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How Eye Movement Desensitization and Reprocessing (EMDR) Trained Therapists Stabilize Clients Prior to Reprocessing with EMDR Therapy

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STABILIZE CLIENTS PRIOR TO REPROCESSING WITH

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HOW EYE MOVEMENT DESENSITIZATION AND

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This dissertation, by Edward H. Brendler, has
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ABSTRACT

HOW EYE MOVEMENT DESENSITIZATION AND

REPROCESSING (EMDR) TRAINED THERAPISTS STABILIZE

CLIENTS PRIOR TO REPROCESSING WITH EMDR THERAPY

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Helping clients develop resources and stability required to tolerate reprocessing memories can be a considerable part of psychotherapy, particularly with clients who are suffering symptoms related to complex developmental trauma or cumulative multiple-event trauma. There is a paucity of research regarding how experienced EMDR Therapy practitioners experience helping their clients to develop resources required to tolerate reprocessing of trauma memories. This dissertation is an in-depth study of five participants, each a licensed mental health practitioner in the State of Washington, who are trained in EMDR and experienced working with clients who are suffering symptoms of trauma. Each participant was interviewed and the interviews were analyzed using Interpretive Phenomenal Analysis. Four primary themes were identified: Therapist Experience, Trauma Conceptualization, Stabilization, and All these Tools. Each participant described their experience in the context of their own motivators, their own conceptualization of what their clients were experiencing, and their understandings of what worked in helping their clients to stabilize throughout the process of therapy. Participants acknowledged the significant role that EMDR Therapy training had in shaping both their understanding and treatment of trauma. They also described the complexity of working with traumatized clients and the importance of common factors, such as relationship, trust, and safety

in their work. This dissertation is available in open access at AURA, http://aura.antioch.edu/ and Ohio Link ETD Center, https://etd.ohiolink.edu/etd.

Keywords: Eye Movement Desensitization and Reprocessing, EMDR, Interpretive Phenomenological Analysis, AIP, Trauma, Complex Trauma, Treatment

Dedication

This dissertation is dedicated to my participants, whose own devotion to and enthusiasm for their therapy practices was informing and inspirational. Your generosity in sharing your time and knowledge left me feeling proud to be a colleague. The breadth of your knowledge and the honesty with which you described details of your own practice has inspired and enhanced my own understandings and practice. You've certainly left me with something to pay forward. Thank you!

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I am also grateful to Katy Murray, who has provided over seven years of EMDR support as the consultant for multiple consulting groups in which I have participated, and to the colleagues in my consulting groups. You have all inspired and informed me, and have frequently humored me as I ventured down various theoretical rabbit-holes.

Dr. Kathleen O'Shaunessey, you have been one of the best coaches and cheerleaders through the roughest parts of this process. Thank you for all of your help, good questions, and good cheer. And, thank you for reminding me why I'm doing this.

Similarly, I want to thank my colleagues at the Student Wellness Services at The Evergreen State College for your support as clinicians and as friends. I have always been inspired and supported by your dedication to our clients and interns and by your willingness to have my back when things got challenging.

Thanks to my Oly Peeps (you know who you are). Without our friendships, conversations, and co-support throughout the years, I would never have completed this venture.

And, finally, thanks to my family and friends, many of whom wonder, "What the heck happened to Ed?" I'll be coming back into the world now. To my sister, Sarah, thank you for some very critical help when it was most needed. And to very best friends, Margo, Robin, and Anne, all of whom have been key to my progress through life, as well as this most recent piece of the pie, I not only say, "Thank you!" but also, "You can exhale now!"

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Introduction

Trauma, whether a single event, or repeated and pervasive experience, is a major contributor to mental illness (Gradus, 2014; Sareen et al., 2013; van der Kolk & Najavits, 2013). Therapists and physicians today, who work with clients experiencing symptoms related to trauma, continue to define and make sense of the effects of trauma on mental health. And research continues to identify the additional impacts of pre-traumatic vulnerabilities, both organic and experiential, on the experience of trauma and the sequelae of the initial traumatic event(s) (van der Kolk & Najavits, 2013).

Our many interpretations of mental health, mental illness, and trauma are deeply embedded in our culture and tied to the economics of psychopharmacology, medicine, insurance, and military readiness (Cushman, 1995; Russell, 2008; van der Kolk & Najavits, 2013). The very structures that compose the current constellation of trauma related disorders as defined by the DSM-5 remain in flux (Cloitre et al., 2009; Cook et al., 2005; D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012; Ford et al., 2013; Nijenhuis & van der Hart, 2011; van der Kolk, 2005; van der Kolk & Najavits, 2013; van der Kolk et al., 2009; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). As such, continuing to refine our understanding and treatment of clients with variations of trauma related disorders is important.

Phase-Oriented Consensus Model of Trauma Treatment

In 1886, Pierre Janet documented treatment of traumatized patients, in which he identified three phases of treatment, stabilization, treatment of the traumatic memory, and development of new, post-trauma, skills (Janet, 1907; van der Hart, Brown, & van der Kolk, 1989). In the treatment of trauma today, most empirically supported strategies are structured in phases similar to Janet's (American Psychiatric Association, 2004; DePrince et al., 2012; Korn,

2009; Korn & Leeds, 2002; Leeds, 2009b; Leeds & Shapiro, 2000; Shapiro, 2014; van der Hart et al., 1989). Leeds (2009a) refers to this three-phased common model as the Phase-Oriented Consensus Model. These phases can best be described in the following manner.

Phase I – Stabilization. In the stabilization phase of treatment, clients develop foundational skills and abilities required during subsequent phases of treatment when clients are directly exposed to traumatic memories. Many of the experiences following trauma involve avoidance of the traumatic memory, or triggering of symptoms associated with recollection of the memory. Skills developed in the Stabilization phase frequently emphasize emotional regulation and affect tolerance (Leeds, 2009a; van der Hart, 2012). Janet (1907) described this as symptom-oriented preparation for elimination of traumatic memories (van der Hart et al., 1989).

Phase II – Treatment of traumatic memories. Treatment of the traumatic memories involves re-exposing the client to the memories of and possibly challenging cognitions related to the overall traumatic experience (Leeds, 2009a; van der Hart, 2012). Janet (1907) noted that in this phase clients identify the traumatic memory, then investigate and modify it (van der Hart et al., 1989).

Phase III – Integration of new skills. Integration of new skills involves enhancing and deepening interpersonal relationships, and developing new post-trauma goals. This work is critical to recovery because individuals who are affected by traumatic events often need a transition back into their lives, to the relationships, jobs, and challenges that they faced prior to the traumatic event (van der Hart, 2012). Again, Janet (1907) describes this stage of treatment as involving reintegration of personality, reduction of remaining symptoms, and other forms of rehabilitation directed towards increasing the durability of the treatment effect (van der Hart et al., 1989).

The Importance of Stabilization in Treatment of Trauma

Often, due to the dysregulation caused by or premorbid to trauma response, it is important to "stabilize" a client prior to directly exposing them to the memory of trauma in order to avoid re-traumatization (Knipe, 2015; Leeds, 2016; van der Hart & Steele, 2013). While these phases are portrayed as discreet, the actual course of therapy can move backwards and forwards between phases, with the need to return to stabilization arising as the client processes traumatic material (Leeds, 2016).

Eye Movement Desensitization and Reprocessing (EMDR) Therapy as Empirically Supported Treatment for Trauma Related Disorders

EMDR, which has recently been also referred to as EMDR Therapy, is both empirically supported and recommended as a mode of treatment for trauma related disorders (Department of Veterans' Affairs and Department of Defense, 2004; Lipke, Shapiro, Hoffman, & Maxfield, 2009; Luber & Shapiro, 2009a; Schubert & Lee, 2009; Shapiro, 2002, 2012b, 2014). The Eight Phases and Three Prongs of EMDR Therapy, which are described in the literature review, can be roughly mapped to the three phases of the Phase-Oriented Conceptual Model (Leeds, 2009a). Stabilization of clients, within standard EMDR Therapy protocols, is primarily documented and recommended in the Preparation phase, Phase 2, of EMDR treatment.

However, as earlier noted in general treatment of trauma, progression through the phases of EMDR as well as the phases of trauma treatment, is often both iterative and bi-directional (Leeds, 2016). A client might come across additional traumatic information in any other phase of treatment. When this happens, clients can be overwhelmed by information and/or affect. At these points, it is critical to re-stabilize the client prior to proceeding to avoid further traumatization of the client (Leeds, 2009b).

Statement of the Problem

A key component in EMDR is bilateral stimulation (BLS). BLS refers to repeated, tactile, auditory, or visual stimuli, alternating from right to left and then back while a client is holding an awareness of cognitions, memories, and feelings during an EMDR therapy session. While BLS, in particular saccadic eye movement, as a component of desensitization has been the subject of significant study (Lee & Cuijpers, 2013), approaches to resource development and stabilization have not received similar scrutiny (Leeds & Korn, 2012). Resource development is taught as both a component of standard EMDR Therapy and as a refined, specific protocol in EMDR strategies for working with clients who cannot initially tolerate EMDR bilateral Stimulation (BLS) or re-exposure to traumatic memories (Korn & Leeds, 2002; Leeds, 2009a, 2009b; Leeds & Shapiro, 2000).

The ways in which trained, experienced EMDR therapists actually develop resources with their clients, including use of BLS as a component of stabilization, have not been subjected to the same level of scrutiny. Furthermore, whether and when EMDR trained and experienced therapists utilize standard protocols for resourcing and stabilizing clients, or whether they utilize other, standard, but non-EMDR related strategies for stabilizing clients prior to EMDR desensitization is not clearly understood.

How do experienced EMDR practitioners help their clients to develop resources required to tolerate EMDR desensitization? With EMDR Therapy as with other therapies that attempt to reduce the client distress related to re-exposure to traumatic memories, the client must be able to tolerate the various components of the therapy without further traumatization before treatment of the traumatic memories can proceed (Knipe, 2015; Leeds & Shapiro, 2000; van der Hart, 2012). EMDR is somewhat unique in that the client can be desensitized without having to

recount in detail the original experiences to the therapist (Knipe, 2015; Leeds, 2009a). That said, the client must be able to bring the memories into mind and to tolerate and regulate state and affect changes experienced during therapy without undue dissociation and affect dysregulation. The client must also be able to tolerate some form of bilateral stimulation in order to participate in EMDR Therapy (Leeds, 2009a, 2009b; Shapiro, 2007).

Therapists utilize different forms of treatment in order assist clients with development of the skillsets and resources required to tolerate EMDR Therapy, particularly desensitization. While a number of specific procedures are taught as part of EMDR basic and advanced training (Leeds, 2009a; Shapiro, 2001, 2002), therapists are not limited to these strategies. In their EMDR Therapy manuals, Hensley (2016), Knipe (2015), and Leeds (2009a) all address the importance of stabilization prior to treatment and recommend various strategies, beyond those specifically contained within EMDR Therapy protocols, for stabilizing clients prior to EMDR Therapy treatment.

Proposed Approach

This study will attempt to expand our knowledge about how therapists who have been trained in and practice EMDR Therapy approach stabilizing their clients. How do they conceptualize trauma and stabilization? What tools do they use? How do they utilize BLS? What is their experience as therapists using BLS in resourcing their clients prior to and during desensitization? How does their approach to stabilization differ from the strategies taught in EMDR training? And where do they feel they need additional information in support of their efforts to increase the effectiveness of the stabilization process?

The project and this dissertation will be approached as an integrative phenomenological analysis (IPA) (Smith, Flowers, & Larkin, 2009) of the ways in which six therapists, trained and

experienced in EMDR Therapy, approach and experience stabilization of clients who present with symptoms related to trauma. Its intent is to further understand the therapists' experience and to inform the field of possible areas of further study and development.

Positions of the Author

This investigator instigates this study with inherent biases, biases based on embedded culture, experience, training, research, and practice. Therefore, it is important to document, as well as I am aware, my underlying understandings and beliefs regarding therapy and EMDR Therapy.

I bring much to the table that affects my views and my work. I am a 65-year-old white male, single, gay, born in 1952 and raised in Southern California in the 1950's and 1960's in an upper-middle-class family with two parents who had college degrees and who worked in academia as teachers and researchers. The community in which I was raised was open to science, but was also "of its time," biased about race, sexual orientation, and even gender related roles. Moreover, we were often blind to privileges we held as the dominant culture.

My own background and orientation towards therapeutic practice is primarily integrative with fundamental leanings towards humanistic and relational psychodynamic/psychoanalytic theories. I further inform my practice with theories around neuro-physiological mechanisms, behavioral and cognitive theories, and the Adaptive Information Processing (AIP) model and its associated Eye Movement Desensitization and Reprocessing (EMDR) therapy.

My first exposure to therapy involved training and participation as a co-counselor in the late 1960's with Harvey Jackins's Re-evaluation Co-Counseling. In 1972, I received training as a crisis phone volunteer with the Thurston-Mason Counties Crisis-Clinic. My original training in psychotherapy was based on Rogerian (Rogers, 1980; Rogers & American Psychological

Association, 1985) and other humanistic strategies involving largely active listening, reframing, and what are today referred to as common factors (Wampold & Imel, 2015).

More recent training came in my doctoral program which included a concentration in integrative adult psychotherapy as well as existential psychology as presented by Laing (1999), May (1983), Spinelli (2007), and Yalom (1980) and the hermeneutic, relational psychoanalytic practices and theories of Orange (2010), Maroda (2010), and Stern (2010). In their own ways, these therapies attend highly to the relationship between the therapist and the client with a significant valuation of countertransference and the effect of managing enactments, rupture, and repair in the therapy sessions.

Physiological mechanisms of trauma proposed by van der Kolk (2002), LeDoux (2015), Cozolino (2010), and Damasio (2010) and their effect on how memories of our experience are processed, are important to me in that they differentiate traumatic memories from normally processed memories. Whereas non-traumatic, normal memories eventually blend or average out with other experience, traumatic memories are not easily modified by subsequent learning and have an enduring effect even when they cannot be consciously recalled (Cozolino, 2010; Damasio, 2010; Leeds, 2016; Shapiro, 2007, 2014).

Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), and Acceptance and Commitment Therapy (ACT) (Hayes, 2004; Hayes, Levin, Plumb-Vilardaga, Villatte, & Pistorello, 2013), all provide me with tools and concepts that I use with clients, particularly for developing self-awareness and skills specific to regulating emotions and tolerating affect.

My introduction to EMDR Therapy and the Adaptive Information Processing model (AIP) (Shapiro, 2001, 2002, 2007; Shapiro & Laliotis, 2010) came in several phases. As a lay

person, I was initially exposed to EMDR when a friend with a complex history of childhood sexual abuse and subsequent dissociative disorder went into treatment in the late 1980s. They shared their experiences and frequent amazement at the subsequent relief of symptoms that they attributed to EMDR.

During my doctoral practicum in 2009, I collaborated with an EMDR therapist who was able to work briefly with several of my clients on individual experiences that had traumatized them. Inspired by what I saw her accomplish, I enrolled in initial EMDR training during the summer of 2010. Subsequently, I have utilized EMDR Therapy with clients for the last 5 years. During that time, I have participated in an additional 2-4 training sessions per year as well as an ongoing monthly EMDR consultation group.

I have also experienced EMDR Therapy as a client. In 2012, I participated as an EMDR Therapy client for 12 sessions and again in 2014 for 8 sessions. During the first stint, I was able to consolidate prior work I had done with a relational psychoanalyst. EMDR Therapy enabled me to eliminate residual feelings and responses that I had learned to tolerate and manage with psychodynamic therapy. In the second, I worked with new issues that I had not previously taken to any other therapist. Those issues and their associated symptoms were resolved with EMDR Therapy. They have not returned.

Much of my practice is informed and shaped by this progression of learning and includes components of common factors, humanistic theory, relational psychoanalytic theory, cognitive and behavioral theories, and the Adaptive Information Processing model. Attachment, trust, safety, and a sense of being understood all increase our clients' ability to be present in session and in their lives. Identifying enactments of countertransference and relationship rupture within the therapeutic relationship, followed by effective repair of the rupture, gives our clients an

effective way to learn to trust and relate. Learning to sit with and observe feelings and thoughts without engaging with them enhances both client understanding and self-tolerance. Finally, activating different types of memory of the past while holding the clients' attention in the present, whether by BLS or quiet engagement, leads to epiphany and change as the brain makes new connections and processes an experience in ways that allows for adaptation.

How I use EMDR Therapy in my own practice varies depending on client need and desire. A number of my clients during any year come in for brief therapy associated with a single traumatic event. Upon qualifying them as appropriate for the treatment, I utilize the EMDR Recent Traumatic Event Protocol (RTEP) during what usually ends up being one to three total sessions. At the other end of the spectrum, treatment of complex developmental trauma can last for multiple years. With clients who have been exposed to significant developmental trauma, stabilization, which often includes development of basic skills around trust, affect tolerance, and emotional regulation, can represent months if not years of initial treatment.

The work with individuals who have experienced complex developmental trauma also involves moving back and forth between different phases of treatment, as working with pervasive insult often results in a repetitive cycle of identifying trauma, resolving trauma and then having additional trauma come to surface for processing. During these cycles, repeatedly attending to resource development and stabilization is thought to be critical.

Underneath all of this lies my basic belief that not only therapy, but also life, is complex, both my clients' and mine. Change comes to all of us slowly, even though some treatment progresses quickly. While EMDR Therapy can facilitate change that is not only rapid, but durable, it represents a small part of a much larger process that involves learning, engagement, rupture and repair, relationship, witness, humor, courage, and honesty. And while EMDR

Therapy provides us with a way to reconnect different parts of our "selves" and facilitates connections that often lead to not only reduction in painful symptoms, but sometimes amazing epiphany and insights, it remains more than the manuals and the protocols and the lights and the clickers. In the end, EMDR, like all good psychotherapy, is the result of what is often very courageous and intimate work between two human beings.

Review of Literature

This literature review begins with a look at some of the history of trauma definition and treatment. The history review is followed by an overview of current research in trauma mechanism and current theories related to complex trauma and complex developmental trauma. Because EMDR Therapy literature often refers to neurophysiological models of trauma (Leeds, 2016; Shapiro, 2007, 2012b, 2012c, 2014), the review looks at neurophysiological components of emotional trauma. Because the study focuses on EMDR Therapy and EMDR trained therapists, the Adaptive Information Processing (AIP) model, which is the theory underlying EMDR Therapy, as well as AIP related theories of mechanism, particularly as they refer to trauma, BLS, and saccadic eye movement are presented.

As the primary treatment modality of this study is EMDR Therapy, foundational basics, particularly the eight phases and three "prongs" of EMDR Therapy, along with protocols utilized for resource development and stabilization, are reviewed and described (Hensley, 2016; Leeds, 2016). This review attempts to provide a condensed overview of EMDR, enabling both the investigator and the reader to more easily contextualize participant responses.

History of Trauma and PTSD

The Oxford English Dictionary Online (2016) describes trauma as "A psychic injury, esp. one caused by emotional shock the memory of which is repressed and remains unhealed; an internal injury, esp. to the brain, which may result in a behavioural disorder of organic origin. Also, the state or condition so caused." This definition aligns with a general public conception of trauma. While initial reactions to trauma and immediate symptoms can be severe and acute, what often becomes even more devastating to our clients are the subsequent chronic reactions to trauma. These responses often start as defenses utilized to reduce acuity of the immediate

symptoms. Unfortunately, over time, the initially protective/defensive reactions can become problems on their own, often with effects lasting and possibly worsening throughout the traumatized individual's life (Knipe, 2015; van der Hart, Groenendijk, Gonzalez, Mosquera, & Solomon, 2014; van der Kolk & Najavits, 2013).

Emotional trauma has long been documented as a part of human experience. Historically, trauma has been primarily diagnosed and treated in the context of war and natural disaster. Crocq and Crocq (2000), refer to the tale of Gilgamesh in the Bible, Deuteronomy 20:1-9, circa 2700 B.C., to demonstrate an awareness of psychological casualties of war, describing fright-triggered symptoms incurred in battle resembling what we might refer to as hysterical blindness today.

More recent literature attributed post-battle injuries that are psychic rather than physical to an array of symptoms, including re-experiencing, nightmares, acting out, derealization and depersonalization, and changes in personality. Historically, these changes and reactions were given labels, such as "vent du boulet" syndrome, railway spine, traumatic neurosis, combat hysteria, combat neurasthenia, hyster-neurasthenia, battle hypnosis, shell shock, war neurosis, exhaustion, physioneurosis, and operational fatigue (Crocq & Crocq, 2000).

Following the Vietnam War, Post Traumatic Shock Disorder (PTSD) as a diagnosis was introduced in 1980 into the third edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1980). This original definition of PTSD, particularly symptoms like flash backs and nightmares described in Criterion B (American Psychiatric Association, 1980), were intended to link the disorder back to war-related events rather than to premorbid or pre-trauma vulnerabilities. PTSD as a diagnosis was designed to counter the Veterans' Administration position that Vietnam War veterans' pathology was not related to the Vietnam War (van der Kolk & Najavits, 2013). The U.S. Veterans Administration,

National Center for PTSD, now acknowledges that "the significant change ushered in by the PTSD concept was the stipulation that the etiological agent was outside the individual" (Friedman, 2014, p. 2). More concisely, as symptoms associated with PTSD could be attributed to the experience of war rather than to prior pathology, treatment could therein be funded by the federal government (van der Kolk & Najavits, 2013).

While this initial PTSD diagnosis settled a politico-ethical requirement to pay for treatment, veterans soon learned to adapt their presentation in order to match the diagnosis in a manner that would obtain help more often and without stigma. During treatment, however, their primary and subsequently reported complaints reverted to emotional regulation, inability to find pleasure and meaning, and deficits of attention, symptoms indicative of pre-battle vulnerability (van der Kolk & Najavits, 2013).

Subsequent attempts to simplify or reduce the definitions of trauma and its long-term results are incomplete at best. This is largely due to the fact that development of chronic post-traumatic responses, or trauma sequelae, is complex, often involving pre-traumatic vulnerability, as well as a deficit in peri- and post-traumatic support systems (van der Kolk & Najavits, 2013). Per van der Kolk's estimate, based on his own experience with clients over years of practice, more than 60 percent of clients reporting PTSD have had multiple and significant pre-trauma vulnerabilities (van der Kolk & Najavits, 2013).

Complex Trauma

Chronic trauma response is rarely the result of a single event (van der Kolk & Najavits, 2013). Other vulnerabilities, premorbid to the traumatic event(s) can include genetic, congenital, and developmental issues. Contributors to post trauma pathology can include a complex trauma history, where factors such as attachment, social and environmental deprivation, and lack of

parental support and shaping, can leave an individual bereft of resources necessary to cope with the after-effects of trauma. Comorbid symptoms can present as dissociation (Knipe, 2015; Nijenhuis, van der Hart, & Steele, 2010; Zucker, Spinazzola, Blaustein, & van der Kolk, 2006), limited affect tolerance, lack of ability to regulate emotions (van der Kolk & Najavits, 2013; van der Kolk & Saporta, 1991), as well as somatic or physical symptoms that are medically idiopathic (Russell, 2008).

