapist'/de OR 'clinician'/de OR 'clinical psychology'/exp OR 'counselor'/exp OR 'mental health care personnel'/de OR clinician* OR professional* OR practitioner* OR psychologist* OR therapist OR psychotherapist OR psychoanalyst OR counsellor* OR analyst* OR staff OR personnel OR training) AND ('experience'/de OR 'health personnel attitude'/de OR 'attitude'/de OR 'belief'/de OR 'qualitative'/de OR 'reaction'/de OR view* OR opinion* OR perception* OR perspective* OR belie* OR

attitude* OR experience* OR qualitative OR viewpoint* OR standpoint* OR encounter* OR reaction* OR use* OR utility OR evaluation* OR account* OR narrative* OR impression*)

Limiter:

1994 – 2021

7. **Applied Social Science Index – *472 results***

(EMDR OR "eye movement desensitization") AND (clinician* OR professional* OR practitioner* OR psychologist* OR therapist* OR psychotherapist* OR psychoanalyst* OR counsellor* OR analyst* OR staff OR personnel OR worker) AND (view* OR opinion* OR perception* OR perspective* OR belie* OR attitude* OR experience* OR qualitative OR viewpoint* OR standpoint* OR encounter* OR reaction* OR use OR utility OR evaluation* OR account* OR narrative* OR impression*)

Limiter: English

1993 – 2021

Proquest – *3990 results*

("Eye Movement Desensitization Therapy" OR EMDR OR "eye movement desensitization") AND (clinician* OR professional* OR practitioner* OR psychologist* OR therapist* OR psychotherapist* OR psychoanalyst* OR counsellor* OR analyst* OR staff OR personnel OR training) AND (view* OR opinion* OR perception* OR perspective* OR belie* OR attitude* OR experience* OR qualitative OR viewpoint* OR standpoint* OR encounter* OR reaction* OR use* OR utility OR evaluation* OR account* OR narrative* OR impression*)

Limiter: English

Appendix C

Systematic Review Inclusion and Exclusion Criteria

Table 1. Eligibility criteria for studies in the systematic review

Inclusion Criteria	Exclusion Criteria
Participants: Mental health clinicians eligible/using EMDR. **Study type:** Qualitative studies, mixed-methods studies or quantitative studies that report on clinicians' views or experiences of EMDR. **Outcomes:** Studies that focus on clinicians' personal views and/or experiences of EMDR in terms of the training and/or delivery of the approach (traditional protocol only). Studies must exclusively focus on EMDR only. **Country:** Any **Language:** English	**Participants:** Non mental-health clinicians eligible/using EMDR (e.g., clients). **Study type**: Case studies, clinical reports, editorials, opinion pieces, books, reviews, papers not reporting primary research findings. **Outcomes:** Studies whereby clinicians' views and experiences of EMDR are not represented, or are not analysed separately within mixed sample studies. Studies reporting on their experience of a specifically adapted form of EMDR (e.g.., where EMDR has been integrated with another specific therapy intervention to form a new adapted intervention, or where EMDR has been applied in an adapted format such as via group/online). Studies that use 'EMDR clinicians' as a sampling strategy but are investigating another phenomenon of interest that is the focus of the paper. Or where 'EMDR clinicians' are used as a sample but asked about their experience of EMDR only from a 'client perspective' during the training role-plays. Studies whereby clinicians outline/describe how EMDR was applied to a client without reflecting on their own views and/or experience of this process (i.e., a client case study). Mixed outcome studies whereby clinicians are reflecting on their experience of both EMDR and other therapeutic approaches within the same survey/interview and results are mixed. **Country:** None excluded **Language:** Non-English language studies

Appendix D

Quality Control Table using MMAT

Qualitative studies

Author and publication year			Evaluation items				
	S1	**S2**	**1**	**2**	**3**	**4**	**5**
Hasandedic-Dapo (2021)	Y	Y	Y	Y	Y	Y	Y
Phillips et al. (2021)	Y	Y	Y	Y	Y	Y	Y
Cook et al. (2009)	Y	Y	Y	Y	Y	Y	Y
Jones-Smith (2018)	Y	Y	Y	Y	Y	Y	Y
Brendler (2017)	Y	Y	Y	Y	Y	Y	Y
DiGorgio et al. (2004)	Y	Y	Y	Y	Y	N	Y
DiNardo & Marotta-Walters (2019)	Y	Y	Y	Y	Y	Y	Y

Screening questions:
S1: Clear research questions
S2: Relevant data to answer research question

Evaluation:
1. Is the qualitative approach appropriate to answer the research question?
2. Are the qualitative data collection methods adequate to address the research questions?
3. Are the findings adequately derived from the data?
4. Is the interpretation of results sufficiently substantiated by data?
5. Is there coherence between qualitative data sources, collection, analysis and interpretation?