Complex trauma definitions have evolved which involve experiences of non-soldiers, often victims of what, today, is referred to as small "t" trauma. These patients, often experienced significant developmental deficits that resulted in difficulties with emotional regulation, attention and concentration, and somatization (Cloitre et al., 2009; Cook et al., 2005; D'Andrea et al., 2012; Ford et al., 2013; Luxenberg, Spinazzola, & van der Kolk, 2001; van der Kolk & Najavits, 2013; van der Kolk et al., 2009; van der Kolk et al., 2005).

Many of these patients were children and adolescents who had experienced repeated systemic insult during development. It is important to note that, "Secure children learn a complex vocabulary to describe their emotions, such as love, hate, disgust, and anger. This allows them to communicate how they feel and to formulate efficient response strategies" (van der Kolk, 2005, p. 403). In contrast, individuals raised with repeated small "t" injury often lack this capability, which is key to resilience.

In further support of the effects of pervasive developmental insult, the Adverse Childhood Experiences (ACE) study provided a link between history of trauma and physical/mental health impacts. Investigators determined that 30% of the subjects had experienced physical abuse, 23.5% had experienced family alcohol abuse, 19.9% had experienced sexual abuse, 18% had experienced exposure to mental illness, 12.5% had witnessed

physical abuse of their mother, and 4.9% had been exposed to family drug abuse (Felitti et al., 1998; van der Kolk, 2005). This strong correlation between the extent of repeated insult and subsequent physical and mental health issues suggests both a need for further study and the importance of identifying and effectively treating the resultant pathologies. These pathologies are now often classified under what is referred to as complex trauma, or complex developmental trauma (Cloitre et al., 2009; Cook et al., 2005; D'Andrea et al., 2012; Ford et al., 2013; Stolbach et al., 2013; van der Kolk et al., 2009; van der Kolk et al., 2005).

Victims of complex developmental trauma often experience multiple comorbid conditions such as strong mood disorders, borderline and antisocial personality disorder, somatoform disorders, bi-polar disorder, and eating disorders. Dissociative, cardiovascular, metabolic, immunologic, and sexual disorders which are sequelae to trauma are frequently misdiagnosed as primary and mistreated accordingly (Cook et al., 2005; van der Kolk, 2005).

Recent efficacy studies have demonstrated that a dual strategy is most effective in reducing many of the symptoms related to complex trauma. This treatment often involves identifying and compensating for environmental and developmental deficiencies. Strategies can include reduction in sources of insult via provision of a supportive environment, accompanied by development of affect tolerance and emotional regulation, movement and physical exercise, mindfulness training, and healthy socialization. (Cloitre et al., 2012; Cloitre et al., 2009; Cook et al., 2005; D'Andrea et al., 2012; Ford et al., 2013; Gradus, 2014; Kisiel & Lyons, 2001; Luxenberg, Spinazzola, Hidalgo, Hunt, & van der Kolk, 2001; Luxenberg, Spinazzola, & van der Kolk, 2001; Spinazzola et al., 2013; Stolbach et al., 2013; van der Kolk, 2005; van der Kolk et al., 2005).

Bongaerts, Van Minnen, and de Jongh (2017) presented some promising results for Intense EMDR, increased frequency of treatment interspersed with physical exercise and psychoeducation for 8 days over two weeks, in the treatment of complex PTSD in adults. Even with subjects diagnosed with multiple comorbidities, this treatment regime appeared to be safe and effective. This small case series, n=6, indicates a need for further study of this approach. It suggests that some individuals who might have been shifted to other forms of therapy for stabilization may be candidates for immediate EMDR treatment of their PTSD symptoms in this format.

Neurophysiological Model of Trauma Effect

Awareness of potential mechanisms of traumatic effect and post-traumatic symptoms has helped to hypothesize a differentiation between traumatic and non-traumatic memory processing (Cozolino, 2010; Damasio, 2010; van der Kolk & Saporta, 1991). Awareness of these potential mechanisms also guides many current therapeutic strategies, including AIP and EMDR Therapy (Bergmann, 2008, 2010, 2012; Lee & Cuijpers, 2013; Oren & Solomon, 2012; Pagani, Högberg, Fernandez, & Siracusano, 2013; Solomon & Shapiro, 2008; Söndergaard & Elofsson, 2008).

Current thinking on trauma and the processing of memories of experience includes the concept that the more primitive components in the brain process constellations of sensational input in the identification of threatening situations prior to the conscious portion of the brain even becoming aware of the occurrence (Cozolino, 2010; Damasio, 2010; Vergne, 2014). While all of this happens in very short order, recognition of danger by the thalamic or limbic portions of the brain can result in elevated levels of insulin, adrenalin (epinephrine), and cortisol in the bloodstream, all of which regulate the sympathetic and parasympathetic nervous systems associated with the fight, flight, and freeze responses to danger. It is only after this initialization

of a physical reaction has started that the more conscious and intentional components of the brain are informed that a threat does, in fact, exist (Leeds, 2016; van der Kolk, 2006).

Cozolino (2010) and Damasio (2010) have proposed that when memories are recorded in the presence of overstimulation of the amygdala, proper processing of the experience by other circuits in the brain is inhibited and memories are not processed to completion. Successfully processed memories create a circuit that modifies and generalizes over time, reducing in intensity while developing or altering meaning within the context of subsequent thought or experience. Incompletely processed memories remain relatively unchanged over time, sometimes inaccessible by normal biographical processing (Damasio, 2010). This incompletely processed experience inhibits subsequent ability to incorporate the experience and normalize it in context of other experiences. The end result is frequently experienced as spontaneous and traumatic replays of memories, triggered by constellations of sensation that are recognized by the amygdala as similar to the original trauma. Stickgold states that "PTSD develops when memories of traumatic events, encoded during an actual trauma, fail to be processed normally over time" (2008, p. 289).

Often, the very symptoms associated with trauma make treatment challenging. When clients experience difficulties with affect tolerance, emotional regulation, dissociation, and state change necessary to tolerate more direct treatment of the trauma symptoms, foundational resources must be developed prior to and during subsequent therapy (Janet, 1907; Korn & Leeds, 2002; Leeds, 2009a, 2009b, 2016; Leeds & Shapiro, 2000; van der Hart, Groenendijk, Gonzalez, Mosquera, & Solomon, 2013).

The Adaptive Information Processing (AIP) model and Eye Movement Desensitization and Reprocessing (EMDR)

Shapiro describes EMDR as "an integrative, client-centered psychotherapy approach that emphasizes the brain's information processing system and memories of disturbing experiences as the bases of those pathologies not caused by organic deficit or insult" (2007, p. 68). Its practices are theoretically grounded in what is known as the Adaptive Information Processing (AIP) model.

Efficacy of EMDR Therapy. Justification of this study merits some review of both the empirical support and challenges that exist for EMDR Therapy. The primary objective of this review is to understand what empirical support exists, and what and why challenges to EMDR practices and underlying theory exist. As this study is primarily related to EMDR Therapy in the treatment of trauma related disorders, the efficacy review is focused on literature involving EMDR Therapy in the treatment of trauma. It is largely based on peer-reviewed meta-analyses of EMDR efficacy studies.

EMDR Therapy, which was originated by Francine Shapiro as Eye Movement Desensitization (EMD) in 1987, is today broadly accepted by practitioners, government agencies like the Veterans' Administration, and insurance companies for treatment of PTSD and trauma related disorders (Acarturk et al., 2016; Chen et al., 2014; EMDR Institute, 2016; EMDR International Association, 2016; Haagen, Smid, Knipscheer, & Kleber, 2015; U. S. Department of Veterans Affairs/The Management of Post-Traumatic Stress Working Group, 2010).

Today, there is no shortage of literature on the efficacy or proposed mechanisms of EMDR. The world-wide web site of the EMDR Institute, Inc. has a specific section, *Research Overview*, that identifies much of the most current and important research underlying EMDR

Therapy efficacy. It lists 15 organizations, world-wide, that include and support EMDR in their treatment guidelines, 15 of the most recent peer-reviewed meta-analyses of EMDR and its role in trauma treatment, 39 randomized and 23 non-randomized studies of EMDR in trauma treatment, 44 articles relating to AIP and EMDR procedures, 20 articles that theorize mechanism, 24 that specifically address eye movement, 24 that look at additional psychophysiological and neurobiological evaluations of EMDR treatment, and 15 articles specific to EMDR in the treatment of military personnel (EMDR Institute, 2016).

Ongoing EMDR research is further supported by the EMDR Research Foundation, which, in addition to funding grants to researchers, provides up-to-date summaries of current studies as well as a depth of information and assistance related to standardizing measures and procedures used in studies.

Shapiro published her first efficacy study in 1989. The study, a single-blind clinical outcome study, followed treatment of 22 subjects with EMD. Study participants ranged in age from 11 to 53 years and were randomly selected to be treated with either EMD or a placebo treatment. Participants selected for placebo subsequently received EMD treatment. All participants had received prior diagnoses of PTSD. All reported symptoms related to traumatic memories that had persisted for more than one year, and in some cases as long as 47 years. Prior to the study, participants had reported being in therapy for between 2 months and 25 years, averaging 6 years (Shapiro, 1989).

Because Shapiro's study represented the initial presentation of EMD, it provided significant detail regarding the therapeutic procedure used, the measures taken, and the author's speculation of underlying mechanism. The study found that EMD was able to significantly reduce symptoms of anxiety as they related to traumatic memories, but that it did not provide

subjects with ongoing coping strategies nor did it resolve all PTSD-related symptoms.

Participants averaged five 50-minute sessions of treatment (Shapiro, 1989).

In order to address some of the deficits of EMD, it evolved to incorporate an integrative model that was based on information processing by the brain and the effects of trauma on "adaptive processing," processing that allows traumatic experiences to moderate in time in the context of more average, general experiences. In the evolution from EMD to EMDR, the process of desensitization was modified to allow clients to follow a natural progression of memory networks, from an immediate traumatic event to prior experiences that the client associated with similar feelings and reactions. This inclusion of past led to the current three-pronged approach of past memories, present triggers, and future desired outcomes, which is now fundamental to EMDR, making it a more complete protocol for providing a more complete and durable recovery from traumatic experiences (Shapiro, 2001, 2002). EMDR as it evolved from EMD was presented by Shapiro in 1991.

Although Shapiro now describes EMDR as an integrative therapy based on an information processing model, she initially described its predecessor, EMD, as a behavioral treatment. As such, she introduced EMD into journals directed towards a community of therapists working with trauma who were primarily behavioral or cognitive behavioral practitioners. Following its initial presentation to the field, EMD's utilization of BLS has resulted in EMD and subsequently EMDR being challenged, particularly by researchers and practitioners who align more with exposure or cognitive behavioral related therapies (Greenwald, 1996, 1997; Perkins & Rouanzoin, 2002). To this day, even some of the guidelines that promote EMDR for treatment of PTSD question the contribution of eye movement and bi-lateral

stimulation (Acarturk et al., 2016; Haagen et al., 2015; U. S. Department of Veterans Affairs/The Management of Post-Traumatic Stress Working Group, 2010).

Where articles challenging EMD or EMDR mechanism or efficacy have been either inconclusive or negative, the studies often fall into several categories. Greenwald (1996, 1997) was able to demonstrate that many of the early EMDR studies with questionable results had failed to keep fidelity with EMDR protocols. Greenwald found that when studies practiced EMDR as taught, utilizing protocols as documented and treatment administered by experienced practitioners, results showed measurable and consistent effects.

In their analysis of critical studies, Perkins and Rouanzoin (2002) emphasize the importance of researchers understanding some of the differences between positivist medical research and efforts to demonstrate efficacy of psychotherapeutic practices. EMDR is a complex and robust set of protocols, underlying which is a depth of theory and highly developed practice involving moment to moment evaluation and intervention by an experienced therapist. The protocols are developed and tested as integrated units and studies that break out their individual components, particularly in search of mechanism, often result in effects and outcomes that are distant and different from those found when the protocol is practiced as a whole.

Perkins and Rouanzoin (2002) also found that some of the studies were poorly designed, and that inadequate fidelity to EMDR practices caused questionable outcomes. They identified flaws in a number of highly critical studies. They grouped examples of confusion within those studies into the following areas: placebo effects, exposure procedures, eye movement, outcomes, and theory. Finally, Perkins and Rouanzoin identified a small number of authors who were writing the preponderance of critical reviews and noted that those reviews were often inaccurate and based on bad data from earlier flawed studies.

Chen et al. (2014) published a quantitative meta-analysis of EMDR research published between the years of 1991 and 2013. The analysis first screened over 333 studies, out of which they eventually selected 26 for inclusion. Their analysis concluded that EMDR significantly reduced symptoms of depression and anxiety associated with trauma and furthermore that treatment where sessions went longer than 60 minutes further contributed to the reduction.

Today, and somewhat in response to these earlier challenges, EMDR Therapy is one of the most studied and analyzed therapeutic approaches in psychology (Chen et al., 2014; Lee & Cuijpers, 2013; Perkins & Rouanzoin, 2002; Shapiro, 2012b). New protocols are introduced with a minimum of single or multiple case studies supporting them. More common practices, such as the use of EMDR Therapy with PTSD, are the subject of continual research published in peer-reviewed journals.

In summary, the vast preponderance of research supports EMDR Therapy as efficacious in the treatment of PTSD and other trauma related disorders. Additionally, research abounds that supports EMDR Therapy as treatment for other mental illnesses, as well as suggesting justification for further investigation.

AIP, the model underlying the therapy. The AIP model is consistent with neurophysiological models in the ways in which it describes the effects of trauma on memory (Shapiro, 2007). With some individuals, when previous trauma has not been resolved, or when resources following an incident are not adequately supportive, when the cumulative effect of repeated traumatization surpasses the ability of the individual's support system to provide succor or meaning, the experience and re-experiencing of reaction to trauma indicates that the information processing system has stored the memory in a manner in which it cannot process to an adaptive resolution (Oren & Solomon, 2012; Shapiro, 2001, 2007, 2012c, 2014). When

subsequent thoughts or stimuli that resurrect the memory, not in context of the good and bad of the whole of experience, but as the original memory, it returns encased in and associated with the same intense feelings and emotions that it originally engendered (Shapiro, 2007; Solomon & Shapiro, 2008).

AIP posits memories are stored into networks of similar context and memories stored in adaptive, working, networks can be processed and reprocessed until they merge with and normalize with other memories of other experiences (Shapiro, 2001, 2007; Solomon & Shapiro, 2008).

Some memories of traumatic experience are mis-stored and cannot normalize and adapt (Cotraccia, 2012; Cozolino, 2010; Damasio, 2010; Leeds, 2009a; Oren & Solomon, 2012; Shapiro, 2007, 2014). Subsequent memories of experiences that are contextually similar to the non-adaptive or trauma related memories store with those non-adaptive memories. Combined and isolated from adaptive memories, these non-adaptive memories form networks that are pathological in that they underlie a whole array of painful, emotional, physiological, and cognitive symptoms. Furthermore, those pathological or non-adaptive networks are resistant to change, and lead to development of defensive responses, which result in more pathological adaptations (Shapiro, 2007). The defensive responses contribute to an endless and progressive spiral of mental pathology (van der Kolk & Najavits, 2013; van der Kolk et al., 2005; van der Kolk & Saporta, 1991). PTSD or complex trauma can be viewed largely as defensive responses to refractory symptoms, symptoms that have not changed because they are associated with non-adaptive networks (Hensley, 2012; Shapiro, 2007; Shapiro & Laliotis, 2010).

AIP proposes that bringing the maladaptive memories, emotional, physiological, and cognitive together in the present and associating them with adaptive networks while utilizing

bilateral stimulation to hold dual attention allows them to re-associate with those adaptive networks. This re-association allows the previously non-adaptive memories to adapt and change in context of other, more general, experiences. In other words, this treatment transforms non-adaptive memory networks into adaptive memory networks which allows them then to be processed and reprocessed in a manner that enables eventual normalization in the context of other experience (Leeds, 2009a, 2016; Shapiro, 2001, 2007).

AIP and mechanism. Eye movement and other bi-lateral stimulation is a key component of EMDR Therapy and of AIP. As with other talk therapies, a physiological mechanism of change has not been identified, however, current research in the physiology of trauma and treatment suggests a number of possible mechanisms (Bergmann, 2012; Lee & Cuijpers, 2013; Yaggie et al., 2015).

Stickgold (2002, 2007, 2008) has associated the saccadic eye movement with the effects of REM sleep, positing that similar to REM sleep, the awake brain, after reactivating memories and during saccadic eye movement, is able to accomplish memory integration between semantic memory and episodic memory that earlier failed due to traumatic exposure (Stickgold, 2007).

Rasolkhani-Kalhorn and Harper (2006) compare effects of bi-lateral stimulation during EMDR to work utilizing tetanic stimulation to reverse long-term potentiation of memory traces related to PTSD symptoms. The BLS causes rapid attentional shifts similar to tetanic stimulation applied to lab animals. Both mediate the effects of fear memories. They attribute this affect to the disruption of the memory circuit related to the fear and suggest that the change represents permanent disconnection.

Bergmann (2010) organized prior research into some of the following possible mechanisms involved in EMDR: Deconditioning model (Dyck, 1993), Orienting Response

model (MacCulloch & Feldman, 1996), Frontal Lobe Activation model (Bergmann, 2000),
REM-Like Physiological Systems model (Stickgold, 2002, 2007), Reciprocal
Suppression/Activation of the Anterior Cingulate model (Corrigan, 2002), Hippocampal Neural
Mapping model (Corrigan, 2002), Low Frequency Stimulation model (Rasolkhani-Kalhorn &
Harper, 2006), Thalamic Temporal Binding model (Bergmann, 2008), and Parietal Lobe
Activation model (Pearson, 2009).

Oren and Solomon (2012) suggest that a combination of the Orienting Response
(MacCulloch & Feldman, 1996) and the Disruption of Working Memory (Gunter & Bodner,
2008, 2009) are the most likely mechanisms of BLS, indicating that "there is good reason to
believe that both theories are correct and interactively contribute to EMDR's therapeutic effects"
(Oren & Solomon, 2012, p. 199).

Lee and Cuijpers (2013) meta-analysis of studies of contribution of eye movements found
that the additive effect of eye movements in EMDR treatment studies was moderate and
significant. In non-treatment laboratory studies, they found that the effect was large and
significant. They concluded that "eye movements do alter the processing of emotional
memories" (p. 238). They propose that while working memory and orienting response models
might account for the effect of eye movement in the non-therapy lab studies, the EMDR process
is more complex and the effect of eye movement plays a significant but reduced role in the
context of other therapeutic components such as mindfulness, exposure, etc. They further suggest
that eye movement has an additive effect in therapy trials they studied, while in lab, non-therapy
trials, eye movement is the effect. This additive nature of eye movement effect in therapy was
further supported by their finding that fidelity to EMDR protocols (i.e., manualized treatment
and full EMDR training of the therapist, acted as a moderator variable).

Bergmann (2008, 2010, 2012) is careful to note the limitations of neurological studies specific to EMDR to date, and acknowledges being mystified by the mechanisms of EMDR's documented effect. While we can envision physiological mechanisms, attribute the brain's reactions to stress, and describe physical models of the relationship between the amygdala, hippocampus, and the frontal medial cortex of the cerebrum, a true and complete physiological model of human processing of experience does not exist (Lipke et al., 2009). Similarly, research into the relationship between the amygdala of rats and a survival fear response cannot be generalized or projected onto the complexity of lived human experience of feeling or not feeling emotions of fear and developing a post trauma reaction (Clugnet & LeDoux, 1990; LeDoux, 2000, 2012, 2014a, 2014b, 2015).

Finally, it is important to note that the EMDR process is complex, involving integration of different types and locations of memory, sensation, body awareness, and a wide range of positive and negative cognitions and emotions (Bergmann, 2008, 2010, 2012; Leeds, 2009a, 2016). EMDR Therapy also involves holding a dual awareness of present safety and past memory. Particularly when dealing with complex trauma, EMDR Therapy utilizes all of the dynamics of attachment, transference, and relationship associated with other forms of talk therapy (Duncan, 2002; Leeds, 1996, 2009a; Shapiro, 2002, 2007; Shapiro & Laliotis, 2010).

EMDR Therapy, Practices and Protocols Based on the AIP Model

EMDR Therapy, as a practice, is a complex, highly manualized treatment regime, integrative in nature, that draws from behavioral, cognitive, and psychodynamic therapies, all in the context of the AIP model (Shapiro, 2007). Almost all of the protocols involve some form of bilateral stimulation that is used along with identifying and working with traumatic memories. These protocols usually include some form of the following: identifying and accessing trauma

content, desensitizing trauma content, recognizing and reducing negative beliefs associated with the traumatic content, and identifying and reducing body/physical senses related to the trauma. After body/physical senses have been significantly reduced, most protocols end with planning and strengthening imagery around desired future responses to situations that have been historically problematic for the client. Variations of the protocols have been created specifically for dealing with issues, like addiction, dissociation, and single recent traumatic event (Hensley, 2016; Leeds, 2016; Luber, 2009, 2010, 2014; Luber & Shapiro, 2009b; Shapiro, 2012a).

Standard EMDR treatment protocols are broken down into eight relatively discrete phases of treatment. Because the experience of trauma relates not only to past memories, but to reactions triggered by present events and resistance towards future events, EMDR Therapy addresses what it refers to as a three-pronged approach to past, present, and future (Hensley, 2016; Leeds, 2016; Shapiro, 2007). These Eight Phases and Three Prongs of treatment are described below.

Eight phases of EMDR treatment. Most EMDR treatment follows these eight phases.

Phase 1, Client History. EMDR Therapy begins very similarly to other talk therapies. In this introductory phase, the therapist builds an initial therapeutic alliance with the client while gathering client psychosocial and medical history. The therapist notes symptoms that the client identifies as problematic and determines appropriateness of immediately utilizing EMDR Therapy as treatment. Based on the client's readiness for treatment, the therapist, along with the client, formulates the case and develops a plan for treatment, identifying targets for treatment, past etiological events, present triggers, and future desired responses to similar situations. Criteria leading to a decision to defer and sometimes even rule out EMDR Therapy, or modify EMDR Therapy strategy, can include, but are not limited to socioeconomic instability, external

crises, health risk, suicidality, self-injury, danger to others, compulsivity, low affect tolerance or emotional regulation, severe dissociation, substance abuse, depersonalization and derealization, bipolar depression, and psychotic disorders. These exclusion criteria can imply the need for stabilization of a client prior to proceeding further with EMDR Therapy (Hensley, 2016; Leeds, 2009a, 2016; Shapiro, 2012a). They can also direct the therapist towards a treatment strategy that cycles between stabilization and reprocessing of memories (Egli-Bernd, 2011; Knipe, 2015; Laugharne, Marshall, Laugharne, & Hassard, 2014; Van den Berg, Van der Vleugel, Staring, De Bont, & De Jongh, 2013; van der Hart, 2012).