Quantitative studies

Author and publication year			Evaluation items				
	S1	**S2**	**1**	**2**	**3**	**4**	**5**
Edmond et al. (2016)	Y	Y	Y	CT	Y	Y	Y
Grimmett & Galvin (2013)	Y	Y	Y	Y	CT	CT	Y

Screening questions:
S1: Clear research questions
S2: Relevant data to answer research question
4.1. Is the sampling strategy relevant to address the research question?
4.2. Is the sample representative of the target population?
4.3. Are the measurements appropriate?
4.4. Is the risk of nonresponse bias low?
4.5. Is the statistical analysis appropriate to answer the research question?

Mixed methods studies

Author and publication year			Evaluation items														
	S1	**S2**	**1.1**	**1.2**	**1.3**	**1.4**	**1.5**	**4.1**	**4.2**	**4.3**	**4.4**	**4.5**	**5.1**	**5.2**	**5.3**	**5.4**	**5.5**
Dunne & Farrell (2011)	Y	Y	Y	Y	Y	Y	Y	Y	CT	Y	CT	Y	Y	Y	Y	Y	Y
Farrell & Keenan (2013)	Y	Y	Y	Y	CT	N	N	Y	Y	CT	CT	Y	CT	Y	Y	Y	CT
Farrell et al. (2013)	Y	Y	Y	N	Y	Y	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Hasanovic et al. (2021)	Y	Y	CT	Y	CT	Y	Y	Y	CT	CT	CT	Y	N	Y	Y	Y	CT
Voung (2018)	N	N	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

S1: Clear research questions
S2: Relevant data to answer research question
1.1. Is the qualitative approach appropriate to answer the research question?
1.2. Are the qualitative data collection methods adequate to address the research questions?
1.3. Are the findings adequately derived from the data?
1.4. Is the interpretation of results sufficiently substantiated by data?
1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?
4.1. Is the sampling strategy relevant to address the research question?
4.2. Is the sample representative of the target population?
4.3. Are the measurements appropriate?
4.4. Is the risk of nonresponse bias low?
4.5. Is the statistical analysis appropriate to answer the research question?
5.1. Is there an adequate rationale for using mixed methods design to address the research question?
5.2. Are the different components of the study effectively integrated to answer the research question?
5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?
5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?
5.5. Do the different components of the study adhere to the quality criteria of each tradition

Appendix E

Ethical Approval for Research Study

UCC
University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

Coláiste na nEalaíon, an Léinn Cheiltigh agus na nEolaíochtaí Sóisialta
College of Arts, Celtic Studies and Social Sciences

Scoil an Síceolaíochta Feidhmí
School of Applied Psychology

University College Cork,
Cork, Ireland.

T +353 (0)21 490 4551 / 4552
E infoapsych@ucc.ie
http://www.ucc.ie/en/apsych/

25th January 2021

Clinical Psychology Research and Ethics

Dear Michaela,

Client Experience of Eye Movement Desensitisation and Reprocessing (EMDR)

Michaela Hammond

Thank you for your ethics application and subsequent changes. Your application has been approved by the Clinical Psychology Research and Ethics Committee and you have full ethical approval for the above named project.

Yours sincerely,

Dr Mike Murphy
Chair Clinical Psychology Research and Ethics Panel

Dr Carol Linehan
Head of School of Applied Psychology

Ollscoil na hÉireann, Corcaigh
National University of Ireland, Cork

Appendix F

Information Sheet

Information Sheet

Client Experiences of Eye Movement Desensitization and Reprocessing (EMDR)

We would like to invite you to take part in a research study. The primary researcher for this project is Michaela Hammond, a Psychologist in Clinical Training, currently completing a doctorate degree in UCC. This project is being supervised by both Dr. Christian Ryan (UCC) and Dr. Aoife Dwyer (HSE). Before you decide whether you would like to participate, it is important you understand what the research project involves, why it is being carried out, and what will be involved if you take part. This page will explain the study to you and will help you decide if you want to participate in the research or not. Take time to read through the information.

What is the research about?
The research is to learn more about the client's experience of undergoing Eye Movement Desensitization and Reprocessing (EMDR) therapy. Clients offer a unique and valuable insight into what is helpful or unhelpful within therapy which is very important for us to understand to improve therapeutic interventions.