Phase 2, Preparation. This phase of treatment involves the therapist providing and helping the client to develop any resources that they might need to participate effectively in EMDR Therapy desensitization, installation, and body scan phases. This preparation and provisioning of the client can include psychoeducation, developing the client's ability to tolerate affect, or state changes, and developing the client's ability to regulation emotions, or to consciously change state. In this process, the therapist continues to strengthen the therapeutic alliance, creating an emotionally supportive environment in which the client can participate in therapy. Depending on the needs of the client, this resourcing period can be as brief as a partial session, or months-long in duration. Prior to moving on to desensitization, clients must be able to tolerate exposure to traumatic memories along with the changes in affect or state that they will inevitably experience. If a client does not have existing positive associations to fall back upon, the positive associations are developed prior to directly addressing the primary trauma(s). If therapy proceeds to addressing the traumatic memories, exposure without adequate resourcing can re-traumatize the client (Hensley, 2016; Leeds, 2009a; Shapiro, 2012a).

Phase 3, Assessment. The assessment phase involves a brief verification that the client is ready for desensitization, followed by identification of specific images, positive and negative beliefs, current emotional responses, and body sensations associated with memories targeted for treatment. Once these details are identified, baseline measures of subjective units of distress (SUD) and validity of cognition (VoC) are taken for comparison as desensitization progresses (Hensley, 2016; Leeds, 2016; Shapiro, 2012a).

Phase 4, Desensitization. The desensitization phase, what many people think of when they conceptualize EMDR Therapy, involves decreasing the distress related to the target memory by reprocessing the target memory with the inclusion of emotions and negative cognitions, until the memory reaches what has been called an "adaptive resolution". This adaptive resolution is identified when the SUD measure reaches a 0. While this can occur in one session, with complex trauma and serious disorders, this can take multiple sessions to reach (Hensley, 2016; Leeds, 2016; Shapiro, 2012a). Utilizing images, beliefs, emotions, and somatic sensations identified in phase 3, the therapist alternates between utilizing BLS for 20-60 seconds, and asking the client to stop, take a deep breath, and report their current experience. When done properly, this BLS/reporting cycle allows clients to follow the network of memories as it exists. Actual intervention by the therapist is minimally directive regarding content, and attends more to tracking the client's reactions during treatment. The cycle of BLS followed by reporting back further supports the client holding "dual awareness," awareness of the past memory while staying present in the "safe" presence of the therapist. Observing the client during this cycle informs therapists when interventions are required and helps to identify when the client is ready to proceed to another phase of treatment.

Phase 5, Installation. The installation phase installs the preferred belief, in context of the reprocessing target. The therapist performs discreet sets of bilateral stimulation while the client concurrently holds the target memory and the preferred belief in mind. Integration of the preferred belief is verified by client reporting a VoC of 6 or 7 (Hensley, 2016; Leeds, 2016; Shapiro, 2012a).

Phase 6, Body Scan. The body scan processes residual disturbance by identifying where it is "felt" in the client's body. It also utilizes discrete sets of bilateral stimulation while the client reports any negative body sensations, until they are neutral or positive. This physical integration supports additional synthesis of the overall experience (Hensley, 2016; Leeds, 2016; Shapiro, 2012a).

Phase 7, Closure. The closure phase is utilized in every session, no matter what the final SUD or VoC scores are obtained. In this phase it is critical to provide the client with resources and expectations for the time between and/or following treatment (Hensley, 2016; Leeds, 2016; Shapiro, 2012a). Reminder of the client's safe/calm place along with utilization of containment exercises, like visualizing placing the work of the current session in a container, gives them an opportunity to ground themselves and to be more fully present prior to leaving the session. Depending on the content of a session, it is important to remind the client of possible side effects, and to invite them to make contact if residual effects are unduly bothersome or uncomfortable (Hensley, 2016; Leeds, 2016; Shapiro, 2012a).

Phase 8, Reevaluation. While this phase is listed last, it is actually the first phase of sessions following a desensitization session, and involves reevaluation of progress, rechecking targets, and verifying whether all of the issues of the treatment plan have been addressed. During

this phase the target or the treatment plan may be modified to accommodate changes based on client experiences (Hensley, 2016; Leeds, 2016; Shapiro, 2012a).

Three-pronged approach, treating past, present, and future. As EMDR Therapy evolved, it became evident that when working with trauma it was important to address the historical memory, the current triggers and their relationship to those memories, and the learned inhibitions and blockages affecting future desired behavior and responses (Hensley, 2016; Leeds, 2016; Shapiro, 2012a). Oren and Solomon (2012) refer to this approach as a "tripartite protocol" (p. 198). Typically, treatment starts with addressing historical memory and progresses through to present triggers and then to future or desired responses. It is not uncommon, however, that traumatized clients cannot tolerate or access past memories. To assist with building foundational resources required to address the past without re-traumatization, therapy with these clients often starts by working with current triggers or even with future desired behaviors and responses before addressing the past (Hensley, 2016; Leeds, 2016).

EMDR and treatment of complex trauma. Stabilization is a particularly critical component in the treatment of complex trauma. In the history gathering process, along with identifying symptoms, triggers, and target memories, it is important to identify undiluted success experiences or, in other words, healthy networks (Leeds, 2016). If these cannot be identified, it is then critical to construct them as part of therapy during the Preparation Phase. Therapists help clients to construct adaptive networks through the development of resources, either utilizing EMDR protocols or other tools. While stabilization and resource development for clients frequently occur in preparation for later phases of psychotherapy, they are also critical components of the later phases whenever clients require stabilization prior to or during therapy

sessions (Hensley, 2016; Knipe, 2015; Korn & Leeds, 2002; Leeds, 2016; Leeds & Shapiro, 2000; Schubert & Lee, 2009; Shapiro, 2012a; van der Hart, 2012; van der Hart et al., 2014).

Stabilization within EMDR Therapy. Standard EMDR treatment involves exposure to or reprocessing of traumatic memories. Clients must be able to tolerate exposure and to regulate emotions in order to accommodate the necessary state changes that occur during the therapy session. If a client is unable to tolerate the process, or unable to return to a relatively regulated state after a session that had not run to completion, the therapy itself could be traumatic (Leeds, 2016). EMDR Therapy begins with gathering client history and determining the client's appropriateness for treatment with EMDR. Comorbid anxiety, dissociation, depression, psychotic disorders, as well as a client's inability to tolerate bilateral stimulation, exposure to traumatic memories, or state change can indicate a need for preparation that exceeds what is normally included in the preparation phase (Hensley, 2016; Leeds, 2016).

Stabilization in the preparation phase as taught in EMDR Therapy training. EMDR training exposes therapists to a number of tools that they can use to enhance their clients' experience both during and after EMDR Therapy. These tools include use of metaphor, visualization, and a number of specific practices used initially in preparation, and later as needed. A partial list of these practices includes:

- Calm/Safe Place: In this exercise, clients are instructed to imagine a place wherein they can feel safe and/or calm. The vision is enhanced by the therapist asking for specific description of the place and of the feelings it invokes. This description can include images, smells, sense of temperature, tastes, sounds, and anything else that the client notices. As the client describes the scene, they are asked to describe how it makes them feel, and to come up with a single word that they can associate with the

image and sensations in the future. The combined image, sensations, feelings, and
identifying word, are re-enforced utilizing BLS.

- Container: EMDR Therapy basic training also provides a "container" exercise that
  therapists can use to help clients to visualize a container, into which they can put the
  work of their session, at the end of each session and later, on their own, between
  sessions if that is needed.

- Butterfly Hug: Initially developed as a self-care mechanism for use with victims of
  Hurricane Pauline, particularly children, clients are taught to cross their arms in front
  of their chest placing their hands on opposite shoulders. They are then asked to
  alternately tap or pat each shoulder. Similarly to other forms of BLS, this action
  triggers a relaxation response that can support clients in their efforts to self-soothe
  and process the experience (Hensley, 2016; Jarero & Artigas, 2012; Leeds, 2009a,
  2016; Luber, 2010).

- Resource Development and Installation (RDI): For some clients, particularly those
  who dissociate in therapy, are not safe, or who do not have emotional resources upon
  which they can fall back when accessing traumatic material, RDI utilizes BLS to
  develop positive resources (Korn & Leeds, 2002; Leeds, 1998; Leeds & Shapiro,
  2000). It is a detailed and formal protocol that supports the client in identifying and
  mastering skills and changing behaviors that would otherwise hinder subsequent
  therapy. The protocol is taught along with other specialized treatment strategies as
  part of the second session of EMDR training (Leeds, 2016; Shapiro, 2012a).

Constant Installation of Present Orientation and Safety (CIPOS). Knipe describes
CIPOS as a procedure to utilize with clients who, due to a severe dissociative disorder or

unusually troubling memories, cannot tolerate accessing the memories without losing any sense

of safety when the trauma-related memory is accessed. He notes that the client's trust in both

their ability to recover and in the therapist is damaged at this point (Knipe, 2015; Luber, 2010).

Individuals with complex trauma have difficulty going into and then coming out of

traumatic material. That is, they are almost driven to go into it, but have difficulty coming back

out to the present and to the safety of the therapy session. The CIPOS procedure first educates

the client about the value of being able to access and then return to the present from traumatic

material. It then educates the client in ways to measure and describe their presence in the session.

Finally, the therapist, in a number of small, repeated steps, leads the client into and out of the

traumatic material, titrating the time and the depth of the memory as the client develops greater

tolerance and greater capability of returning from the memory to the present (Knipe, 2015).

Other approaches to stabilization. Stabilization is not limited to bi-lateral stimulation. In

fact, it is probably safe to assume that most of Stage I stabilization process associated with

treatment of trauma is performed utilizing other methods than those utilizing BLS under EMDR.

These can include, but are not limited to use of psychopharmaceuticals, talk therapies like

dialectic behavioral training, cognitive behavioral therapy, and mindfulness training, and

development of basic life skills, and exercise, meditation, and healthy play (Leeds, 2009a,

2009b, 2016; van der Hart, 2012).

Potential Risks / Ethical Issues

As participants are experienced, graduate level, licensed therapists, therapeutic support

proffered to participants in clinical trials is an unlikely necessity. What is necessary is

documentation of the potential risks associated with sharing information regarding their practices

as therapists. This risk falls into two primary areas: 1. Therapists in Olympia, Washington are

part of a small community. It is possible that the primary researcher will know some subjects as colleagues. 2. Subjects could experience some level of discomfort related to disclosure of practices as therapists.

This study investigates not only standard practices as recommended by EMDR Therapy orthodoxy, but also "off-label" and supplemental practices, problems and challenges, gaps in the practice, and desires for more study/information and education. In order to allow participating therapists to be open to sharing this information, confidentiality, both in intent and practice, must be insured to the extent practical by encryption and sterilization of source data.

No information that could identify clients will be intentionally collected as part of this study and as such, subjects will be requested to provide an alias that will be used for their interview and will be reminded/requested not to divulge any demographic information in interviews that could identify a specific client.

All participants will be informed that the primary researcher is part of the EMDR Therapy community as a practitioner, as a participant in a monthly consultation group, and as a participant in supervision for certification.

Significance of the Study

The use of bi-lateral stimulation for stabilization and resource development has been both taught (Leeds, 2009a, 2009b; Leeds & Shapiro, 2000) and challenged within the EMDR community (Hornsveld, de Jongh, & ten Broeke, 2012; Korn & Leeds, 2002; Leeds & Korn, 2012; Leeds & Shapiro, 2000). Leeds has studied and presented the literature surrounding use of resourcing and stabilizing with both EMDR and other trauma treatment strategies (Leeds, 2016).

What has not been studied is how experienced EMDR trained therapists who use EMDR in their practice actually help their clients develop the skills and resources required to tolerate

subsequent therapy. Do they use the strategies as prescribed by their EMDR training? What informs decisions that they make during the process? Do they use them in ways that differ from their training? If they have developed their own approaches to resourcing, how have they modified the protocols, and why did they modify them? What roles do non-EMDR strategies and tools, such as Dialectic Behavioral Therapy (DBT), Cognitive Behavioral Therapy (CBT), or Acceptance and Commitment Therapy (ACT) play in resourcing clients? What other practices or strategies do they utilize to support their client needs for stabilization during treatment?

Better understanding of actual resource development and stabilization practices should contribute to enhancing and refining future EMDR training and research.

Methodology

This chapter describes the utilization of Interpretive Phenomenological Analysis (IPA) as a core methodology for this study as well as the procedures and forms used to select participants, collect data, analyze that data, protect confidentiality, and destroy source data after it is no longer needed. It also identifies potential risks and lays out both the significance and the limitations of the study.

Interpretive Phenomenological Analysis (IPA)

IPA provides a philosophy, methodology, and structure that supports qualitative phenomenological investigation of multiple cases wherein the question involves ways in which people make sense of major life experiences (Smith et al., 2009). IPA draws its understanding and approach from existential phenomenology and hermeneutics bringing a Heideggerian notion of fore-understanding to existential bracketing and a Gadamerian concept of context and the hermeneutic cycle. Smith et al. (2009) summarize this relationship as "It is phenomenological in attempting to get as close as possible to the personal experience of the participant, but recognizes that this inevitability becomes an interpretive endeavor for both participant and researcher." (p. 37). They then goes on to suggest that "Without the phenomenology there would be nothing to interpret; without hermeneutics, the phenomenon would not be seen" (Smith et al., 2009, p. 37).

Additionally, IPA draws from ideography in its commitment to detailed in-depth analysis as well as the limited perspective of particular individuals in a specific context, by utilizing small, sometimes even single-case, samples. Idiography, while acknowledging the individual's immersion in their world, culture, and relationships, also proposes that a single person can offer a unique perspective on their relationship to the phenomenon being studied. Thorough analysis at a

case level followed by a comparison of cases provides yet another hermeneutic, that between the particular and the general (Smith et al., 2009; Smith & Shinebourne, 2012).

This study proposed that a therapist's practice qualifies as a major lived experience. As such, how therapists experience, conceptualize, approach, and treat clients is an important aspect of our understanding of the therapeutic process. When therapists are trained in specific approaches, such as utilizing EMDR Therapy to treat client reactions to trauma, it is important to understand how they use EMDR. What do they experience as effective or challenging? What do they feel that they need or lack in training and support? How do they think around why they do what they do in the therapy session? It is important to understand what they experience and how they conceptualize during their practice.

This study engaged the participants in an exercise around thinking about and questioning what they do and how and why they do it. Subjects participated in a semi-structured interview (Creswell, 2007; Smith, 2008; Smith & Shinebourne, 2012). Each recorded interview was transcribed and then analyzed as an individual case. After all cases were individually analyzed, an analysis was performed across all cases.

Utilizing IPA (Smith et al., 2009) methods described below in Data Analysis, interview contents were deconstructed in a manner that allowed for a study of each participant's meanings from their words as well as the development of emergent themes. Throughout this process, the data was reviewed by the analyst in the context of a hermeneutic/Gadamerian dialog between the analyst's pre-understandings and the concepts and new understandings emerging from the interview data (Gadamer, Weinsheimer, & Marshall, 2004; Smith et al., 2009; Smith & Shinebourne, 2012).

Multiple case study. Smith et al. (2009) recommend using around 6 cases for a study of this type. Furthermore, they recommend the sample be "reasonably homogenous" in order to "examine convergence and divergence in some detail" (p. 3). For this study, each case represented an individual therapist/participant and their experience.

Participants. Five experienced, practicing, licensed therapists were selected to participate in the interview. All participants had completed full EMDR Therapy I and II training and had recently participated in ongoing EMDR consultation support groups. They all utilized EMDR Therapy with no less than 10 percent of their clients. All participants endorsed experience using EMDR with clients who had been diagnosed with symptoms of complex trauma and/or PTSD.

Because we were looking for a small number of cases, and because IPA looks for similarities within a relatively homogenous sample of cases (Smith, 2008), participants were recruited using referral, opportunistic, and snowballing techniques. Initial referrals were solicited from EMDR consultants in Thurston, Pearce, and King Counties who were aware of EMDR practitioners who might meet the qualifications requested by the study. Qualified EMDR practitioners were also asked for further referrals. Criteria for inclusion were the following: Mental health practitioner, licensed in the state of Washington, completion of EMDR Therapy I and II training, three or more years of EMDR practice, recent participation in a consultation group, and utilization of EMDR with at least 10 percent of clients.

Qualifying volunteer participants were scheduled for 1-2 hours at their convenience. Interviews were held in the participants' offices. No compensation for participation was provided beyond what participants experienced and learned from the interview process. All participants were offered access to an Adobe Portable Document Format (PDF) electronic copy of the dissertation upon its completion. They were also e-mailed encrypted copies in PDF format of

their transcripts along with a reminder of the opportunity to change interview content or to withdraw from the study prior to beginning of cross/case data analysis. None of the participants responded with either changes or requests to be withdrawn from the study.

As all participants had earned graduate degrees and had prior exposure to research, participant related documents were written taking their education level into consideration. The necessity of any therapeutic follow-up to the interview was considered highly unlikely, however, information regarding local resources for consultation/therapy relating to the interview was made available to all participants. In their informed consent, participants agreed to assume financial responsibility for any consultation and therapy related to the interview process.

Semi-structured, in-depth interview. Smith et al. (2009) describe the qualitative research interview as "a conversation with a purpose" (p. 57). Utilizing a semi-structured interview format accommodated the objective of asking for specifics while allowing participants to provide responses that expand the original questions in ways that give the participants meaning. A schedule made up of questions that were both expansive and open-ended was developed.

The actual interview was guided, rather than dictated by the schedule. Where appropriate, the interviewer followed the participant's lead in order to better understand and document their concerns and interests.

Interviews were conducted one-on-one with participants. Participants were encouraged to be both descriptive and analytical. As the participants were "experts" in their practice, the interview was designed to allow them to think about, share, and reflect that expertise with the observer/interviewer in ways they may not have previously considered. As such, this model proved valuable to both parties (Smith et al., 2009).

Interview questions and schedule are documented in *Appendix G: Interview Schedule*.

Steps of the Method

      Development of materials. Materials utilized in this study have been organized within Appendices A through F and includes the following:

- Recruitment Flyer (see Appendix A). This single-page handout provides potential participants with an invitation to participate in the project. Its intent is to spark interest in the project by providing a brief overview and to provide interested candidates with information needed to contact the primary investigator.

- Online prescreening interview form (see Appendix B). This document contains contact and demographic information which is required to select and follow-up with interested candidates for participation.

- Prescreening phone interview schedule/script (see Appendix C). This document provides a standardized telephone screening dialog script. It solicits the same information that is contained in the online prescreening interview form.

- Contact List (see Appendix D). This list contains all project related contacts as well as additional contacts outside of Antioch University Seattle in case participants have concerns regarding project practices or ethics.

- Project specific informed consent and description (see Appendix E). The informed consent document for this project was developed for participants who have graduate degrees in psychology and some level of experience with research. That said, the document includes a description of the process, reminds the participants of their access to their interview transcripts and their ability to remove themselves and their data from the study without explanation or penalty, describes the need for participants to protect their clients' confidentiality during the interview, and discusses the efforts

taken to keep the raw data confidential. It also describes possible benefits of the

project and notes some of the legal limits of confidentiality. The final section of the

consent is a six-point confirmation of participant understanding which includes

current contact information for the investigator and their faculty research advisor.

- Project description (see Appendix F). A 2-page overview of the project was made

  available specifically during recruitment of participants and subsequently upon their

  specific request. This document is a hand-out for participants and other interested

  parties that provides a high-level description of the project.

Subject selection. Immediately following the Antioch University Institutional Research

Board (IRB) approval of this project, we began recruiting and selecting the participants for this

study. Potential candidates were identified via recommendations solicited within the EMDR

trained therapist community in the State of Washington. Information packets were distributed via

e-mail, and five final participants were selected from respondents. More details of the Subject

Selection process are described in the Introduction to the Results section below.

Data collection. The means of collecting. storing, protecting, and deleting data are an

important part of eventual project success.

Semi-structured in-depth interview – schedule of questions (see Appendix G). Smith et

al. (2009) recommend utilization of an interview process that supports adequate coverage of the

topic while allowing participants to expand on the material anticipated by the investigator. A

semi-structured in-depth interview provided a schedule of open-ended questions that, while

suggesting opportunities for discussion, did not limit the responses or evolution of the

conversation.

Recording process, equipment. An audio recording of each interview was created on a secured laptop. No video recordings were made. During each interview, a duplicate, backup, audio recording was created using a separate digital recording device. Because the backup recordings ended up being higher quality than those recorded on the laptop, they were copied immediately to the laptop after completion of each interview. The non-secured digital file residing in the recording device was then deleted. The audio recording was reviewed for confidential content, none of which was found in any recording.

After review, the digital recording file for each of the first three interviews were transmitted to Trint, https://www.trint.com/, for transcription. Trint, a computerized transcription service, had been initially selected because of low cost. Their error rate, however was quite high, resulting in excessive review and correction time after receiving completed transcripts. Rev, https://www.rev.com/, was subsequently used for transcription of the fourth and fifth interview. Rev's error rates were acceptable. Both services offered encrypted transmissions and confidential transcription.

Data protection. In any project involving human subjects, confidentiality is a significant consideration. As such, it is important to protect any source data that could be linked to an individual participant. Protecting this data not only reduces participant risk of unintended and undesired exposure, it supports participant honesty and open disclosure of information that they might otherwise withhold. This project protected participant source data by always storing and transporting it in encrypted files on password protected media. Furthermore, data was backed up to encrypted files on physically secure disk drives. Both the laptop and desktop computers which have been utilized by the project have run the latest versions of Microsoft Windows 10 (operating system), Norton Security and Backup (anti-virus, firewall, and webpage / email

screening), and Retrospect (encrypted, secure, backup and recovery software). Dropbox, which was used for online mirroring of computer data files provided a minimum of HIPAA compliant security, both for their data storage and transmission. In the end, no confidential data other than that utilized for participant contact and screening was stored electronically. Contact and screening data was stored separately from interview data. No file names contain obviously identifying data.

Data security, backup, and transport. All computer work handling raw and/or unsterilized data was limited to two computers, one desktop and one laptop. Data on these computers was mirrored to a secure Dropbox account, unique to this project, which was accessible only by the investigator and the Faculty Advisor. Digital audio files were maintained on these machines and on Dropbox until the dissertation was successfully defended. Files downstream from initial transcription were sterilized of information identifying either the participants or their clients. Prior to analysis, participants were given the opportunity to review, modify, and/or remove their interview data from the project, without explanation.

Identifying information in audio recording. Although participants were requested not to provide any identifying information in their interview, all audio file transcripts were reviewed for active sterilization of any information that identified either the participants or their clients. No identifying data was found. No changes were needed.

Locked files for all paper documents. All paper documents containing information identifying participants were stored in a locked file cabinet in a locked office.

Source data destruction. All source (raw) data will be destroyed not more than 120 days after it is required for this project. Furthermore, in the case of disablement or death of the primary investigator, responsibility for, access to, and directions for deleting source data files

will be provided to a personal agent who will be identified in both project documentation and in a codicil to the primary investigator's will.

Data analysis. Analysis of collected data represents one of the most critical components of this project. Proper analysis of data within IPA allows investigators to identify and isolate themes in individual cases, while standardizing terminology and labeling of data in a manner that supports cross-case analysis (Smith et al., 2009).