Why am I being asked to take part in this research study?
You have been invited to take part in this research study as you have previously completed EMDR therapy with a clinical psychologist. We are therefore interested in hearing about your views and personal experience of EMDR therapy.

Do I have to take part?
Participation in this study is completely voluntary. You do not have to participate if you do not want to – it is completely your choice. You can also change your mind about taking part in the study any time you like. Even if the study has started, you can still ask to stop and withdraw, and you do not have to give us a reason. You can also refuse to answer questions during the study. You can withdraw your data from the study at any stage up until the interview finishes. Your decision to participate or not will have no impact on the current or future health care service you receive.

What will I be required to do if I participate?
Should you choose to participate, please contact the researcher Michaela Hammond (contact details below) to express your interest in the study and complete the consent form. The researcher will then contact you to answer any more questions that you have about the study and to arrange an appointment to take part in an interview with the researcher. Due to COVID-19 restrictions, the interview will take place online using the platform Microsoft Teams or via a phone call if you do not have access to a laptop/computer. At the interview, you will first be invited to provide some demographic information and the researcher will then ask you some questions about your personal experience of completing EMDR therapy,

including what you may have found helpful or unhelpful. It is estimated that the interview will take approximately 60 minutes to complete.

What will happen to the data collected in this study?
The information you provide will be kept confidential and anonymous and will be available only to the research team – Michaela Hammond, Dr. Christian Ryan and Dr. Aoife Dwyer. The only exception is where information is disclosed which indicates that there is a serious risk to you or to others. Once the interview is completed, the audio-recording will immediately be transferred to an encrypted laptop and wiped from the recording device. The interview will then be transcribed by the researcher, and all identifying information will be removed. Once this is done, the audio-recording will also be deleted and only the anonymized transcript will remain. This will be stored on the University College Cork OneDrive system (a computer storage system whereby UCC students can securely save and share files) and subsequently on the UCC computer system. The data will be stored for ten years. The information you provide will contribute to a doctoral thesis submitted by Michaela Hammond and may also contribute to research publications and/or conference presentations.

Are there any possible benefits of taking part?
There are no personal advantages of taking part in this study. However, your involvement will help us to gain a greater understanding of EMDR and how clients experience this therapy intervention. This is important to help us gain a better understanding as to what may be helpful or unhelpful in therapy, and how clients make sense of their experiences.

What are the risks of participating in this study?
This study is interested in exploring the experience and process of EMDR as a type of therapy, and the interview will not be focusing on the trauma you may have experienced itself. Therefore, it is not envisaged that you will experience any distress by taking part in this study. However, we acknowledge that your EMDR therapy will have been related to a potentially sensitive area for you, and thus you are under no obligation to take part in this study or answer any question you do not want to answer. You may also stop and withdraw from the interview at any stage. At the end of the interview, I will discuss with you how you found the experience and how you are feeling. Should you experience distress arising from the interview, you will be signposted to relevant supports.

This study has obtained ethical approval from the UCC School of Applied Psychology Ethics Committee.If you have a concern about how we have handled your personal data, you are entitled to this raise this with the Data Protection Commission.
https://www.dataprotection.ie/

How to take part in this study:

If you would like to take part in this study and/or have any queries about this research, you can contact me the primary researcher Michaela Hammond by sending an email to 119224823@umail.ucc.ie or phoning/messaging me on **086 024 1293.** Alternately, you may contact the primary supervisor, Dr. Christian Ryan (UCC) at christian.ryan@ucc.ie. I would be grateful if you could express your interest within the next two weeks if possible. If you agree to take part in this study, please also read and sign the consent form overleaf.

Thank you for taking the time to read this information sheet and consider participating in this research study!

Appendix G

Consent Form

ucc
Coláiste na hOllscoile Corcaigh, Éire
University College Cork, Ireland

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

I…… agree to participate in Michaela Hammond's research study, *Client Experiences of Eye Movement and Desensitisation and Reprocessing (EMDR).*

The purpose and nature of the study has been explained to me in writing.

I am participating voluntarily.

I give permission for my interview with Michaela Hammond to be audio-recorded.

I understand that I can withdraw from the study, without repercussions, at any time, whether before it starts or while I am participating.

I understand that I can withdraw permission to use the data within two weeks of the interview, in which case the material will be deleted.

I understand that anonymity will be ensured in the write-up by disguising my identity.