Reading and re-reading. It is important that the participant becomes the focus of each case analysis. To ensure this focus, IPA analysis began with the investigator immersing himself in the original data. This immersion began with the analyst reading and rereading the interview transcript and listening to the recorded interview. This process slows down the analyst's tendency towards "reduction and synopsis." At the same time, phenomenological "bracketing" can be at least temporarily supported by the analyst noting their own thoughts and responses in a separate notebook (Smith et al., 2009, p. 82). The repetitive nature of this process, (i.e. reading and rereading), acknowledges the changes in interpretation that can occur with growing familiarity with the material, in that each subsequent reading of the transcript builds on the prior understanding of the data.

Initial noting. Smith et al. (2009) refer to this step as "the most detailed and time consuming" (p. 83). The aim of initial noting is the development of a set of notes and comments on the transcript that is both detailed and comprehensive. While relatively unconstrained, this is, again, an initial pass of the data, focusing on engagement with the material and identification, not only of key objects of concern, but of their meaning to the participant. Smith et al. (2009) recommend breaking comments down into processes that are discrete and that have different focuses. As an example, they note three possibilities: descriptive comments, linguistic

comments, and conceptual comments. They also recommend deconstruction and de-contextualization of the transcript, such as reversing the order of sentences in a paragraph as a means of avoiding anticipation of an assumed meaning of what the participant is saying.

Initial noting is an iterative process, involving engaging with the data from differing perspectives. Smith et al. (2009) note that "These differing approaches share the fluid process of engaging with the text in detail, exploring different avenues of meaning which arise and pushing the analysis to a more interpretive level" (p. 91). The specifics of approach are often determined by the content and context of the data collected.

Within this analysis, initial noting was performed utilizing the online analysis tool, Dedoose (2017). Dedoose was used to build a database of media, excerpts, descriptors, memoranda, and codes. Initial, sterilized transcripts were uploaded as media to Dedoose. Each transcript represented a single case, or interview. Within Dedoose, the initial transcript was read and re-read, with the analyst defining and breaking out excerpts for further review and analysis. Each excerpt was reviewed from three different dimensions or perspectives. The first dimension represented the language as presented by the transcription of the interview. The second dimension represented the meaning attributed to the participant by the analyst. The third dimension represented the meaning given to the concept by the analyst. Memoranda, or notes were developed that represented each dimension for each excerpt. Creating separate notes and readings for each dimension represents an attempt to bracket each off for analysis.

In the final/third pass, the analyst included their interpretation of notes from previous passes for each excerpt. Doing this added an additional hermeneutic circle, that between the initial transcript and each of the notes for previously analyzed dimensions.

Developing emergent themes. This step of the analysis works primarily with the initial notes, rather than with the source data for those notes. The analysis reduces the volume of the data without reducing the complexity found in the patterns and relationships in those notes. What originated as a narrative flow is broken up and re-organized into emergent themes. Smith et al. (2009) give this process a hermeneutic connotation, describing it as breaking the interview into parts that "come together in another new whole at the end of analysis in the write-up" (p. 91).

Developing themes "involves an attempt to produce a concise and pithy statement of what was important in the various comments attached to a piece of transcript" (Smith et al., 2009, p. 92). This involves multiple hermeneutic circles, one between the whole and the parts of the text, and a second between the participant's understandings and meanings and those of the analyst. Again, IPA's inclusion of both phenomenology and hermeneutic analysis includes the attempt at bracketing off the analyst's bias while acknowledging and engaging that bias into the analysis (Smith et al., 2009).

In this study, themes were developed by the reviewing the memoranda and deriving codes that described the memoranda contents. As they were being developed, codes were grouped and re-grouped hierarchically and contextually, eventually allowing themes to emerge. The analyst then associated the codes from the memos back to their original excerpts. Doing so allowed a back-reference to the original transcript excerpts from the memos and their derived codes, supporting inclusion of original text to support the subsequent analysis.

Searching for connections across emergent themes. Starting with a chronologically ordered set, themes are grouped into clusters that are related. Themes that are similar are then organized together, and those in opposition, organized apart. Themes are then grouped,

separated, and organized to evolve superordinate themes using processes like abstraction, subsumation, polarization, and contextualization (Smith et al., 2009).

Eventually the process slows and the emerging structure of the themes is represented graphically, or in a table. Smith et al. (2009) suggest a table that includes themes, grouped by superordinate themes, linked to transcript page and line and documenting pertinent key words from the transcript. This function was accomplished by utilizing links within the Dedoose database.

In this analysis, the Dedoose component, code, was utilized to create themes. Themes, derived from memos, were then grouped and organized hierarchically to identify superordinate themes. Associating Codes back to source excerpts as well as to derived memoranda supported automated generation of a report that supplied data organization similar to the table of themes grouped by superordinate themes proposed by Smith et al. (2009).

Moving to the next case. It is inevitable that what is learned in each case will impact the analysis of subsequent cases (Smith et al., 2009). To the extent possible, it is critical to bracket off what has been learned in each case to hold to IPA's idiographic component. It is important with each new case to follow a systematic approach that will support the emergence of new themes. In support of bracketing, each case will be completely analyzed and the data set aside prior to beginning analysis of any subsequent case.

In this analysis, each case was analyzed separately and all data except for previously defined codes was excluded from the analysis of subsequent cases. Each new case involved adding new codes as appropriate to existing codes. While each case did not utilize all of the codes generated by previous cases, the eventual result of each set of additions was a saturation of codes. The final interview contributed less than one percent of new codes to existing code base.

Identifying patterns across cases. Once tables have been created for all cases within the study, they can be compared for similarities. This analysis can involve backing off into theoretical context in which themes or superordinate themes represent a "higher order quality" (Smith et al., 2009, p. 101). Smith provides an example of a master table that re-organizes the themes of a study, interleaving the examples and quotes from each case where appropriate.

After all cases had been coded, the codes were summarized and reviewed as a whole. This review highlighted codes/themes that were superordinate across cases and provided a structure and outline for the discussion.

Results

Introduction

Information regarding the study was e-mailed to 20 potential participants suggested by EMDR consultants. From that initial mailing, six participants responded. Three of the responses indicated self-elimination based on selection criteria or availability. The remaining three respondents qualified based on experience, practice, and consultation group participation. Two participants were subsequently recruited via conversations with members of the EMDR therapist community. A total of five individuals met the criteria and agreed to participate in the study. During the fifth interview, it became apparent that the coding had become saturated as less than 10 new codes were added to the existing 215. I decided at that point to stop recruiting more participants.

Participants included one male and four female practitioners. All participants fell within the ages of 40 to 65 years old. All had valid licenses to practice as mental health professionals in Washington State. All had completed EMDR I and EMDR II training. All had used EMDR Therapy in their practice for more than three years. All participants utilized EMDR with at least 10 percent of their clients. And all participants were either currently involved in EMDR consultation groups, or had been involved within the previous 12 months. Three of the participants had a blended practice that included mental health clinic and private practice. Two of the participants had exclusively private practices. Four of the participants had Master level degrees, and one of the participants had a Doctorate. This sample size of five participants supported in-depth exploration of each case narrative while allowing for analysis that included data crossing all five cases.

Participant Descriptions

The EMDR Therapy community in King, Pierce, and Thurston Counties is relatively small with many of the practitioners meeting for both training and consultation. Although demographic and descriptive information was collected on participants, teasing out meaningful differences in the demographics proved difficult in the context of confidentiality, even when using pseudonyms. For that reason, no description beyond gender and approximate age will be provided for each narrative. Even so, the narrative stands on its own without inclusion of additional background information. Pseudonyms and approximate ages are provided in the next section in Tables 2-6, each of which presents superordinate and subordinate themes emerging from one participant's interview.

Primary Findings

Data derived from the five interviews were rich with content and meaning. During analysis, the five interviews resulted in 262 excerpts, and 443 notes. Over 200 individual codes evolved to identify and group concepts presented in the excerpts and notes. In the end, four superordinate themes surfaced out of the analysis. These included *Therapist Experience*, *Trauma Conceptualization*, *Stabilization*, and *All these Tools*.

As codes were grouped and organized hierarchically, *Therapist Experience* evolved out of several of the higher-order themes that had surfaced during the analysis. These included *Drive to Understand*, *Drive to Help*, *Drive to Relate*, *Evolution of Practice*, and *Understanding Limitations*. These higher-order themes represented participants' relationships to most other themes in the interview. However, they overlapped significantly with each other and, by themselves, did not qualify as superordinate.

Trauma Conceptualization as a superordinate theme, included a broad range of concepts ranging from physiological models, to pre-trauma vulnerability, to various causes, forms, and results of traumatic experiences.

Stabilization and *All of These Tools* evolved out of a separation of generalized treatment strategies and concepts from specific toolsets. Understandings, strategies, and approaches to stabilization of clients were organized under *Stabilization.* Specific toolsets and discussion of psychoeducation were included into *All of These Tools*.

Originally a separate theme, *Theoretical Orientation* was eliminated. Although initially trained with different theoretical orientations, the therapists interviewed for this study described a wide range of practices and beliefs that generally included Common Factors (Duncan, 2002), Rogerian acceptance of the client (Rogers & American Psychological Association, 1985), the importance of safety, and the critical importance of therapeutic relationship. Other practices such as EMDR, CBT, DBT, mindfulness, and body related, somatic therapies, were described as tools, as means to an end. Similarly, case conceptualization originating from Family Systems, Psychodynamic, or Cognitive Behavioral origins quickly evolved to more integrative formulations that were largely based on the EMDR Therapy Adaptive Information Processing (AIP) model and its conceptualization of trauma.

Table 1

Study-Wide Superordinate Themes (n/N)

Superordinate Theme	Subordinate Theme	(n/N)
Therapist experience		
	Drive to understand	(5/5)
	Drive to help	(5/5)
	Drive to relate	(5/5)
	Evolution of use	(5/5)
	Understanding limitations	(5/5)
Trauma conceptualization		
	Effects of trauma are profound	(5/5)
	Big-T vs Small-t trauma	(5/5)
	Complex developmental trauma	(5/5)
	Impact of AIP on concept of trauma	(5/5)
	Visualizing trauma	(3/5)
Stabilization		
	Stabilization as part of all treatment	(5/5)
	Relationship	(5/5)
	Client Strengths	(5/5)
	Transition between EMDR and resourcing	(5/5)
	Lots of trial and error	(4/5)
	Slow and safe	(4/5)
All these tools		
	Tools included in EMDR I and II training	(5/5)
	Other tools	(5/5)
	Psychoeducation	(5/5)

Table 2

Case A – Themes for Gerald, Male, Age ~ 62

Superordinate Theme	Subordinate Theme
Therapist experience	Drive to understand
	Drive to help
	Drive to relate
	Drive to balance
Stabilization	Balancing cognitive, emotional and somatic experiencing
	Increasing intimacy tolerance
	Trust
	Getting to safety
	Conversational
Trauma conceptualization	Triune brain conceptualization
	Suppression of memory
	Trauma circuits as survival mechanism
	Childhood trauma
	Trauma and sequelae can be barrier to relating
	Pre-Trauma vulnerability
	Out of mind
All these tools	Lots of trial and error
	Life skills development
	Mindfulness
	Reminding clients of strengths
	Calm/Safe Place
	Conforming vs. taking risks

Table 3

Case B – Themes for Heidi, Female, age ~ 50

Superordinate Theme	Subordinate Theme
Therapist experience	Drive to understand
	Drive to help
	Each client is unique
	Discomfort with protocols
Stabilization	State change
	Building healthy networks
	Engaging multiple senses with imagery
	based resourcing
	Deep breathing
	Mindfulness
	Humor is important
	Lots of trial and error
Trauma conceptualization	Impact of AIP on concept of trauma
	Big-T v. Small-t trauma
	Physiological model
	Client is often unaware of having been
	traumatized when they come in
	Pre-Trauma vulnerability
	First responder (vicarious trauma)
	Cumulative effects of trauma
All of these tools	Grounding
	Earth, Air, Water, and Light
	Top Ten Life Experiences
	Calm/Safe Place
	Container
	Resource Development and Installation
	Develop checklist

Table 4

Case C – Themes for May, Female, Age ~ 57

Superordinate Theme	Subordinate Theme
Therapist experience	Drive to understand
	Drive to help
	Drive to relate
	Understanding limitations
Stabilization	Client comfort early in the process
	Hope and Concern
	Develop a plan with client
	Assessing client readiness
	Importance of going slowly
	Getting to safety
Trauma conceptualization	Everyone experiences trauma
	Effects of trauma are profound
	Impact of AIP on concept of trauma
	Big-T v Small-t trauma
	Client is often unaware of trauma when they come in
All these tools	Psychoeducation
	RDI as a gentle introduction to EMDR
	Container and Calm/Safe Place
	Clients don't always use Calm/Safe Place
	Pillars of Life

Table 5

Case D – Themes for Zelda, Age ~ 64

Superordinate Theme	Subordinate Theme
Therapist experience	Drive to understand
	Drive to help
	Evolution of use
	Discomfort with protocols
Trauma conceptualization	Client is often unaware of having been traumatized when they come in
	Impact of AIP on concept of trauma
	Complex developmental trauma
Stabilization	Stabilization as part of all therapy
	Balancing cognitive, emotional, and somatic experiencing
	Recognizing client strengths
	Using RDI with Children
	Ending a session
All these tools	Bringing in nature
	Psychoeducation
	Somatic work

Table 6

Case E – Themes for Zoe, Age ~ 44

Superordinate Theme	Subordinate Theme
Therapist experience	Drive to understand
	Drive to help
	Drive to relate
	Understanding self as therapist
Stabilization	Client comfort early in process
	Meeting client needs
	Importance of going slowly
	Getting to 2nd order
	Motivating client to continue
Trauma conceptualization	Complex developmental trauma
	Physiological model
	Big-T v Small-t trauma
	Current vs Past trauma
	Inadequate DSM definition
All these tools	Using RDI with Children
	Anna Gomez – Thought Kit for kids
	Modeling Behaviors
	BLS with puppets
	Somatic Resourcing

Discussion

Introduction

All participants fully engaged in the interviews. Their responses were well thought out, well informed, self-disclosing, and intimate. As the interviewer in all cases, I was impacted by what I heard and had to work hard not to move from an interview process into an unstructured conversation. Their input was that interesting.

Participants did not hesitate to ask for explanation of questions or to revise the structure to better accommodate their style of response. Each one took time and made the effort to ensure that they could bring their ideas and content into the discussion. As a result, while each interview fulfilled the intent of the semi-structured interview schedule, each took on its own life and provided a unique insight into the participant's world. As the interviewer and the analyst, I was inspired to give them their most accurate and meaningful representation in subsequent analysis.

Participants discussed their understanding of trauma, its effects on their clients, and the approaches and strategies that they used to help those clients. They talked about how they had incorporated EMDR Therapy into their practice and about how their exposure to EMDR Therapy and the Adaptive Information Processing (AIP) model had impacted their understanding of trauma and of their clients. Each also brought up issues relating to their experiences as therapists that were important to them. Gerald discussed the importance of balance and of relationship in therapy and in change. He also talked about the difficulty working with complex trauma associated with exposure to battle experienced by war veterans. Heidi discussed the breadth and importance of EMDR related training as well as the impact of cumulative trauma on first responders. Zelda discussed a variety of ways in which she had adapted EMDR standard protocol to accommodate session limits and co-therapy. May and Zelda discussed some of the

challenges associated with lack of acceptance of EMDR efficacy, as it was initially introduced into the field of psychology, along with an appreciation for the supportive research that has been performed over the last 20 years. Many discussed some of the issues related to practicing in a community mental health environment, seeing clients who were starting out as relatively naïve about or even biased against psychotherapy, noting the importance of going slowly, developing trust and a sense of safety. Zoe described developmental trauma and the impact it had on her clients. She also discussed the importance of trust, of going slowly, and of recognizing and building onto strengths that clients bring into therapy.

Therapist Experience

Much literature today focuses on the experience of the client in therapy or the efficacy of treatment. After all, it is the client experience that therapy is intended to affect. This study, however, examines how therapists experience their work. As such, the first superordinate theme to surface from the interviews was *Therapist Experience*. In these interviews, participants described their experiences around working with their clients. From the many themes that emerged from the data, the higher-order themes, *Drive to Understand*, *Drive to Help*, and *Drive to Relate*, evolved early on. As data from the five interviews was consolidated, I initially considered *Therapist Motivations* as a higher-order theme. However, each of these subordinate themes stood out to the extent, that I decided to represent them individually. In the end, five higher-order themes, *Drive to Understand*, *Drive to Help*, *Drive to Relate*, *Evolution of Practice*, and *Understanding Limitations* were included under the Superordinate theme, *Therapist Experience*.

Drive to understand. All five participants discussed their experience in the context of developing multiple layers of understanding with effort and over time. They were intensely

interested in their work, and while they used different language and organization to describe what was happening, they each discussed ways in which they thought about their work, ways in which they conceptualized and thought about their clients, and ways in which they understood themselves in the process of working with their clients.

Zoe discussed ways of assessing clients in order to better understand their progress in therapy. Here she describes getting information up-front and then later, as work with the client proceeds.

> I'm practical too. I'm looking at symptom reduction. I use screens, I use the PHQ, the Beck Depression Inventory, the Beck Anxiety Inventory, I do an Achenbach assessment that will start out with an adult self-report, and then we'll do it again later. That also informs, to me, how effective the treatment is that I'm utilizing, and so maybe there's trauma and this person's dealing with substance use to cope with distress that's related to depression. (p. 15)

Gerald described his understanding of the ways in which some of his clients experience emotional responses that are triggered by reminders of earlier traumatic experiences. Here, he portrays what a client may initially present, when they first come into his office.

> If there's an emotion of fear with the trauma that's attached to the memory of the trauma, then when someone is reminded of that memory it comes back with that same fear, sometimes the same level of fear. (p. 2)
>
> But when somebody comes into my office they generally think about how broken they are. And they've never put it into these words. They know perhaps that they feel fear but they don't know why. They don't know what it's about. So that sort of the fear may come up without the memory of the trauma. (p. 2)

> It may be triggered because something that's said or something that occurs reminds them of that experience. But they can't deny their feelings, even if they continue to pretty successfully stuff down the memory. (pp. 2-3)

Heidi discussed her understanding of compassion for what clients have gone through. Here she describes how they have survived, and how she feels about the effect that she has had on them.

> Most of the time it's just a lot of compassion for what they've gone through. I, you know, I experience I think over and over again the, just the amazement at the personal stories of each and every human being that walks in my door. It's pretty remarkable, what they've done, what they've been through, some of them, and how they've managed to cope. And so, I kind of appreciate the value of the story of their lives. And so, those are positive things. I think, with EMDR it's a very positive feeling. I feel like I'm making a difference in some of their lives. (p. 6)

May discussed her understanding of how she responded to her client reports of traumatic experiences. Here, she describes how the effects of listening to client's trauma experiences have had on her have changed over time. She takes that further to discuss what she understands about the effect of her expressing some level of feelings in therapy sessions has on clients.

> So, I used to take things home much more than I do now. And I would say some of my own feelings from my… That might be described as, hopeful, determined, and caring. I don't know if that's a feeling, exactly. Sometimes I will feel sad. Although, not so often. Often, I feel moved by people describing relationships that matter to them and it's not unusual for me to be wiping my eyes in session. (p. 5)

Interviewer: OK. So, you really make things, it really sounds like a strong differentiation between moved and sad. (p. 5)

May: Yes, that's true. And I'll say to folks, "That's really touching to me. I'm so moved by that. But I'm not weeping. I'm leaking." And I think for most people, that's fine. Nobody ever looks afraid. You know, in my private practice I work with lots of therapists. So, they're like, "Great, no problem. Glad you're human." (p. 5)

Zelda discussed her understanding of her strengths as a therapist. Here, she talks about the role that her strengths of intuition, emotional intelligence, and tolerance play in her approach to therapy.

I think that I am strong in intuition, and I'm strong in, sort of, emotional intelligence. I can guide people, cognitively, back to center a little bit. I don't find myself an incisive interventionist or anything like that and never have been. It's not my identity.

But I recognize I have a pretty wide tolerance of every aspect of human behavior. And in that knowledge and acceptance, I think I can help people come back to a sense of themselves, find their resources, and go on with their life after being crippled by depression, anxiety, transition, and grief. (p. 2)

And here, Zelda describes how she starts with understanding her clients' motivation for coming into therapy, what they are looking for and what has worked and not worked in the past. Early on, she negotiates an agreement with clients that they will let her know what is working and not working in therapy as it proceeds.

So, it begins with their motivation for coming in to therapy. Like their goals, and what they want. I'm always curious about a history of therapy in the past. Usually people have

one. What worked and didn't work. And an agreement with them that they will keep me

posted about what's working and not working. (p. 7)

Drive to help. Psychotherapy and mental health are often referred to as helping

professions. Throughout the interviews, participants described many ways in which they were

motivated to be effective and helpful to their clients.

Here, Gerald portrays his attempt to get answers to how-to questions from an expert in

the field, Bessel van der Kolk, at a presentation.

I went down there to learn from the expert. How do we do this? What am I missing?

What do I need to know? I mean, tell me. You're the expert. You've been doing this

forever and ever. Tell me the truth here. Right? Give it to me straight.

And he said, "Well, we have all these tools. Like, EMDR works when it works.

Play Therapy works when it works. Hypnosis works when it works. Where, you know all

these things that we have available to us. If something's not working, you know,

according to the DSM 5, according to the AMA, according to APA, the American

Psychological Association, according to whatever. Ethically speaking, you could do

these. You can diagnose. You can do these therapeutic methodologies. You can have

what you can ethically bill for and be paid by insurance companies. And if your client

isn't getting anything from them you're not doing any good. (p. 18)

Here, Gerald shares both his frustration that there weren't simple solutions and his

motivation to get it right for his clients.

Ethically you might be doing everything perfectly. But what's the point in that. If he, if

what you're doing isn't working, by god, try something else. That's what I took away from

that weekend. Pissed me off. I wanted the answer, but what he said was, "It's up to you."

You know, you do this. You do that. It takes work. It takes us being so very curious and working so very hard to do the right thing. (p. 18)

Zoe, when discussing stabilization, noted that she tries out tools and therapy approaches before passing them on to clients.

About stabilization, I think one of the key things for me is that I don't really tell clients about anything that I myself haven't either done or I'm willing to practice for my own self. In particular with my base practice, that's something that's been integrated into my life and my work for a really long time, but there might have been a time many, many years before, when you asked that question earlier, where I could talk about mindfulness but I really wasn't applying it. From the DBT perspective, there's a strong emphasis on, "Don't even come to do this work if you don't know what it is that you're doing from your own experience." (p. 16)

Zelda addressed several ways in which she has evolved a style of working with clients. Here, she discusses approaching trauma without labeling it as trauma, to avoid victimization.

And so, with that as the goal, then, you know, we sort of conceptualize together. We do an inventory. But unspoken, I'm evaluating how to go about working with trauma without it being so overt. I don't want them to identify 100 percent with being a trauma victim because I think that it is heavy in that I think that there's a lot of, resilience that can reside in someone, even if they have an ongoing trauma history.