I understand that disguised extracts from my interview may be quoted in the thesis and any subsequent publications if I give permission below:

(Please tick one box:)	Yes	No
I agree to quotation/publication of anonymous extracts from my interview	☐	☐

Signed: …… Date: ……..

PRINT NAME: ……

Appendix H

Interview Guide

Client experiences of EMDR
Interview Guide

Introduction/Rapport building

Rough Guidelines:

- Welcome participant. Thank participants for their interest in the research study and taking the time to participate.

- Ask them how they are feeling about the research. Normalise any nerves/apprehension. Ask participants if they have any questions or concerns about the research/information sheet/consent form.

- Explain that I just want to hear their story and am interested in them and their experiences. Explain that there are no right or wrong answers. Explain that I will have a number of questions I will ask but they are encouraged to discuss whatever they feel is most relevant to them in as much detail as they feel comfortable.

- Describe the interview as like a one-sided conversation. Explain to them that I will say very little as I want to hear about their experience; and some of my questions may seem obvious at times but this is because I want to understand how they understand things.

- Reassure participants that they can take as much time as they want in thinking about the questions and in responding. Normalise silence and taking time to gather thoughts.

- Remind them that I am aware that speaking about their experience of therapy may elicit memories of their difficulties and if they want a break or to stop at any time due to feeling overwhelmed or fatigued, not to hesitate to state this as previously discussed. Remind them that they also don't have to answer any questions which they would not be comfortable to do so.

- Remind them I will be audio-recording for my own record, so that I don't miss anything that they say, and this also frees me up to listen to them rather than be distracted taking notes.

- Remind them once more of the limits of confidentiality.

- Ensure a sense of rapport is established and ask do they have any questions before we begin? Do they understand what I have said so far? Are they comfortable and ready to begin?

B. Demographics

Participant number:

Age: Gender:

Clinical presentation:

Approximate number of EMDR sessions attended:

Type bilateral stimulation used in session:

C. Semi-structured Interview Schedule

1. Could you start by telling me about any previous experiences you may have had with therapy before EMDR?
Prompts Could you describe what therapy approach you received? How did you find it*?*

2. Could you describe how you came to receive EMDR?
Prompts: Referral – what brought them to be referred to psychology; what circumstances led them to attending services and engaging in EDMR; where they any other options offered?

2. Can you tell me about what your expectations were about EMDR before you started?
Prompts: What did you know about the therapy beforehand? What was your initial reaction on hearing about/seeing the pulsars and bilateral stimulation process?

3. In your own words, can you describe your personal experience of EMDR?

4. When you think about the experience of EMDR are there any significant elements of the process that stand out for you?
Prompts:

5. Can you describe your experience of working on your chosen memory during therapy and the techniques used to do so?
Prompts: What was it like to choose and work through the memory?; what was your experience of the SUDs, positive image, VOC etc.; What was your experience of the bilateral stimulation and equipment used?

6. Can you describe your experience of the therapeutic relationship during EMDR?
Prompts: What role, if any, did they play in your experience? Was it different at different stages of therapy? Did it differ compared to what you expected? Did it differ compared to previous therapies you completed?

7. What were the most helpful aspects of EMDR in your experience?
Prompts: What parts of your experience did you like or find beneficial (if any)?

8. What were the most unhelpful aspects of EMDR in your experience?
Prompts: What aspects did you not like/find hard? What aspects of the therapy would you change?

9. Can you describe what influenced your level of engagement in the therapy?
Prompt: What factors kept you attending and engaged/ what factors made you disengage? Did you level of engagement change over the process? Engagement in therapy vs other aspects of service you receive?

10. Can you describe any changes, if any, you experienced by engaging in EMDR?
Prompts: Physical, emotional, cognitive/thoughts, relationship with self; what did changes mean to you?; rate of change (in stages/gradual/sudden?); expectation versus reality; what do you feel had the greatest impact on change?

General Prompts and Probes for all Questions:
Can you tell me a bit more about that?
What do you mean by [phrase/word]?
What is that like?
How do you feel about that?/ How does that make you feel?
This might sound like a silly question, but why [e.g., is it helpful, hopeful, difficult etc.]?
Can you give me an example?

D. Closing Interview Segment

- When the interview is reaching a natural end, ask participants is there anything I haven't asked or that we haven't discussed which they feel is important to their experience.
- Gather and clarify any background information which was not naturally accumulated during the course of the interview or the initial information meeting. Ensure I have key descriptive information.

E. Interview Debriefing

- How did they find the interview experience?
- Check in how they are feeling.
- Check if they have any questions or comments.
- Thank them for their participation.