When they realize how bad their trauma history is, they get really heavy and dark and sunk. They see their friends with trauma history really dark and sunken. So, I try to keep an eye, also, on the resiliency while we're organizing traumatic reactions to things. (p. 1)

And here, Zelda describes tailoring the EMDR standard protocol to fit with her style of working with clients and with their requests or insurance requirements for insurance driven reductions in session length and number.

> So, here's my cowgirl version. We will do a little bit of a trauma timeline, working from the present trigger and doing the float-back. And finding out earliest times, the first time they felt that way. As much as they can remember.
>
> Before that. I make sure they're super educated about EMDR and then point them to all the resources. A lot of people have seen an EMDR therapist before me and I hear all kinds of stuff didn't work. "It was horrible." Or, "Oh my husband saw this person was so fabulous, so I'm going to come." 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.
>
> The second session going over what we might target in getting prepared and even doing all the like protocol, the targets, and SUDs, all that stuff.
>
> Then, usually about the third session, I like to get going…Sometimes I'll even start it at the end of the second one, not with a big thing, but maybe resource building so they're familiar with it. For people that are kind of impatient to get going. (p. 5)

Heidi talked about utilizing tools for grounding for most of her clients. Here she describes adapting and customizing the tools as needed.

> Well, just about everybody that comes in my door regardless of what they're there for within the first two or three sessions gets the deep breathing exercises because I feel like that's really a basis for a lot of things. And I'll tailor it to the person. (p. 7)

Some people who are much more linear or left brain. I'll give them the physiological reasons why we do it and then other people don't really need that. But I think it's important for people to know the value of taking a belly breath and actually stopping and breathing sometimes. So that's one of the first things I do with just about everybody. (p.8)

Drive to relate. As participants discussed ways of resourcing clients, they repeatedly returned to discussion of relationship. At times, they discussed relationships and relating specifically, but more often, they described the ways in which they and their clients experienced each other. Relationship, empathy, trust, and engagement were described as critical components of their practice. And not surprisingly, they all engaged and related with this interviewer in a lively manner during our interviews.

Gerald based many of his perceptions of his clients and of their progress on their development of relationship. Here, he discusses the importance of relating with his clients in session.

Yes. Join me, in this room. And everybody wants to. Really, I think everybody wants to. So EMDR, like any other therapy, to my way of thinking, requires a connection. It has to be real, not fake. It's not them answering questions and seeing that I'm intelligent, based on my questions. They don't care about that. Some people look at my diplomas and say, "OK he's got a master's he must know what he's doing." But if I can't connect with them, they don't care about that. And the real work, I think the real therapeutic benefit comes from, starts with, this place of, "Are we human and together do we have a connection?" "Can I trust this person?" "Are they good to me?" "Do they listen to me?" "Do they get me?" "Do they judge me or, do they just accept?" (p. 18)

While Heidi never used the word, relationship, she described the experiences she has with clients in the context of empathizing with them based on her own history.

> So, I think I have a lot of life experience, and that gives me the ability to understand people in a lot of different ways, because, I feel like I've experienced so many different things in my life that I can I guess I can empathize or put myself in the shoes of many other people. And if I haven't personally experienced it I've seen it in other realms. (p. 4)

Here, Heidi describes how her earlier position as a first-responder enhances her ability to relate with clients whom she sees today.

> I was a first responder for twenty-two years. So, let me rephrase that. I just found myself thinking about what caused people to do what they do. And so, I feel like just having that enriches my ability to understand them, and not judge what they're doing or where they're coming from in some of their views. I also think one of my gifts has always been compassion. And you become a good teacher. (p 4)

When asked what was not effective in her practice, Zelda talked about boundaries and the tricky nature of support in her relationships with clients. Here, she describes concerns that she has possibly lost clients where they were looking for more active interventions than she has provided.

> I think I've lost the client or two, who thought I was too kind; and they really wanted someone to push them around more. And you have to do what you do naturally as a therapist. For some clients, I can be a little bit more interventional, assertive. But maybe, being too understanding isn't very helpful. People really want boundaries. Assertive boundaries… Like it is with parenting, too strict or too allowing. Those aren't very helpful. (pp. 8-9)

Zoe described a form of interaction with her clients that involved both trust and risk. Here, she addresses having a capacity for empathy while holding space for the more painful components of therapy.

> The therapist that I am now, I've been doing this a long time. I think part of it is that I feel pretty competent myself with the choices that I make related to an individual. I really listen and look for and help bring out an individual's strengths, so we can build on that resource that they already have. I feel comfortable and confident doing that with them, and then I offer a lot of capacity to be empathic and hold the space for really getting it. I can be there with people, in a way, to affirm their experience and also acknowledge the difficulty of the experience, and oftentimes say, "Well, as painful and challenging as that is, you're here right now and that says a lot about you as a person. You've made it this far, so let's build on those strengths while we're also dealing with these other parts." (p. 4)

Zoe also discussed the importance of boundaries, and empowering clients to support themselves. Here, she describes her response to a client as she is handing them back the credit for work done in a session.

> Sometimes clients, this one in particular too, will say, "Thank you so much for," whatever work it is and I always give it back to them, I'm like, "Yeah, you're doing all the work, I'm just purely kind of reflecting some stuff back," and that's the place I like to be in. I do not want to be anybody's person that they ... I know you can't see that on the recording, but a person that comes, that they feel like they have to go to, to be okay. I do not want that for them, and I don't want it for me. (p. 5)

May mentioned, multiple times, the importance of getting the relationship off to a quick start with new clients in a community mental health environment. While she hesitated slightly in

her response to questions about her strengths as a therapist, here is an example of how she views her capacity to relate to new clients.

> I think I'm good at helping people feel comfortable early in the process. So, the biggest part of my career has been in community mental health, working with adults between about 20 and 65.
>
> So, I have lots of experience working with people who are very afraid of coming in for services. And I think maybe I would consider it a gift that I have that often after the first visit, people say to me, "Well that wasn't as bad as I thought it would be." Or, "I think we can actually do this." Or, "I like you." Or, "I think this can help."
>
> But I have a very non-threatening and non-confrontational style. And so, I think it makes people comfortable and it makes it easier for them to work. Now, I might not zoom some people along as fast as some more confrontational therapist could. So that could be a weakness of mine. But in terms of connection, and communication, and instilling hope or opening the window for hope to be, to come in, I think that those are my strengths. (p. 3)

Evolution of practice. Participants reported various ways in which both their understanding of trauma and their practice evolved over time. Specifically related to EMDR, most therapists changed their relationship and perceptions of EMDR as a treatment modality over time. Most utilize the standard protocol, both in form and format. Most also acknowledge spending a significant amount of time with clients building foundational stability, prior to a directly addressing trauma utilizing EMDR.

In terms of therapist experience, most practitioners described holding a dialectic between wanting to conform to the standard protocols while acknowledging the validity of other modes of

work and the need to move back and forth between EMDR and talk therapy. All of the

participants considered EMDR an important part of their practice.

Heidi trained in EMDR early in her therapist career. Here, she describes some of her

initial experience followed by what she did, over time, to incorporate additional training and

consultation into her practice.

> It's so awkward at first. And I was a new therapist. I mean I got to [EMDR] training right
>
> away. So not only was I a new therapist, but I was also doing something that was not just
>
> sitting there talking to somebody. It felt awkward, but I guess one thing I really like about
>
> myself is that I've always just jumped into things, and I guess, not with caution to the
>
> wind, but with some caution, I jump in anyway and do the best I can with what I know.
>
> And then, I sought consultation as well all along the way. I have stayed in an
>
> EMDR consultation group and sometimes have paid for specific individual consultation
>
> on things where I felt either stuck or the person was more complex. And then, I've taken a
>
> lot of training in EMDR. I'm kind of a training junkie. And that has expanded and
>
> enriched my, my EMDR skills. Having a lot of different views, some are a bit more
>
> conservative EMDR views, and some are some of the adjunct that are still EMDRIA
>
> approved.
>
> I always look for EMDRIA approved trainings. and just building that into my
>
> practice so that I have more to offer the individual that comes in my door. Because what
>
> works for one person may not work for another. So, and I found that having more tools in
>
> my tool belt from all this EMDR training has really, has really helped me be a better
>
> EMDR clinician. And I still review like right now I'm reading the EMDR Primer. (p. 20)

In discussing how he his practice had evolved, Gerald talked about initially thinking EMDR was just about following the protocols.

> And by the way, when I first started being trained with EMDR I thought to myself, "This is going to be scripted. This is going to be, you know. I know it's powerful and I want to learn it. But it's just going to be this thing. And I'm going to pull it out, you know. I mean, I'm gonna read the scripts [protocols]." And what I found is that it takes as much intuition as anything I've ever done. (p. 40)

Zelda noted how EMDR had changed for her over the years. Zelda trained early in the evolution of EMDR and EMDR, itself, evolved. She presents, here, a somewhat unique perspective within this study, in that she was aware of preferring EMDR earlier in its development to EMDR as it evolved into more and diverse protocols.

> I found myself being an extremely effective EMDR therapist for the first 10 years before it got really organized more and more. And more people put their claim on, you know, different modalities and all these different steps. And then, it got a little overwhelming to me. (p. 3)

Zelda also observed that her clients are getting more complex. Here, she notes that she spends more time developing resources and stabilizing clients than she does practicing EMDR reprocessing.

> But it seems like more and more. Rather than get a client who has had a single incident, I get people referred that have histories. And it's so complicated, and it's more than... So, a lot of that's psychoeducational stuff. That and that maybe we can clear up some parts that might give them more resources about the other parts. That could be a very long-term thing. (pp. 5-6)

Here, Zelda discusses problems that she has had and changes she has made, over time, in the types of BLS she utilizes with clients.

> Interviewer: An extension of that [question] would be, "What types of bilateral stimulation do you use?"
>
> Zelda: Well, I went from strictly doing eye movement [manual] to using a tapper [electronic] in hand [and then] from a tapper to a light-bar. I use mostly the tapper now. But the two modalities that I use are eye movements still but the tapper more. And I usually don't touch people like tap on knees or anything like that. (p. 10)
>
> I think that I like the tapper because I like how you can immediately change it to being slow for resource building versus faster for processing intense material. It's really easy.
>
> [Regarding manual eye movement BLS] There was a period where I did it enough that I worried a little bit about tennis elbow. Like I had some purpose.
>
> Interviewer: Like the eye movement?
>
> Zelda: Yeah. They were out there you know. And I still like to use it for some; because, I do find you process more intense things. This is an ongoing thing in supervision because I kind of have a little idea that you don't process as intense material with a tapper as you do with your eyes. (p. 11)

Zoe described how differently she works now with trauma history than she had in the past. Here she talks about working more in the "here and now" with less initial emphasis on history.

> In some ways, I'm probably less ... I don't know what other people do. But and this is good, because it's taken me a long time to actually be comfortable enough to do it the

way that works. But I'm a here-and-now provider, oftentimes. So, if something's going on

in a person's life and we can sort out where it comes from, those are the pieces that I start

from.

I started out in my early training to do the whole history, and then try to go

through this thing. That just didn't work for me, and it didn't work for clients, probably

because I wasn't doing it right. I don't know. But it didn't get at what was happening here

and now enough. So, I start with that, and then I'll go to other things later. (p. 15)

Here, Zoe discusses how her use of homework changed over time. She reports evolving

from following standard CBT practices to paying attention to what she felt her clients could

handle and to what they would actually do between sessions.

So, in CBT, for example, there's lots of forms and to do lists, and homework. I would say

those tools and techniques absolutely have a place, and, a lot of times, depending on the

client and where they're at in their stabilization, they're more effective. But just sort of

issuing those as, "Yeah, go home and do this," and you might teach it once in here, and

then they leave with, "I'm supposed to do this x number of times."

I just found that really ineffective for 98% of the clients, and it's because they're

already overwhelmed. They already have an internalized, "I'm not good enough"

landscape, but let me give them a to do list in their already overwhelmed state of being,

that they're supposed to be, quote, "Motivated" to do, because if they're really invested in

their therapy, then they come back and do it. I just eliminated all that, I just don't find that

it was relevant to what was true for the lived experience. It might work nicely in other

experiences. But with trauma in particular, not helpful. (p. 13)

May and Zelda both reported the impact of EMDR therapy's acceptance by the therapy community has had. May and Zelda have practiced EMDR for multiple decades. Both noted challenges in the beginning.

Here, Zelda describes some of the feedback that she got from colleagues, particularly psychologists regarding EMDR as therapy.

> I just wanted to tell the story of being an EMDR therapist in the 90s and the first decade of the 21st century. I got a lot of negative feedback from friends who have your Ph.D. in psychology. "What are you doing?" You know, that's like. "There's no field study." "It's not a valid form of therapy." "It's, like, a placebo." Or, no, no, "It's a double placebo that the therapist also thinks it's helping." Or, blah blah blah. and.... (p. 17)

Here, Zelda describes the case that motivated her to get initial EMDR training. A client had been molested at age five. Zelda had seen the client for several years and at age eight the girl learned that her molester was going to get out of prison and was terrified. Zelda took the EMDR I training. She then utilized EMDR with her client and was able to reduce the terror to reasonable level fear and concern.

> And it was scary having her be my first [EMDR] client, because, at first, when we were working it made her disturbance worse and worse to bring up images for worst image and then it would be like AHHHH. And then I thought, "oh my god, I'm messing her up. What am I doing? Oh my god, I'm going to make this so much worse for her." And then, after about the fourth set or fifth set, I saw her face relax. And she went, "Ahhhh. Ohhhh." I said, "So what's going on?" She goes, "It went away."
>
> And so, we kept doing it, and it was gone. And so, she had a regular fear. But she knew what was going to happen and she trusted that it was an amorphous monster fear.

And it was like, "oh my God." It was a really amazing thing to see. And I had many experiences like that, that first time doing EMDR. (pp. 17-18)

When she noticed the changes in clients during reprocessing, Zelda was convinced that EMDR was a good tool, and she no longer felt a need to defend it as a practice.

So, when my friends, with all of their fancy criticism based on all their clinical experience. They didn't even make me defensive. It was like, "You know me. Of course, I am the last person to describe the dynamic that makes it fly. I don't know. It works, you know bilateral stimulation, left brain right brain integration. You know, we have a lot to learn about the brain. But this works." (p. 18)

May noted discomfort describing this new and different therapy to her clients and how that had changed over time.

I think when I first began to use it, it was so [new]. In the agency where I work, there were maybe two people out of hundred and something who were using it. Maybe one of those two were really using it as we are trained to use it, and I used to feel so uncomfortable describing it.

And now I feel much more confident describing it. I feel really accepting of whether people are interested in it or not. I don't feel like, "Oh, I described it badly again. No wonder they don't want to try it.", which is just how I felt really early in the process. Now I feel like, "Well, I described it well enough and they can decide if they want to try it or not." In my private practice, almost everyone who comes to me comes for EMDR. (p. 19)

Understanding limitations. In discussing limitations around how and when to utilize

EMDR reprocessing, participants paid a lot of attention to what their clients brought into the room. Both when initially assessing for appropriate treatment, and continuously afterwards regarding participants noted the importance of aligning their work to the current status of the client.

Zelda, when discussing the moves in and out of using EMDR with a client over time, noted that sometimes clients just don't want to do EMDR.

I think partly it's the client's desire to process without the structure of EMDR. like, they really need some time to just go over things.

When asked, Zelda explained that it was more than just wanting to talk.

And kind of organize. And maybe there're things that have come up, stressful events in current times, and they need to process more in a therapeutic setting without the EMDR and then move back in when they feel kind of ready and motivated or some of the stuff that they're struggling with in present time. We decide that might not have been so hard for them if they'd processed this other stuff through EMDR kind of making a decision that way. It does kind of come and go. Yeah. (p. 6)

May brought up issues related to clients who have unrealistic expectations of results that they are going to get from EMDR, clients who are not stable enough yet for EMDR reprocessing.

I'm thinking about those borderline clients that come to me and they're really. Their expectations [are] that trauma processing is going to happen fast and it's going to be super helpful and life is going be great. And I'm saying, gosh, first year, you know, I'd like for you to not be being hurt before we go to that. Some of them just leave treatment just like, "You're not fast enough for me so. Bye. bye." So, I'm like, "OK. Probably not fast

enough for you. And maybe we do need to say goodbye, but if you want to come back, I'm here." (p. 16)

Here May also discusses using Resource Development and Installation (RDI) for some clients who are not ready for EMDR reprocessing.

> Sometimes for clients who have those problems with consistently practicing safe place and container and they're insisting on EMDR, RDI is a way of beginning a process that is part of the EMDR process.
>
> Still, in the preparation phase, I'd say that can meet that demand that they want to have EMDR without going to trauma processing if I don't think they're ready. And sometimes I'll say, "I don't think you're ready and here's why. There is current trauma being added to your trauma tie-ups, and, therefore, we're not going to unpack something from the bottom of it. That would be too much. It would be unethical of me to do that. And it would be too much for you. It would be destabilizing." (pp. 9-10)

Gerald discussed overall limitations in the context of working with war veterans who have been suffering from PTSD for extended periods of time. Here he describes a single event involving one of his clients.

> It's hard. So, I work with a lot of Vietnam vets, and these are guys who after 45 years still, you know, still get triggered. They are practicing out of [a local military base]. You know. And they got rockets out there now apparently that make a lot more noise, and you know, these guys are aren't, aren't…
>
> One of my clients, on 9/11, when he was at work and he saw the buildings fall he actually drove. Drove home in a fugue state. Grabbed his gun out of his safe. Grabbed his

ammo out of another safe. Loaded his, got a hunting rifle and went to his window. Right.

And he was trying to acquire a target, as if he were back in Vietnam.

What do you do? I mean, he came to his senses before he pulled the trigger. I

don't know what. I think he was probably looking for a certain type of, certain look of an

individual. It's a good thing he didn't see one. (p. 12)

Summarization of Therapist Experience. As participants engaged in the interviews, it

became immediately evident that they were each passionate, in their own way, about their work.

It was important to them to understand their clients, both what the clients presented and what

was happening underneath the obvious presentation and self-understanding. All participants had

been trained in EMDR and worked with traumatized clients. All endorsed EMDR Therapy as an

important part of their work. All endorsed the Adaptive Information Processing Model as

foundational to their understanding of trauma.

Curiosity and motivation to understand became evident in the ways in which the

participants engaged in the material we discussed. Participants presented stories of their clients in

great detail, describing multiple dimensions of their clients' histories, their experiences, and their

growth as they proceeded through therapy. Participants also demonstrated clear understanding of

the EMDR related protocols that they used and of many of the theories that underlaid their

practice. Finally, participants all were often introspective during the interviews, questioning their

own strengths and weaknesses, and describing their own growth and changes in their practice

over time.

Along with understanding their work, participants described the importance of their work

having an effect on their clients. Each took seriously their understanding of what worked, and

what didn't work. Each described examples of both. And, each described how they had learned,

over time, to be more effective. Not all participants showed interest in learning additional EMDR protocols or practices at this time. However, all participants acknowledged wanting to improve and refine the skills that they had already developed. All of the participants noted the importance of EMDR Therapy consulting groups to that refinement. Each participant also noted specific ways in which they had tailored their practices to meet specific needs of clients, or to accommodate their own strengths and weaknesses as therapists.

Along with the drive to understand and the drive to help was a clear description of the importance of the therapeutic relationship to effectively practicing psychotherapy and acknowledgement of a strong motivation to develop and maintain that relationship with their clients. In different ways, each participant described the development of a therapeutic relationship with their clients as a primary component of their practice. In describing the tendency of clients sometimes to start and stop therapy, several of the therapists suggested that the benefits of the relational part of the therapy could stand alone as being therapeutic, particularly when clients had to terminate therapy prematurely. Within the context of the therapeutic relationship, participants highlighted trust and safety as important precursors to EMDR reprocessing.

All participants were able to describe ways in which their practices had evolved over time. While these descriptions varied, particularly in relationship to the duration of EMDR practice, each participant portrayed a sense of growing competency and comfort with bringing customizations and personal interventions into their practice. Additionally, all of the participants endorsed evolving an understanding that trauma is an underlying factor in much of the anxiety and depression that they observe in their clients.

Zelda and May, both of whom had trained in EMDR early in its development, noted an appreciation for the changes, over time, in acceptance of EMDR as an efficacious treatment for trauma. They both told stories about discomfort after demonstrating to themselves that it worked for their clients, when they could not get support from other therapists for their practice.

Finally, all of the therapists openly discussed their own strengths and weaknesses, including descriptions of clients with whom they had struggled. They all contrasted how quickly EMDR could work with how slowly the stabilization of a client sometimes went.

Trauma Conceptualization

A good portion of the interviews was spent discussing ways in which the participants conceptualized trauma. All of the participants endorsed changes that EMDR training and the Adaptive Information Processing model have had on their conceptualization of trauma. Evolving from looking at trauma as a separate issue, participants reported coming to recognize a high correlation between trauma and more frequently reported symptoms such as depression and anxiety. The high-order themes that were consolidated under *Trauma Conceptualization* were *Effects of Trauma are Profound*, *Big-T vs. Small-t Trauma, Complex Developmental Trauma, Impact of AIP and EMDR Training on Concept of Trauma,* and *Visualizing Trauma*.

Effects of trauma are profound. From flashbacks and fugue states, to difficulties working and maintaining relationships, to characterological disorders, anxiety, and depression, participants described challenging and sometimes horrifying symptoms experienced by their clients as sequelae to their exposure to trauma.

Heidi talked about the range of disorders that can result from trauma. Here, she describes effects that she has observed, specifically in terms of whether people can accomplish and complete developmental steps that contribute to subsequent quality of life.

Well, the effects are, I mean for most people, pretty profound. It can be anywhere from

dissociation, and eating disorders, to an inability to have stable relationships, or, you

know, good jobs because it affects their, affects their motivation sometimes, and their

ability to do their schooling. You know, in a normal, more normal, I say normal with

quotes the fashion because you know I guess the ideal is you know a child goes to school

and they go through elementary middle school high school right into college. But if you

had some trauma somewhere along the way I think you're even more likely to have

hiccups that take you off that road you know down another road.

So, I think it really affects the quality of their life and their ability to enjoy their

lives fully as fully as we can as human beings and to be in the moment. A lot of times

they're not in the moment they're worrying about the past or worrying about the future.

(pp. 2-3)

Here Heidi discusses how even the subtle reactions to past trauma can have significant

impact on clients' relationships and their lives.

Well if there are things that are unresolved in their life that they haven't worked through

it sometimes there are sort of reenacting things without knowing it. So, I'm not going to

say that every time you have an argument with your spouse that's just because of some

unresolved trauma. But if there's a pattern of this kind of argumentative behavior or there

are arguments that seem to come out of the blue. Or, there's distance between the couple

where, in the beginning, they were very close. Or, with friendships, people can't build

friendships because there's no trust so some of the deep underlying reasons for

relationship problems are the trust issues around traumatic experiences as a child or an

adolescent. (p. 4)

Gerald discussed the defensive response to trauma as being survival oriented. Here he describes how the memory of the incident or incidents gets "stuck," appearing irremediable.

These horrible things that happen to us. That gets stuck for a number of different reasons. I think often times of, like, pushing them down. This is something that right now I can't deal with or it's too big. Whether it's an accident or an attack or whatever it is. And I need to I need to shove it away so that I can survive them all. (p. 1)

Here, he then describes how the traumatic material appears to be stored in one place.

But not only is it shoving it away, but when I shove it away everything goes with it. All of the emotion, all of the whole experience, all the images, everything is stuffed in one place. (p. 1)

Here, he describes how when we access the traumatic memory, often inadvertently, it comes back in ways that feel out of control.

And that place that we stuffed trauma into. A particular trauma for example can be brought back up unintentionally. And that's the source of the suffering. When that comes back up with all of the emotion, all of the energy, the images, the memories. (p. 1) Sometimes it's about thoughts. When all of that comes back up, then the person suffers. And it's, it's, because it's powerful when it comes back up, it feels out of control; feels like it's got a life of its own. (pp. 1-2)

Here, Gerald describes how often trauma reactions impact relationships, and how individuals come in, motivated by relationship issues, or are pushed or brought in by partners.

Sometimes that has nothing to do with trauma, right? There is this maybe general feeling of disease, of an inability to connect. And so, we are relational beings. And trauma absolutely becomes a barrier. If they're in a relationship with someone they love and they

keep getting angry or afraid or whatever it is in the presence of this person that they love

then they're feeling like they need help and they don't know why and maybe their spouse

will bring them in, [partner saying,] "This person sucks". (p. 3)

Big-T vs. Small-t trauma. Participants differentiated between types of trauma that their

clients reported. Most reported both the rarity of and ease of working with the effects of a single

traumatic event. They went on to discuss the complexity and durability of Small-t trauma, trauma

caused by repeated injury and insult.

Here, Gerald notes the rarity of having someone show up reporting a traumatic event and

asking to work on it.

I had one person come to me saying I've diagnosed myself with PTSD and I want you to

fix me. I heard you got EMDR so fix me. That's a one off but it'd be nice if they all did

that. (p. 4)

Here, Zoe describes Small-t trauma in children as chronic, ongoing, and often,

incomprehensible.

Trauma happens when level of distress or threat to being causes a response. With

children it is particularly visceral, emotional, and psychological, partially because they

cannot contextualize what is going on. Often not a single incident, but chronic, ongoing

exposure to situations that feel out of control, not safe, unpredictable. (p. 2)

She goes on to describe how it is the adaptations to the trauma reactions that become the

eventual pathology.

People adapt, and what we see as symptoms are often the adaptation. And the adaptation

is not working well at the point that they come to get therapy. (p. 2)

Heidi and Gerald discussed the challenges they experienced working with clients who had cumulative effect of trauma such as first responders and military. Both participants associated their clients' vulnerability to adult PTSD with childhood trauma.

Here Heidi discusses working with clients who are exposed to cumulative trauma.

All combat and then then also cumulative trauma to me is really a big thing. I work with a lot of first responders and they deal with this one trauma after another. And, at first it may not bother them, and even later on they don't think it bothers them. But, if you dig deep they start having problems with feeling numb or empty or being angry all the time. And you know when you look at the situation sometimes that can be unwrapped to the traumas they see day in and day out. And, interestingly enough, a lot of times it goes back. It connects with something that happened in childhood as well, even if that thing in childhood was a Small-t. And then, these cumulative traumas that first responders see, we could probably consider those casualties. Although first responders would not consider it that way, I think most of the rest of us would. (p. 2)

Here Gerald brings up how, versus being traumatized by something that happened to us, trauma can also result from the feelings associated with things we have done to others.

Not only that but for him, the trauma for him was killing people. He was on one of those big guns and so he was bombing villages, and civilians, and whatever. Right. It's his job to do as he was told. When that kind of thing happens and you're filled with shame and guilt and remorse and you're filled with fear and terror and helplessness and hopelessness, which he was a lot, I don't know that at the time it would have been appropriate for him to be in his right mind. (p. 13)

Gerald, similarly to Heidi, theorized about the role of childhood trauma in vulnerability to adult PTSD.

> It is my opinion, and I'm not the only one who said it, but it's my opinion that, in order to really develop PTSD, the beginnings of it start in childhood. That's my opinion. So, anybody who goes to a war zone and comes back with PTSD, we can look at their childhood and see the beginnings of this trauma in their childhood. (p. 14)

Complex developmental trauma. Complex developmental trauma, or the pervasive effect of repeated insult (Small-t trauma) during critical developmental periods of their clients' lives, came up specifically in several interviews. Participants described how trauma often originates early in life, how children develop adaptive behaviors to experiences that they do not understand and often cannot even describe, and how pervasive and treatment resistant the effects of complex forms are.

When asked, how she conceptualized trauma, Zoe started off by noting there was not diagnostic for complex trauma.

> So that's an interesting question. I think for me, I appreciate that the individual is going to have their own experience, which may be defined as trauma to them, but it may not fit a particular example of trauma. So, what I know from years of working with children in particular, is that we know there's no complex trauma diagnostic. Right? (p. 1)

Zoe first described how children are often not able to comprehend situations that traumatize them.

> Developmental trauma has been on the docket, but that trauma is the experience when an individual feels such a state of distress or threat to their being that there is a response to that. And so, for little children who don't have a context of even what's happening, it's

going to be very visceral, emotional, physiological. They may not even know what's happening isn't supposed to happen, but they feel it. They've witnessed domestic violence, there's abuse, there's erratic emotion and behavior in this perpetuated way, that happens more than once, often many times for kids. (p. 1)

Zoe also describes how people initially come in when the ways in which they have adapted to cope with the trauma no longer work for them.

When I work with kids who have been exposed to those kinds of experiences, they may not have a single incident, like when we think about post-traumatic stress, is an incident. But they may have had chronic, ongoing exposure to situations where they simply felt out of control, in the sense that there was no safety, they weren't sure what was going to happen next, unpredictability. The fear state kicks in, we know the whole physiological response, and then they adapt somehow, right? People adapt, and so when people are coming in and talking about a past experience, oftentimes what we notice first is that ways they adapt, or they've developed for coping isn't working for them particularly well now. (p. 1)

Gerald, in his description of an adult client understanding, or not understanding, that what was going on with her in her adult relationships tied to her childhood experience of sexual abuse that started at age six.

When you're. So, imagine yourself as a six-year-old. Doesn't matter whether you're a boy or a girl who's being molested. Your defense to that, your reactivity to that, is basically you're hopeless and helpless. Helpless, utterly helpless. Any kind of emotional mental physical reaction to that is going to be useless. So here she is, developing a way of being

that included not knowing how she felt. So, she lied to herself, lied to herself about her

condition, her position, her safety or whatever. Right. (p. 34)

And, again, Gerald also associates the trauma response to survival.

So, in order to survive, and to do that she had to let go of understanding her impact, the

impact of that decision on herself. She chose to survive, which we all do. We're going to

do lots and lots of horrible things and be ashamed about it in order to survive. That's what

she did. And children are supposed to survive (pp. 34-35)

Gerald, who works with war veterans, also discusses the impacts of pre-morbid, or pre-

trauma experience in life on the post-trauma prognosis and resilience.

It's my opinion that, in order to really develop PTSD, the beginnings of it start in

childhood. Anybody who goes to a war zone and comes back with PTSD, we can look at

their childhood and see the beginnings of this trauma in their childhood.

General rule, that's where it begins. I mean I've worked with people who had

pretty good childhoods who, whose trauma wounds aren't anywhere near as complex,

who, very rapidly recovered through EMDR. (p. 14)

Impact of AIP and EMDR training on concept of trauma. Participants credited their

EMDR initial and subsequent training and consultation groups with much of their current

conceptualization of trauma. Their views of trauma largely aligned with the AIP model and its

presentation of adaptive versus non-adaptive memory networks.

Gerald described the view of trauma that he associates with the EMDR Institute, their

consultants and trainers.

Interviewer: So, I guess what I'd like to start out with is, "In your own words, tell me how

you conceptualize trauma, its effects on your clients and your approach to treatment."

Gerald: So, you know, EMDR Institute, and our EMDR consultants and trainers all have their definitions of trauma. Sort of the, these horrible things that happen to us, that get stuck for a number of different reasons. Um, I think often times of like pushing them down. This is something that right now I can't deal with or it's too big. Whether it's an accident or an attack or whatever it is. And I need to I need to shove it away so that I can survive them all.

Interviewer: OK. So, so…

Gerald: Not only is it shoving it away, but when I shove it away, everything goes with it. All of the emotion, all of the whole experience, all the images, everything is stuffed in one place.

Interviewer: OK.

Gerald: And that place that stuff that we stuffed trauma into. A particular trauma for example can be can be brought back up unintentionally. And that's, that's sort of the suffering. When that comes back up with all of the emotion all of the energy, the images, the memories of. Sometimes, it's about thoughts when all of that comes back up then the person suffers. And it's, it's, because it's powerful when it comes back up, it feels out of control; feels like it's got a life of its own. (pp. 1-2)

Zelda described how her thought has evolved, much due to her EMDR training and exposure.

Trauma, that has really been a shift thinking about trauma. From being a therapist for so long, I conceptualized trauma when it was presented to me as an initial issue. And in time, realized that a lot of people came to therapy for depression and anxiety that was a consequence of trauma; but they didn't identify it as that. And then, I came to realize it

was a traumatic reaction. So, I look for that now with clients that come for all kinds of

different motivations and goals. (p. 1)

Later on, Zelda described the impact of EMDR on her approach to stabilization, how it

changed over time.

You know, with me, through my time, it became a more conscious aspect of a session. I

think probably there was always an aspect of it in the beginning, but you know it's like

coming clear that "Oh yes that's pretty important that this happened." EMDR training has

really helped inform me. Informed me in the session and stabilization. Though, I think I

would have anyway, even if I didn't have EMDR training. Understanding that's an

important element for a client. (p. 15)

May discussed how she is still learning a lot about EMDR and trauma after 15 years.

Here she talks about how the training has affected her thinking about trauma and trauma

recovery and how the affects her conceptualization of many of her patients.

Well being trained in EMDR about 15 years now. Took me, I felt. I'm still learning a lot.

But I am thinking about healing trauma and trauma recovery often now; because of that

training.

So, I guess I'm thinking about it in the back of my mind that I'm with almost all of

my clients I'm using affect containment, early in treatment, whether or not I'm going into

any trauma processing with EMDR. (p. 2)

Later May described how EMDR strategy of approach is comfortable for her because it is

supported by underlying research.

I feel like I have, in my own brain, the sequence of preparation and then trauma

processing that really makes sense to me. I didn't make it up, you know Francine

[Shapiro] developed it and researched it and all the other people who have studied and written about EMDR helped with that. So, I feel confident about, kind of like with cognitive therapy. Well, here's how I'm going to introduce it. Here are some of the early tools that I'm going to teach it with. Here are the homework assignments I'm going to give. So. I feel comfortable and confident mostly about the work. (p. 19)

And Heidi attributes her understanding of Small-t and Big-T traumas to what she has learned from the EMDR community.

I conceptualize trauma in a pretty broad sense. And I think even before I got into EMDR, which was actually pretty quickly out of grad school, but I think I've always had a broad view of what trauma is, but I love the way the EMDR community explains it with the Big-T and Small-t traumas because that seems to help clients understand that when they were called stupid as a child how, for some people, that's traumatic, for a lot of people, that's traumatic. (p. 1)

Visualizing trauma. Originally, this high-order theme was titled *Physiological Model.* However, it became apparent in the analysis that participants, while visualizing physiological components, were not very anatomically accurate or complete in their descriptions. However, these descriptions, in the interviews and for their clients, provide an important mechanism for holding a concept and coming to an understanding of what is happening with trauma responses clients are experiencing. These portrayals might be referred to as functional models as opposed to physiological models. In any case, participants all expressed interest in what happens in the brain.

Participants referred to various ways in which they conceptualized what was going on with a client, talking about pathways and the roles of the amygdala, hippocampus, and prefrontal

lobe in the creation of involuntary reactions that lead to many of the post traumatic symptoms experienced by clients.

Heidi described the effects of repeated Small-t trauma. Here, she talks about well-developed and maintained neural pathways which provide a child with the message and information needed to support them feeling important, valued and good about themselves.

> And so, we keep, we're going through these small things because these neural pathways. I look at them like a pathway that's been taken care of for a child and a child's been made to feel important. Their neural pathway for feeling of normal importance is nicely pruned and well-kept and the flowers are blooming and fertilized and the path is nice and neat and very well-traveled. (p. 22)

She then noted that where that pathway was not so well established and maintained. Here, she identifies those as pathways we work with when we use EMDR.

> But this other neural pathway for another child, because that neural pathway was not taken care of, and you [as a child] weren't given the messages that you're important, that neural pathways overgrown with weeds, and sticker bushes, and the you know the pathway is not too, even the ground is unstable. And so, what we're trying to do by doing many stops at these Small-t trauma memories is, we're trying to open up that neural pathway. Prune it, fertilize it, and get it to grow. And they seem to like that as an explanation for why we're going for the Small-t traumas. (p. 22)

Here, Heidi describes the limbic brain in a way that supports her theory regarding engaging all the senses and beliefs associated with a resource when installing it utilizing BLS.

> Well in this particular situation with the calm place and the top 10. I think it makes it more rich, more real, and something that that the client can access a lot easier. If you

brought in all the senses and the beliefs or thoughts about yourself with that particular resource it just makes it more rich.

And you know, I really love neuroscience, but I'm not a neuroscientist or anything. But I believe that there are parts of the limbic brain that are going to key on some of those other senses and make this more accessible resource for them if you've used all those things to strengthen it. So, the more and the more components that you've got that are using different parts of the brain give more strength to the work. (pp. 9-10)

Gerald talked about the triune brain. Here he describes its role in trauma reactions, and how explaining that to clients helps them to understand what happens when they react to trauma related triggers. He referrers to that reactive state as being "out of my mind."

Gerald: Because of trauma we hide from ourselves certain aspects of ourselves to survive. So, when they walk in my door and they're absolutely unaware of these things that are going on for them. For instance, "I'm out of my mind." Right? Somebody walks in there they're out of their mind. All they're doing is they're feeling emotional. An emotional state as an example. Right. "I'm afraid," or "I'm angry," or "I'm whatever." "I'm disappointed." "I'm full of grief."

If they're out of their mind, then it might be very helpful for them to understand that and to help them gain access to their mind. Especially, if their thinking drives them to these emotional states that feel so out of control. What a great gift to them. between sessions, if they can learn, if they know how to get back to their minds rather than let their hidden habitual patterns of thinking take them to the emotional states. (p. 9)

Interviewer: I really like your use of that phrase, "out of your mind." Can you describe that. (p. 9-10)

Here Gerald differentiates between the amygdala and the prefrontal cortex, and then ties them into the concept of a triune or three-part brain.

Well, again, you can think of it as the amygdala instead of the prefrontal cortex if you want to think of it that way. I out of this part of my mind now.

Interviewer: And when you say the Amygdala what does that mean?

Gerald: Well I'll just let's go to the triune brain if you wish. Right? It was just more simple way. You know, the reptilian, then the mammalian, and the human brain. The human brain is the one we all want to say we're always in all the time. Wouldn't it be great if we could really be there all of that would be? And yet we have those other parts of the brain the emotional brain if you will and in the survival brain.

And we and they need to be there if there's a tiger in the grass about to come at us. We don't want to be wondering "Is that a tiger." And, "What should I do?" "Should I pick up a stick or climb a tree?" You want to you be right. You need to survive. So, you need to have that out-of-your-mind place to survive. You know, these real dangers.

Interviewer: Yeah.

Gerald: When you're a child, or when you're in an accident, or when you're in a war zone, or whatever, you're in, that part of your brain comes on board. It must. It has to because it's about survival. So that's, that's when you go out of your mind. And when it becomes trauma, that stuck place, that stuff inside of you that you can't... Because you stuff it, it has power over you and you and it drags you back in there, that stuck place is out-of-your-mind. You will return to that amygdala that that's the place of survival where you can't really think. (p. 10)

Summarization of Trauma Conceptualization. Participants viewed trauma fairly consistently, with all reporting an understanding of trauma and effects of trauma that align fairly closely to that portrayed by the Adaptive Information Processing (AIP) Model. All participants endorsed the need for initial stabilization of the client. All endorsed a model that includes memory mis-processing associated with trauma. Each described in detail the refractory nature of traumatic memories, and the seeming randomness of their recall. All of the participants differentiated between Big-T and Small-t trauma, describing the different effects and treatment associated with each.

Several of the participants extended their conceptualization to include complex developmental trauma and the cumulative trauma associated with the experiences of first responders and military personal. Zoe, who had significant experience working with children, noted her own distress that there is no current diagnosis available for complex developmental trauma.

All of the participants utilized quasi-neurological models to visualize and conceptualize what goes on in the brain associated with trauma. They described how they utilize these models to help their clients understand how they are being effected by the traumas they have experienced.

What all of the participants acknowledged in their description of trauma was the initial need to stabilize their clients, and, when appropriate, the effectiveness of EMDR reprocessing at reducing and eliminating trauma related symptoms. Again, all of the participants acknowledged the importance of EMDR in their practice.

Stabilization

Participants endorsed stabilization as not only the first, but often the only therapy that they are able to offer clients. Often clients are not ready or able to commit to the expense or time required for long-term therapy. All clients, but particularly clients who have not been previously exposed to therapy, need to establish certain foundational stability before addressing deeper or more pervasive issues.

Clients who have difficulty with relationships, will bring interpersonal challenges into the relationship with the therapist. Clients with chaos in their life will bring that chaos into the therapy. Many of the post-traumatic defenses, often reactions to initial trauma related symptoms, both impede treatment of the actual trauma and are treatment resistant themselves. For that reason, stabilization, which is important to all therapy is even more critical to working with traumatized clients. Six higher-order themes were grouped under *Stabilization*: *Stabilization a Part of All Treatment*, *Relationship*, *Client Strengths, Transitioning between EMDR and Resourcing*, *Lots of Trial and Error*, and *Slow and Safe*.

Stabilization as part of all treatment. Participants recognized the need of stabilization for most of their clients, beginning from the first session and the introduction to psychotherapy. This requirement was viewed as independent of modality, diagnosis, or eventual use of EMDR.

Heidi endorses grounding her clients from the very start.

I think it's important for people to know the value of taking a belly breath and actually stopping and breathing sometimes. So that's one of the first things I do with just about everybody. (p. 8)

Zelda noted addressing stability, particularly stability between sessions. Here she discusses reminding clients of the support systems that they already have and by having them plan how to utilize those supports.

> I think that people need more now as far as stabilization; and so, that is something that I always check in about with clients. What their resources are? Who they call? Who they would call? "What happened since the last time I saw you?" "What were your low spots?" "What were you concerned about?" "What do you need around that?" And setting up more, you know, like, stuff like there's apps on phones now. Like, "What are you going to do under these circumstances?" And actually, have people have it in their wallet or have it written down on them. So that they know. Included in those resources are family, friends, therapists. (p. 4)

Zelda also discussed the importance of checking in with clients specifically about stability and how they are doing, both at the beginning and ending of each session.

> I always check in, at the end, about how they are doing; and, in the beginning, how they were in between. They might have had a rough patch since last time they saw me. That lasted a day. This is what they did. Their negative or positive coping strategies. And then we're checking how are they doing often. Well, some are so much better when they're coming in because they're coming here for therapy so they feel better already. Some may feel worse because they're coming in. (p.15)

May described starting with stabilization early in the process and how she considers client difficulties using stabilization exercises, such as Calm/Safe Place and Container, to be indicative that more stabilization is required prior to EMDR reprocessing. First, she establishes safety.

So, start with a really thorough assessment. Including danger to self, danger to others. I

really don't go anywhere near even the preparation phase for EMDR. If I have a client.

who is actively at risk, then I think my job is to get as many supports in place as possible.

Contract with the client. Hospitalize if necessary. Although, that's been very rare in my

work even in community mental health. So that part is aside. (p. 5)

Whether or not she is using EMDR, May utilizes variations of resourcing tools to help

clients contain affect.

So, I guess I'm thinking about it in the back of my mind that I'm with almost all of my

clients I'm using affect containment, early in treatment, whether or not I'm going into any

trauma processing with EMDR. And then, often after that I'm using safe place if they're

agreeing to EMDR. And if they're not, but would agree to bilateral stimulation, you can

use that with the safe place. Or we can use it without stimulation and it's an acute anxiety

reduction tool. (p. 2)

Zoe portrayed resource development as a construction project. Here she talks about

utilizing imagery, relaxation, and mindfulness in her work.

Sometimes I'll use this image of what we're going to do with each piece. It's like, we're

going to build a bridge across ... It could be an empty space, or it could be a river. So,

with each piece, we're going to just keep adding a stepping stone, so that you have a place

to land. So those are things, and then I'll do various relaxation exercises, or mindful ways

practice, but again it all comes back to connecting to yourself in some way. (pp. 10-11)

 Zoe also described an introduction of resources that is interleaved and brief, within a

session.

Oftentimes I'll just, even with the five or ten minutes, I'll say, "You know what, just try

that out and then just notice. You don't have to do anything, you don't have to write it

down, you just notice. Just notice the experience of it, and the when we connect again

we'll check in and see what you noticed about that." So that's where I'll weave in that

mindful-based practice and awareness. That's the place that I'll start at, and then

eventually I'll be more directive with some actual grounding techniques, and I might, if

we're going to pursue EMDR, or I might even us it even we're not going to do

reprocessing with EMDR, but then we'll introduce ... So, there's a bunch, there's five

different somatic resourcing exercises and activities that I use, and then we also can use

this Calm/Safe Place, building the container. (p. 7)

Relationship. Participants endorsed the importance of relationship in the therapeutic

process, not only in context of client comfort and safety, but as a critical component of

stabilization and eventual outcome. The act of building a trusting relationship between client and

therapist is therapeutic on its own.

Zoe discussed building trust by relating with a client. Note how she brings the concepts

of safety, pacing, and titration of intensity into her work.

Interviewer: [in response to an earlier statement regarding trust] When you find

somebody that doesn't have trust, how do you work with that?

Zoe: Pretty slowly, right, so building their rapport and relationship here, so that, ideally,

they can have enough of a sense of comfort here, or some people say safety, and that I'm

going at a pace that reflects that I'm not going to throw them off a cliff, or they're going

to end up falling off the cliff, either way. So, I would say that I might temper things until

I can see evidence that that's shifting, and the evidence I might look for is hearing about

how they related to other people, whether it's in their workplace or with whomever they are in relationships with, if they are. How they relate to themselves, are they consistent in coming to therapy? (p. 11)

Heidi discussed the importance of bringing humor into the therapy session.

I also I also use humor. So, having the strength of a good sense of humor I laugh at myself a lot of times which, is, I hope, sometimes modeling for the client that that's OK to do.

Interviewer: Like, if I heard you laughing, I can laugh at myself.

Heidi: Hopefully, they'll learn to laugh at some of their foibles because we were all human and we just sometimes make mistakes. Some of them are not funny. But, some of them, in retrospect, can be looked at as slightly humorous. (p. 5)

Gerald discussed the importance of modeling relationship for clients, modeling qualities that they may have not previously experienced in their life.

She developed a relationship with me that was different than any male she'd ever had. And I think that is so important for counselors to understand. That's what all of our clients are doing. I hope, I mean, I think that's sort of the goal. Of developing a relationship with us that's healthier, that's deeper, that's, that's more caring. There's you know like positive regard and congruence are hugely important. (p. 27)

Gerald also brought a conversational style into his work with clients. Although he had not initially thought of it in that context it came out while he was describing an interaction that he had with one client in particular. This next thread is quite lengthy. However, it serves to illustrate Gerald's experience in multiple ways: interacting with this client, observing this client, and interacting and relating with this interviewer during our interview.

So, with him it's interesting with him, sometimes we talk about the cars. He loves to drive his car. He's got three Mustangs and he can come in the room up "here" and by the time I talked with his Mustangs he's back down to earth again.

Interviewer: What, what do you think about that conversation. What changes in him?

Gerald: He's excited about. He loves his cars. He loves driving his car. He loves being. You know, giving the thumbs up when he drives by in one of his Mustangs is one of his collectibles. You know he he's. He gets a lot of strokes in that, you know. And he knows they're really great vehicles. And so, he gets a lot of enjoyment out of just driving them. So, this brings him down to earth; back to the place where life is good, where he's successful. He's. You know he's got these things that he acquired through his hard work that he's very proud of. Right so he's, so there's no judgment from his mother on these cars. One way to look it right. This is all him.

Interviewer: You did something interesting as you were talking about that. You did a state shift.

Gerald: Yeah, yeah, shoulders back chest out. He's just confident.

Interviewer: OK. So, when the two of you were talking about cars something happened.

Gerald: Absolutely.

Interviewer: I was just watching you as you were talking and...

Gerald: So, I love my car too. You know, we talked about going out on the track and we take our cars out on the track. So, we're both very excited about it. So, there's a place where we can actually connect in a way that's you know down to earth and real and it's about something he enjoys. I mean I remember one of my first clients ever and my internship was, umh. Talk about diminished. He was like down, diminished so small. It's

just cruel. I didn't know what was going on with him but we started talking about Japanese and he's teaching himself Japanese as he likes the Japanese Anime, and he likes this like that of Japan and I got him to talk about Japanese and he's like all these different words.

And you could see him flower and unfold then open up and start... The first time I had ever seen a smile on his face when he was talking about learning Japanese. And I thought there's something powerful here. I'm not sure what it is. There's this sense of accomplishment, of success, of purpose, of enjoyment. All of this stuff is wrapped up in these things that we do these hobbies. I believe that the creative process. Whether you're driving a car by the way or learning Japanese is essential to what we are as human beings.

Interviewer: That's really interesting. And you know, here we're talking about stabilization. You're talking about not knowing, sometimes, how to stabilize somebody.

Gerald: Right.

Interviewer: You're talking about all of these formal tools. And then, you just told me about something you do.

Gerald: That works.

Interviewer: That works.

Gerald: That I have never been trained.

Interviewer: And you did this totally, totally, magnificent shift that you're talking about. That's really cool. Well, see. This is why we're doing this interview.

Gerald: Well you know, basically we're talking about human interaction here. We're talking about two human beings interacting. That's I mean, that's so know I'm a trained

humanist. Right? Maybe that has something to do with this. We are all human beings and

we need to have that connection. We yearn, right, to belong. (pp. 15-17)

Client strengths. Participants addressed the importance of recognizing and reminding

clients of the strengths that have allowed them to survive and described ways in which they

utilized existing client strengths as resources. Strengths can vary and include thing like skills,

resources, accomplishments, relationships, just about anything that when brought to mind allows

the client to shift to a more positive state.

Zoe described strengths as natural resources and relationships. Here, she discusses

identifying supports that they have or don't have in their life.

The other part for stabilization is looking at their natural resources, which I talked about,

and support systems. Do they have support in their community, or in their family? Some

people do, and some people don't. So, I don't make that a have-to thing, because that can

open up a whole other thing. Somebody might not feel like they can trust people. We

examine those options, but ... (p. 11)

Similarly to the concept of natural resources, Zoe discussed building on strengths that

were already there. Here, she emphasizes making incremental changes in ways that increase

individual self-efficacy, acknowledging how challenging client current situations can be.

Absolutely. Build on the strengths that they have, and then introduce a couple of options

for strategies or approaches as we're then working with the trauma. So, I might teach

them some breathing technique, or we might do some grounding exercises. Or just

highlight the things they're already doing. I tend to avoid adding new things if I can build

on what they already have, because just from working with people, and maybe my own

life experience, just adding more stuff to do when you're already feeling like life's hard

doesn't tend to be very effective. So, if I can build on what they have and then just make

it manageable, kind of this gentle and incremental process, then people feel empowered,

and they find their own power. (p. 3)

And Gerald, again, in the discussion of the client's car, described how the client did a

state change when he thought about something he did well.

He's excited about. He loves his cars. He loves driving his car. He loves being you know

giving the thumbs up when he drives by in one of his Mustangs is one of his collectibles.

You know he he's. He gets a lot of strokes in that you know. And he knows they're really

great vehicles. And so, he gets a lot of enjoyment out of just driving them. So, this brings

him down to earth; back to the place where life is good where he's successful. He's. You

know he's got these things that he acquired through his hard work that he's very proud of.

Right so he's so there's no judgment from his mother on these cars. One way to look it

right. This is all him. (p. 15)

May describes an exercise, Pillars of Life, that she does with clients, that has them recall

and document positive aspects of their life.

One thing that I, I do like for folks that have access to issues and need to go slow. Is

protocol called Pillars of Life. I don't know if you've heard of it.

Interviewer: I haven't.

May: It's a really early resourcing protocol and it helps people identify positive people,

places, and experiences from birth to present. And they do a little bit of drawing. They do

a little bit of positive cognition. And so, I have in my mind, and they have on a piece of

paper half a dozen or maybe more, positive life experiences. So, after the container and

safe place, if I think they're wanting to do some work but not really ready to do trauma

processing. That is a super helpful experience. And again, if they were the leave

treatment, if their life was kind of chaotic. Or, they were they had some access to issues

and were in and out, that is a really useful resource for them to have and to refer back to

because it only has positive people places and experiences. From early childhood and

until the present. (p. 13)

Transitioning between EMDR and resourcing. Participants described when and how

they moved between utilizing EMDR and talk therapy. The decisions they made were informed

by a balance between readiness, appropriateness, availability, and willingness of the client.

Participants observed that the majority of their clients came in with complex trauma histories,

and that treatment was not linear or even, sometimes, progressive.

These clients were prompted to spend time developing resources which always included

developing a stable relationship with the therapist. Participants presented EMDR as a treatment

that was utilized after clients had developed skills and stability required to tolerate reprocessing

the trauma without risking further traumatization. Participants also represented stabilization as

taking considerable time.

Gerald described one particular case, involving developmental trauma, in which he spent

more than two years, working with a client on trust, relationship, and stability prior to directly

addressing the trauma that she was experiencing with EMDR.

I started seeing her about the same time but because her trauma was so some of her

trauma was so fresh and some was so deep she wanted to get to know me she really

wanted that connection we were talking about before we started EMDR. (p. 22)

Here, Gerald describes one year of treatment where the client's focus was on rapport with

the therapist.

Well like I said, the first year she really wanted to have a rapport. She didn't want to start

EMDR. (p. 22)

He follows that with a description of working help her maintain a balance between head, body, and emotions.

She was molested as a child by her stepfather, and I don't know why she chose a man

[therapist], but maybe it was... Maybe it was good. But we did EMDR and it was much

more complex, much more ancient. She had lots of boyfriends who were abusive after

this childhood that she had.

And there was a lot of reassurance. There was a lot of me trying to get her back

into her head, out of her body, where he was feeling things, right. She would get

physically sick two days before she came to see me every week. And I would say, "are

you sure you want this?" [And she would say,] "I want to get this out behind me." And

so much into her body. I had to coach her and coach her and coach her just to keep her

thinking about being there with these tremendous feelings. (p. 22)

Gerald then talked about how her therapy eventually resolved. Here, he describes her accessing a memory that was very old, where she could only access one sense, the color "blue," and how he continued the reprocessing at that point.

But at the time she reached the culmination of this of our treatment with phase four, she

just called out a color. I don't remember what color was. "Blue." I don't remember what

the color was but she said, "blue," and I tried to I tried to get it cognitively. Was that the

guy's color of his eyes? Was that the color of the painting? of the color of the covers? and

not, not just blue. All right. Go with that. You know, and so I try to allow my clients to

take me. Right? It's not about me trying to make them go someplace.

Interviewer: It's, it's following whatever comes up. Is what you're saying.

Gerald: Yes. Just being very aware and cognizant of what they're experiencing and allow that to happen. And if you know if I have any kind of that I like to be able to help. Right? And it'd be nice to help but sometimes the best I can do is, "Go with that".

Interviewer: What you seem to have expressed with her was that she came up with something vague. It sounded like you checked to see if you could clarify it. And when you found that you couldn't.

Gerald: I just say, "Go with that." (pp. 22-23)

Here, Gerald describes how quickly, when a key memory is processed, resolution can come to the client.

Interviewer: You went with that. And what was the effect of that.

Gerald: That was. That was near the end of it. [client] "You know, I'm feeling pretty good." So, we did the SUDs [subjective measure of distress reported by the client]. And the next day, when she came in the next time, and it's like, [client] "It's [SUDS] about one". Really? Is it going to get any less than that? [client] "I don't think so and that was a terrible thing for my stepfather to do to me." You know, you're probably right. It was terrible. And we did some follow up work. We did the rest of the phases and I haven't seen her since. It took it took about three years of working with her. (pp. 22-23)

Finally, Gerald describes why he thinks the work took three years. This is not a simple answer. For the client, it involved developing trust with Gerald, working with a man. It involved learning how to trust in herself, and how to make better partner and relationship decisions. Gerald was also candid that some of the time spent involved his own learning curve.

Interviewer: You say three years. What about the work took three years?

Gerald: Well like I said, the first year she really wanted to have a rapport she didn't want to start EMDR. We talked about it within the, I think I probably got training while I was seeing her, in fact, so there was that too. But even after my first weekend of training 1st EMDR training] she wasn't ready. [After] my second week [2nd EMDR training] she still wasn't ready yet. They were about six months apart. But somewhere in the next few months, she became ready and I began I began to realize that she was ready. But it was about connection. I really want to have this connection with my clients. I want them to trust me and she had a lot of trust issues with men like. Rightly so, right. Given her stepfather and all of her relationships after him, she wanted to work that out. She wanted to be, feel, as if could she could trust me to do this work with her.

Interviewer: So really there was a huge amount of time that you spent…

Gerald: Right. So, it wasn't about EMDR at first. This is about you know the therapeutic methods I was trained with. This is not EMDR that we were doing at first.

Interviewer: Look. Here's what you told me. You told me you know she has a lot of issues. She made a decision to work with a man. You spent a lot of time with her getting her out of really strong body responses. Not getting out of them so much, but as bringing in the head stuff.

Interviewer: OK. So, there was a lot of time that it sounds like, again, a lot of learning or a lot of stuff that. What was she doing in there. You weren't ready to do EMDR either.

Gerald: Right.

Interviewer: With her.

Gerald: Right.

Interviewer: With her work, what was accomplished up front?

Gerald: The whole humanistic approach. You know, if what we're missing is *belonging*. So, one of the things that she needed men for, she needed tough guys. She picked the toughest guy in any crowd to be safe. She didn't want some wimp guy because then both of them are going to be in trouble. Right? She wanted the toughest guy in the room so that she was safe wherever she went. Problem is the toughest guy is going to end up turning themselves on you. And that's kind of what happened.

Interviewer: Wasn't safe for her?

Gerald: So right and so we worked on that quite a bit the whole cognitive dissonance between what she wanted versus what she was getting. And we worked on what it is to be, to have, a nice guy.

I mean you know I think I'm a nice guy. I think I'm not a tough guy, right. That's just not what I am. And so, I think for her there was this "whir? what?" "Who are you and how can you help me?" And yet she stayed with me.

And so, there was a whole big learning thing about what it is to be... And she and I, we actually talked about us through a number of relationships during the time we're together and I kept telling her she was trading up. Right?

She kept trading up. Look at this guy. Look at how he treats you.

You know. Isn't that wonderful? Even though he dumped you, or you dumped him, or it's the right reason. Wasn't he better than the guy before?

Oh my god yes. He didn't beat you once. You know he's not a drunk like my... Right. These are the kinds of things we're talking about.

Interviewer: So, does that fit with what you were saying earlier about, kind of, filling the pieces that weren't there, from development.

Gerald: Yes. Right. So, what is what is it to have a trustworthy man in your life who

actually has positive regard for you. And it's not a mental exercise, it's a real experience.

And that's what I think that all therapists need to provide their clients. We have so much

power. I believe this from my, my first day of school of grad school. I have believed that

we have a lot of power. And oh my god, we better use it. We better be careful. You better

do no harm. But we had better use it. And that's what I believe my job is. (pp. 24-26)

May discussed timing of reprocessing, noting the need for both therapist and client to be

available for multiple contiguous weekly sessions. Here she observes that inconsistency in

scheduling and availability can leave clients unsupported during the multiple weeks that

reprocessing can take.

So practical concerns for sure. Like we were talking about earlier if we're going to do a

trauma processing session, Am I available? Am I in town? Am I available by phone? Are

we going to have another face to face at the longest in two weeks? So practical concerns

like that. And then, what's happening with the client? And I do, kind of, zoom out and

look at the bigger picture. (p. 17)

Here, May attends to upcoming events in the client's life that may trigger old trauma

reactions.

If there's something coming up that I think would be triggering, like a family reunion for

example. I might not do trauma processing right before my client leaves for a family

reunion where a perpetrator would be or other reminders of trauma would be unless we

had enough time to do a couple sessions before that. (p. 17)

And here, May considers the client's capacity for judging their own safety in her decision

whether to start EMDR reprocessing.

So, things like that. If my client is in the middle of changing jobs, or has a new

supervisor, or is about to get married, or has their divorce date coming up in court. For

any life stressor that's significant, then I would talk with my client about it and if my

client is a therapist sometimes they'll say, "I'm really aware that I have this coming up but

here are the supports I have in place and here are the ways I'm taking care of myself and I

still want to do the work." I'd probably honor that.

　　　For my clients who aren't therapists, I would probably make an executive decision

saying, "I think that's too big a life event to use a whole bunch of your energy for trauma

processing and then not really have the energy to go in and manage something that big."

Or, "I wouldn't want you to go on your honeymoon having just processed this trauma.

You wouldn't be able to reach me and I wouldn't want you to need to reach me on your

honeymoon." Let's do that after you get back and are settled. And most people are fine

with that honest discussion. (pp. 17-18)

Heidi discussed how the decision to use or not use EMDR differs for each client. Here,

she notes that often clients are not ready for EMDR, even that they might be put off by the

concept of EMDR.

With each person, it's different. Because I really believe in the EMDR process, I am

always thinking about that. The minute someone walks in the door. Of course, it's their

choice. Some people don't want to do it for one reason or another. But so, I'm always

looking at it through that lens, through a person's lens, because I think a lot of times,

depression and anxiety, people come in for that, depression and anxiety, not realizing that

it links to these Small-t traumas that they experience.

So, my view of trauma really shapes how I do therapy because I think I always look at it and I look at most people's presenting issues through the lens of trauma, not that I want to say that everybody has had trauma and I don't have that. I mean I sort of have that view. But I wouldn't tell the client that in such fashion because it might put them off. It takes a while sometimes depending on the person to work into that concept. (p. 5)

When clients' initial presentation involves prior diagnosis or self-diagnosis of PTSD, Heidi often considers EMDR early on in the work.

You know, it depends on what the person, what the clients come in for. You know, if they come in saying I have PTSD. They've already self-diagnosed themselves or taken something online that says, "you have PTSD," I will talk to them about EMDR within the first couple of sessions. Sometimes, they seek me out because I do EMDR. It's remarkable how many people search me out because I do EMDR. (p. 19)

When clients' initial presentation involves depression and anxiety, Heidi takes history, works on rapport, and provides psychoeducation about trauma. She frames the work in ways that allows her and her client flexibility.

But if they are coming to me just because of general depression and anxiety once I get their history and talk to them and build a little rapport, I will sometimes talk to them about some of the things they've experienced in their lives and I'll give them the discussion of Small-t Big-T trauma so that they understand, you know, why they may be feeling some of the... This is such a common belief is "I'm not good enough." And that goes with so many depressed people. And usually it's coming from those, you know, some defining moments in their childhood. (p. 19)

When Heidi brings up EMDR as an option, she leaves it open for the client to decide whether or not to use it.

> So, I'll bring up EMDR as a possible thing to use. And it depends, you know, if the person seems like, "oh, that sounds like a great idea. Let's do it." You know, we'll start working towards that. Some people will say, "well, OK. Well, maybe someday." I'll get, I get a sense from them whether they're interested or not. And then I also get a sense of how helpful it will be.
>
> So sometimes I will remind people of it a few times so that they remember that there are other ways besides just talking about their problems of actually doing a more robust type of therapy that will actually change something. And then, some people that just aren't interested in it. We just, we just talk. And I flow in and out of it. In and out of that just kind of naturally. I guess, like you would have a natural conversation with a friend. (p. 19)

Even after starting work with EMDR, Heidi verifies that EMDR would be the best approach at any given time, and walks between EMDR and talk therapy based on that assessment.

> You know it's if a particular day they come in and they are having had a hard week. Or, they're sick you know, they've got a cold. Well, you know, did you want to work on the EMDR today. They're not really feeling it. Or sometimes I'll say you know I think you had such a hard week let's debrief and talk about it and we'll get back to EMDR next week. So, it's just sort of a natural flow in and out, of in and out of it. But I blend them so much that it's hard for me to actually tease them apart. (p. 19)

Zelda addressed client preferences in her discussion of moving in and out of working

with EMDR standard protocol.

> I think partly it's the client's desire to process without the structure of EMDR. They really
>
> need some time to just go over things and organize.
>
> And maybe there're things that have come up, stressful events in current times,
>
> and they need to process more like in a therapeutic setting without the EMDR and then
>
> move back in [to EMDR] when they feel ready and motivated or [want to process] some
>
> of the stuff that they're struggling with in present time. Or, we decide that that might not
>
> have been so hard for them if they'd processed this other stuff through EMDR, kind of
>
> making a decision that way. It does kind of come and go. (p. 6)

Zelda also described interleaving EMDR therapy with other forms of talk therapy in split

sessions where 20-25 minutes were set-aside, when client requested, for EMDR Reprocessing.

> Well, I think it's just when I've got enough material to begin the process or if you've
>
> already done the couple of intro sessions, then I'll often use it with my clients that are
>
> familiar with it and have used it in the past. We will save 20 to 25 minutes at the end of a
>
> session just for EMDR. They like to mix up.
>
> They will bring it up at the beginning of the session or the session previous that
>
> they'd like to do some EMDR. I mean, check in at the beginning of the session about it.
>
> And then, process some stuff pre-EMDR. That actually happens with a couple of clients
>
> kind of regularly. But it's funny, because I would say that they're EMDR clients because
>
> I'd say maybe 70 percent of our therapy is not in EMDR. But they... I might bring it up
>
> sometimes. I'd say, more often, they bring it up, that they want to do it. They want to do it
>
> for part of the session. (p. 13)

Here, Zelda talks about handling clients who were referred by their primary therapists for a specific EMDR intervention. For these clients, she structures a limited set of sessions.

> Some people really want only six sessions you know who have a therapist and the therapist sent them to me just for six. So, I agree to that, that we will evaluate at the end and see if you want more. (p. 5)

Zoe discussed starting with the "here and now" with clients in a number of different ways. Here, she talks about working first with resourcing and resolving issues in the present. At some point, she might choose to go into reprocessing older material. That decision, however, is usually based on how the client's past is affecting their current experience.

> Right. I got you. I would say I typically always start with the resourcing piece, right, and then rule around where a person's at for dual attention or dissociation. So those inform just from good practice or something, right, like I know where I'm starting. Then with the client, so a lot of times I start from the now, what is interfering with the person, and then we do that idea of where that comes from, and that flow back, or some experience of what the root of that piece might be. I target the thing to work on first, or I choose to do the reprocessing part based on how much that seems to be creating a current level of dysfunction for that person, and then that's a place I start from. (p. 15)

Lots of trial and error. The challenge to find resourcing and stabilization strategies that work with clients was a common theme with participants. Participants noted that each client is unique and brings in an array of likes, dislikes, capabilities, liabilities, and vulnerabilities to their work. They described the challenges associated with finding something that works for the client. They discussed different approaches, but primarily, identifying with clients what works, and utilizing whatever that turns out to be.

Gerald's original statement and frustration around there being no "right" answer, merits a second mention here.

You know, you do this. You do that. It takes work. It takes us being so very curious and working so very hard to do the right thing. (p. 18)

Gerald discusses the therapist's obligation to try a variety of things. Here, he describes having to build trust with a client while she was testing him.

I get the feeling that if I didn't pass the test she might, she might have had a much more difficult life, like if she couldn't. It's one thing to have stepdad but it's another to have a counselor somebody who's you know trained and paid to do the right thing. And if I didn't pass the test. This could have been devastating to her. (p. 27)

And here, he talks about different forms of resourcing.

Interviewer: And then, in the context of EMDR, how do you approach stabilization with your clients?

Gerald: This is the meat of the problem here. Right?

Interviewer: Well I'm not sure. OK.

Gerald: So, this is also one of those unique things. I mean some of my clients do really well with the very basics. With, you know, let's try a Calm/Safe Place. And we'll install that. Right? And for some clients that works well. And I encourage them to keep practicing. And I want this to work. And if it doesn't work, we need to either strengthen it or try something else. So those are the basic things we're taught. Or, you know, maybe container. Some people really like the container. This is so unique to every client. Right?

One client I had, he was on Uranus and his problems were on Earth and he could, you know, at any moment, he could use Star-Trek teleportation device and put all of his

problems on Earth because that's how far he wanted to be from... And that worked for him. I mean, it's great, wonderful. Some people, if they're having such a hard time getting out of their head, then being in their head, trying to stabilize is the absolutely the wrong thing. (p. 6)

Gerald also described working long-term with a client who was a traumatized Vietnam veteran with significant developmental vulnerabilities. Here, he talks about some of the client's developmental issues.

His father was World War II vet, Battle of the Bulge. He just didn't want to have kids. He didn't relate to his children. He kind of was hidden away. He was either working or in his office. He didn't do anything with his kids basically. And his mother was overbearing, and controlling, and very judgmental, and called them lots of names and belittled him on a regular basis. (p. 14)

Here he describes working, fairly quickly with the client's father-related issues noting that there was little charge in the client's father-related responses.

And so, this is where we went. We went to his father first. We took care of his father pretty rapidly. He feels today like he does not resent his father. He's very sad. His father, that he had the father that he had. It's inappropriate that his father would have children. But there's very little emotional energy left about his father. (p. 14)

And here, he talks about how issues with the client's mother and with his experiences in Vietnam have been more pervasive, and how they have had to be revisited.

His mother however we keep coming back to. And we've worked on his mother a number of different times. We've worked on his chain of command a number of different times. He made a mistake in Vietnam that we've worked on a number of different times. And we

haven't been able to stabilize, to take away, to a degree that I feel comfortable with, confident about, that his reactivity. When he gets triggered, there are times today when he has a difficult time. Just, you know, dealing with his wife, dealing with the world. (p. 15)

Here, Zelda describes a process that involves following the client, determining what they can tolerate and allowing them to set the pace of their work.

And then kind of moving into agreeing on their priorities, what they really need to focus on, which is a moving target. We might start with depression and move into trauma. Unfold as they feel safer and safer and able to face within themselves some things that happened early on in their life that they have not wanted to face. And that can come and go. You know, really, that's not up to me. I'm pretty sensitive about not pushing.

And here, she discusses considering everything and anything.

Other paradigms. See, what else do I use? I use everything. I like to do chair work. You know, I like to do writing exercises, and prayer, I don't know. It seems like therapy is pretty eclectic these days. Throw in the kitchen sink.

Interviewer: So, jumping in with whatever it is they need at the moment.

Zelda: Or, finding out what their motivation will allow them, you know.

Interviewer: OK. Yeah. It's like what's most effective.

Zelda: Yeah. (pp. 7-8)

Zoe discussed having the flexibility to use tool, that had been developed for working with children, with an adult client.

But I was working with kids and a teen with that, and then I have this adult client who, no matter how I seem to ask the question, really struggled to formulate their thought, so I was like, "I'm just going to pull out these cards and see," and then boom. Then it was

enough of something they could see, "Oh yeah, absolutely." Then they could dial into

what was going on, and then we broke that down, and could start to be more aware of

their thoughts, and see where those stemmed from. (p. 9)

Slow and safe. Participants had noted how quickly therapy went when their clients were

stabilized and able to tolerate EMDR reprocessing. They also emphasized how important it is to

slow therapy down to a speed that clients can tolerate, particularly in the beginning.

May talked about consciously slowing clients down, emphasizing the need for safety in

order for the work to proceed. Here, she discusses assessing clients' ability to utilize basic

stabilization skills in and between sessions.

And now we're working in therapy with someone who is stable enough to be safe. Part of

what I'm looking at with affect containment is, "Are they able to establish a container?"

And, "Will they use it between sessions?"

So, I'm kind of a slow poke in terms of if someone is able to establish a container

but doesn't use it between sessions. Reviewing why that's important. Maybe reviewing

the container in session again to see if they look relieved or if they report relief after

putting things away in the container. If people, if clients aren't practicing stabilization

skills between sessions. That's a big red flag for me. Because, if their life is too chaotic

for them to do that, or they don't remember to do that, or they don't seem motivated to do

that, that's where we stay until that's a more consistent skill.

Interviewer: So, utilizing a container and being willing and able to step aside from chaos

are considered real critical before proceeding.

May: Yes, they are.

Interviewer: To doing deeper therapy. Right? (pp. 5-6)

Here, May notes that when clients seem unable to practice some of the basic stabilization exercises it can be indicative of personality disorders.

> May: Right. And I think when people can't do that. Often that's an indication an axis two issue. That really would warn me to go very slow any way towards trauma processing.
>
> One client I'm thinking of in particular has so much chaos from domestic violence. Even though she's separated from her partner, that she's not practicing her container or her safe place consistently. And so, we just keep talking about, "What about this domestic violence that's happening in the present?" "How can you be more safe?" "Who can support you?" "If you're having present trauma, it doesn't make sense for us to start to try to unpack the bottom of the pile if the top of the pile's getting heavier from current abuse." (p. 6)

May also looks for dissociation to inform her decision regarding whether to proceed to reprocessing. Here, she describes administering the DES II dissociation assessment instrument to clients.

> At the same time. I'm asking people to do the DES in session with me, the Dissociative Episodes Scale. And then, we're talking about their responses that are maybe over 20. So, I'm looking at that with them in session usually after the treatment plan is complete. We can do the container. So, maybe in the third session the container. And there's time for the DES in the third or fourth session. That's also an indicator for me. About whether to go slow or whether to proceed. Where they are, and what kinds of things they have to learn and how much dissociation they're experiencing. (p. 7)

Here, in addition to administering the DES, May asks clients directly about their

experiences with dissociation. Note that she also acknowledges the rapport and relationship

building nature of the conversation.

> I'll just ask. So, tell me about the times when you think you've done something but you
>
> can't remember if you've done it. People say, "Well, I thought I mailed letter but it was
>
> still on the hall table at home." That might be different than if they say, "I thought I'd
>
> dropped my child off at daycare, but when I got to work they were still in the back seat".
>
> Really different. So, I think it's just helpful to ask about their responses. And I
>
> think we're building rapport in that process. And I might or might not be presenting
>
> information about dissociation that early in treatment. So, I would say it's more for my
>
> information than for educating them.
>
> And often people scores on the DES are fairly low and they're more around
>
> absorption. I forget all of the scoring categories, but if they're having highway hypnosis
>
> or able to read a good book or movie and not be aware things around them, I'm not as
>
> worried as if they're having, losing time. (pp. 7-8)

Zoe described teaching clients that therapy is not about throwing them into risk, but

building resources, often a step at a time, so that they could tolerate and even thrive, in the

context of their traumatic memories.

> Absolutely, so even if people come in and they're like, "I don't want to deal with all this
>
> stuff." I'm like, "Great, and so we're going to start here, and here's why." I'm like, "This
>
> is my approach, someone else might be like, 'Yeah, let's just dive in.'" And I'm like, "I'm
>
> not going to throw you in the middle of the ocean without a noodle to hold onto." You
>
> know, one of those Styrofoam things?

Interviewer: Mm-hmm (affirmative).

Zoe: That's just not who I am and how I do it. Sometimes people are a little taken aback, because they're ready to roll and they just want to tell their whole story and get it all out there. We take a step back to do this other piece, but inevitably people get it. They're really like, "Wow!" (pp. 3-4)

Here, Zoe starts with resourcing, explaining the objective of feeling comfortable enough in the current moment that it is possible to work with distressing thoughts and images from the past.

So, I think the other piece is that place I go to first when I'm working with someone, where there's been some kind of traumatic experience, they've had an experience that's really shaped a lot of internal distress for them, is that I always start with, "Okay, so let's figure out how we're going to resource you, and help you to feel comfortable in the place that you are now enough that then we can begin to work with the things that caused you distress." (p. 2)

Here, Zoe explains to the client that preparation for trauma work requires first learning to regulate their distress. this work is not about throwing the client off of the cliff, expecting them to fly. It's also not about control. Zoe notes the importance of managing clients' expectations.

So, I explain it oftentimes like, "You're here because you're standing on the edge of the cliff, I'm not going to kick you over the cliff and say, 'Let's just fly and figure it out as we go.' I feel it's really essential that a person is able to regulate their distress, have something on board in a way that they can feel a little bit a sense of influence over their emotional or physical state. I tend to avoid the word control, because I don't believe that anybody controls anything, I think that that's an illusion. Ultimately there are so many

things coming at a person, especially someone who has trauma, that this idea that they

should be able to control it and manage it is, I think, another way for people to feel

shame. (pp. 2-3)

Here, she discusses providing clients with resourcing tools in a manner that does not

overwhelm them.

Yeah, small, familiar, gentle, incremental, so that's the idea, that we're just going to

slowly build in that. Then there's tools that I might use, like for some people, "Here's a

blank calendar, why don't you pick something," or they can set a timer on their phone and

do a breathing exercise. Now occasionally some people have really, for years, not done

anything to support themselves. I might then introduce four square breathing, or a

breathing exercise. I might do a somatic resourcing exercise that's really about noticing,

and that's where I'll pull in a mindful-based practice. (pp. 6-7)

Summarization of Stabilization. These interviews centered largely around the

discussion of stabilizing clients. Participants in this study noted that treatment of stand-alone,

single-event, simple trauma is very rare. Most frequently, the clients that they worked with had

either experienced some form of childhood developmental trauma, or cumulative trauma

resulting from first-responder or military exposure to repeated insult. Both of these forms of

trauma resulted in complex pathology that required complex treatment strategies, with prolonged

stabilization or frequent transitions between stabilization and treatment of trauma.

All participants noted that they started most clients out with stabilization of some kind.

Many of the participants used EMDR Container and Calm/Safe Place, or similar visualizations

for clients, whether or not they were considering subsequent EMDR treatment. Some considered

the history gathering as part of relationship and trust building. Participants acknowledged that

they worked with a broad spectrum of clients and that they varied their requirements for

stabilization on the abilities and prior experience of each clients.

Along with determining overall safety with clients, participants described working with

clients to develop resources that would increase their emotional regulation and affect tolerance.

They worked on the therapeutic relationship as a resource. And, they helped the client to identify

existing strengths, as well as relationships, supports, and resources available in their life outside

of therapy.

To develop these capabilities, participants mentioned a number of tools that they use.

Many of these tools are based in mindfulness, metaphor and imagery, but therapists also included

psychoeducation and basic life-skills learning where that was needed. One of the interviews

resulted in a discussion about the value of basic conversation in therapy as a form of resourcing,

particularly when discussing things about which the client feels good, or competent.

Participants noted interlacing stabilization with other components in therapy. They

described stabilization as a stand-alone component of treatment. Participants viewed stability as

a variable state, dependent on what is happening in therapy as well as what is going on in the

client's life outside of therapy. And, the real-time changes in state require frequent returns in

therapy to stabilization practices.

Participants also recognized that stabilization in therapy varies greatly for each client and

that a lot of therapy involves trial and error. While therapists might have a toolbox full of tools,

not everything works for every client. Often, getting to stability requires trying out a number of

strategies.

Finally, participants endorsed the importance of small, incremental, gentle changes.

Participants noted the importance of going slowly, even when clients want to forge ahead on

their work. Part of stabilization is helping clients, particularly those who have been exposed to chaos and neglect, to identify what they are actually ready to handle.

All These Tools

While tools were not a primary component of the interviews, participants referred to a number of specific tools and practices that they associate with helping their clients stabilize and develop coping skills and resources.

EMDR standard protocol tools. Participants all noted utilizing resourcing tools that were part of the EMDR standard protocol, Calm/Safe Place, and Container. Several mentioned using Resource Development and Installation (RDI), a resourcing tool that is taught as separate protocol.

Other tools. In addition to the EMDR standard resourcing protocols, participants described a number of other tools that they used with clients.

Zoe talked about training in Somatic and Energetic Resourcing.

> Debra Littrell did a training actually, Somatic and Energetic Resourcing, so there's five. There's self-awareness, or simple self-awareness, there's reconnecting with innate signals, there's containment, eyes open, eyes closed, and recognizing truth. (p. 10)

And, here, Zoe discusses using Ana M. Gomez's Thought Kit for Kids.

> Yeah, okay, so I've used that, and then the other thing that I do is, Ana Gomez has done a lot of work with kids specifically, and so I think the protocol still fits within a standard protocol for kids, and then I use this tool, because she has Thought Kit for Kids.
>
> This has been super cool and super fun because, and I've used these with adults, but there are these cards, and the cards, they have them for younger children or adolescents. So, some are called good thoughts, the other are mixed up thoughts, so that's

for kids, and a little less binary than good/bad, and then for teens similarly they have positive thoughts, and then negative thoughts. These thought cards are great, so what kids seem to like to do is they'll flip through the cards, and I've done this actually with adults who struggle sometimes with ... They're so removed from how they think or feel about themselves that they are like, "I don't think about anything," or, "I don't feel anything," right, they're that far detached.

So, I can say, "Well why don't you, just for now, pull out these cards and look at each one, and the ones that you connect to or make sense to you, set them aside, and the ones that don't." So, they'll use this deck, and it's great because then they'll take whatever those positive thoughts or negative thoughts are, and with the negative ones, that's when they'll modify it and use it like a flow back, "So tell me, when's the first time that you had that thought?" They'll tell me an experience, and then I might even attach a SUD to it early on, and that's sort of like, in a way ... I don't know if it's a backwards way, but collecting some of the history, but working it back from the thought to the earliest time when they could remember a memory associated with it, but I'm using these cards as tools, and then that becomes the map for the treatment. (pp. 8-9)

May described a specific tool, Pillars of Life, which she used to help clients better remember the resources that they have had in their life.

One thing that I do for folks that have access to issues and need to go slow, is a protocol called Pillars of Life. I don't know if you've heard of it.

Interviewer: I haven't.

May: It's a really early resourcing protocol and it helps people identify positive people, places, and experiences, from birth to present. And they do a little bit of drawing. They

do a little bit of positive cognition. And so, I have in my mind, and they have on a piece

of paper, half a dozen, or maybe more, positive life experiences.

So, after the Container and Calm/Safe Place, if I think they're wanting to do some

work but not really ready to do trauma processing, that is a super helpful experience. And

again, if they were the leave treatment, if their life was kind of chaotic, or they had some

access to issues and were in and out, that is a really useful resource for them to have and

to refer back to because it only has positive people places and experiences. From early

childhood and until the present. (p. 13)

Heidi discussed using a number of tools. Earlier in this document she had mentioned

giving clients a check list.

Well there's a whole list of things I do. Um, and I try to keep sort of a check box. In the

way I chart, I actually list resources, stabilizing resources, I'm giving them, so that, not

only can I review whether they're using them, but also, I know what I've taught and what

I haven't taught. (p. 7)

And, here, she discusses using a tool called Top 10.

The Top 10 is thinking of the top 10 experiences in your life and actually listing them in a

book. I give them a little three by five book that they can carry in their pocket. And this

tends to be a little more for men than for women, only because sometimes men are

resistant to the fluff of the calm place. And really, sometimes that's my first responders.

(p. 8)

Heidi also talked about tools and approaches, that she uses with dissociative clients. Here,

she mentions grounding exercises, noting one in particular that she calls The Five Senses.

But if I notice it or they describe these behaviors, I will do some grounding exercises. With quite a few people, even if I have a hint of them being a little dissociative, or if they have trouble being in the moment. Either way, the grounding exercises are good. So, you know, some of it is just the experiencing, you know, your feet touching the ground and how it feels to sit on the chair and actually noticing it, and go through you know very slow exercise of noticing what's going on right now, in this moment.

I will have them do what I call The Five Senses exercise. So, they name five things in the room and I have them practice right there. So, they name five things they see in my office and then I'll ask them to feel four things right now, in my office. So, they, and this is not emotional feeling, this is actual physical feeling like, "I feel my feet in my shoes and my scarf on my neck." That kind of thing. And then, three things that they hear, two things they smell, and one thing they taste. So, we go five, four, three, two, one. But it's using all the senses. And that brings them very present. And if they dissociate, even at home, if they feel that they have a habit of, you know, staring at the wall, I ask them to do this exercise to become present, and then go do something else, rather than just sitting there staring at the wall. (pp. 11-12)

And here, Heidi discussed using a tool called Earth, Air, Water, and Light.

Earth, Air, Water, and Light combines some of the things that we've already learned. Earth is the grounding of feeling your feet on the ground or feeling your bottom sitting in the chair. And of course, the four elements are most commonly heard as earth air water and fire. But I changed it to light.

So, the earth the air is taking in deep breaths. The water is feeling the water in your body. And I guess that during my discussion of this while we're learning this

particular resource, I'll talk about the air being one of the physiological ways that the

body calms itself and shuts off the fight or flight system and turns on the relaxation

response. And according to Elan Shapiro, water is as well. Because, if we try to make

more saliva is the idea. So, water is your saliva because that's always available and if you

try to make more saliva and swallow it it's getting your digestive system to work which

again is telling the brain that you don't need to be in fight or flight since the digestive

system is one of the things that shuts or slows down during your flight. So that's the

water. And then, light is to light up your imagination with your calm place. So, I will give

them this bracelet that reminds them to do it. And so that's another EMDR one that I

really like. Definitely doesn't have to be for early intervention. (pp. 12-13)

Psychoeducation. Participants discussed ways in which they provided psychoeducation

for clients, particularly when it came to describing the processes of therapy, the effects of

trauma, the dynamics of relationships, and supportive lifestyle habits. May described using a lot

of psychoeducation with many of her clients.

Lots of cognitive therapy and psychoeducation, all the time in community mental health.

All the time. Less so with my clients who are therapists. Although, sometimes it doesn't

hurt to review things. And what I call interpersonal therapy that I don't know that it's

really formal interpersonal therapy but talking to people about boundaries about healthy

relationships about assertiveness. I don't have any family systems background or any

family therapy background but I do talk to adults about healthy communication. And I

call that on my disclosure statement I call that interpersonal therapy.

Interviewer: That's a great term, though. I mean, it's really descriptive It's talking about

how do you interrelate with the people around you.

May: Yeah. How do you get closer to the people you want to be closer to and set limits for people who might take advantage of you or hurt you? (p. 14)

Zoe described explaining to clients that most of work of therapy happens outside of the session.

But really, bringing the client's self and stuff into this space and trying to bridge those. I often warn clients too, like, "So you know that most of the work is not happening here, it's happening between." And there's another sort of segue, even with the EMDR, so the reprocessing, if that's what we're doing, is going to continue to happen in-between, you know that end statement, the closure statement, "So here's some ways that you might want to think about what to do with that." (p. 11)

May discussed psychoeducation as a motivational part of resource building. Here she discusses explaining to a client how using the container exercise can be helpful.

And, one of the things that I'll be very explicit about clients is, "If you're not using your container and your safe place and we're processing trauma; at the end of the session we need to be able to put that away whatever isn't finished and into that container and help you feel safe before you leave my office. That's really essential. I don't want you to go out into the world in a state of trauma. That wouldn't be right." So, sometimes that's helpful and I think motivating clients to practice. Like, "Ok. I need to do this because. We'll be able to do some hard work and then have a boundary between hard work and my day-to-day life. I'll be ok when I leave. I'll be tired but I'll be OK." (p. 10)

Here May talks about psychoeducation at the end of therapy, in this case, how to respond to the return of depressive symptoms.

Yes. Which is really important. That's a great way to think about it. Yeah. You know

when I'm doing psychoeducation with someone at the end of treatment I'll say, "What are

the things you're going to watch for that your depression is coming back? Who are the

people that can help you to watch for those? What resources can you use at home first?

Who's your prescriber? How are you going to get to them?" You know, I do that with

other modalities of treatment. So, that would be the thing for me. (p. 21)

Here, May talks about the need for psychoeducation with clients who are in abusive

relationships.

And then I just have a surprising number of people who are involved in abusive

relationships of some kind. And so. I end up doing a lot of psycho-education lots of that,

and lots of repetitions of that. This is such a, difficult pattern, to end.

Interviewer: Yeah. What do you think? As I was listening, I was thinking, well. You

know. There's a lot of things that clients who fall into that, may not really know about

relating. May not have ever had a model?

May: And may not believe that they really deserve that. Like they deserve. When you've

been in a domestic violence relationship for a long time. I think there's that word,

hopelessness. (p. 15)

Zelda noted that along with other therapy, she asks and educates clients about how to

support a healthy mind-body. Here, she describes doing this in a manner that it is acceptable to

the client.

…looking at their lifestyle and what they do to support a healthy body-mind. I'm not any

big health nut physically, but I do inquire about sleep habits, eating habits, drug and

alcohol habits. And we talk about that. I tell my experience of the effect those things

might have on their depression or anxiety or difficulties in the present moment, and, of course, the latest wave, which is a really helpful way, which is mindfulness and meditation, and trying to get almost every client to move in that direction. But gently, and no shoulds; because, I have experienced my own huge resistance and abhorrence to shoulds. (p. 7)

Summarization of All These Tools. All of the participants acknowledged familiarity and use of the EMDR standard protocol tools. Several participants endorsed their use bot as preparation for EMDR and as stand-alone or with other tools. One tool, Resource Development and Installation, which could be considered an extension of the Standard Protocol tools was also used by one of the participants with clients who were not ready for EMDR reprocessing, but who wanted to do work with bilateral stimulation.

All of the participants mentioned a number of other tools for stabilization tools, this included a large array of specific and generic practices and toolkits, with different intents and objectives, that therapists had picked up. All participants noted components of psychoeducation in their work. What therapists taught clients varied widely by therapist specialty and client population, depending on specific needs.

Overall, the tools component of the study was probably the least valuable. Tools are readily available, differ in value by client need, and usually require little training or preparation by the therapist.

Conclusion

Introduction

This study started with the question, "How do experienced EMDR practitioners help their clients to develop resources required to tolerate EMDR desensitization?" In exploring the experiences of EMDR Therapy trained therapists working with clients who were experiencing symptoms related to trauma, we got answers that were nuanced and that expanded significantly on the original question.

Five therapists participated in the in-depth semi-structured interviews, each of which lasted from between one and two hours. Each participant discussed, openly and in great detail, their conceptualization of trauma, their experiences working with their clients, their strengths and weaknesses as therapists, and their use of various combinations of interactions, interventions, tools, and practices to help their clients resolve problematic symptoms and improve the quality of their life. Although these conversations were initially framed in the context of EMDR Therapy, participant responses were not limited to EMDR related treatment concepts.

Participants shared their motivations and passions about their work. They shared their excitement around finding solutions that worked. They shared lessons learned about limitations, expectations, and boundaries in their practice. Each talked about working with clients, from beginning to build a therapeutic relationship, to challenging and supporting clients through difficult times, to the end of therapy when they would often watch change take on a life of its own.

Participants each described various types of clients with whom they worked. They also described the importance of identifying the uniqueness of each client and of that client's story. Participants described clients who often lived in the context of chaotic attachment and lack of

trust. They described clients who did not know what to expect as reasonable treatment from another human being. They described clients who, in the context of emergency response or of battle, had learned to set aside emotions in order to take care of others. They described clients who, over time, had learned to defend themselves by shutting out pain or by disappearing, dissociating.

Participants also described the respect that they had for their clients, viewing them in the context of being survivors, acknowledging the strengths that had allowed them to survive, and even thrive in their lives. Participants also described how when clients decided to come to therapy it was because the ways in which they had survived trauma no longer worked. Adaptive behaviors that had worked had become unsustainable and stopped working.

While participants talked about types of clients with whom they worked, they also insisted that each client had individual needs from therapy and each client responded to different resources in different ways. Participants each discussed a complex decision-making process that leads them to use or not use EMDR reprocessing. The therapy that they described often started and ended with stabilization, not always getting to the point where EMDR reprocessing came into the picture. And, once their clients did start EMDR reprocessing, participants described frequent returns to stabilization, particularly after clients accessed new memories or ran into life changes.

Finally, while participants noted that some clients come in looking for and needing only brief therapy, often requesting EMDR, they also emphasized that many of their clients required mid- and long-term treatment. They described those clients as having more complex trauma histories and as needing treatment that often included lengthy up-front stabilization. All participants described ways in which they incorporated EMDR Therapy into longer term work.

Interestingly, participants also described a sense that other therapists might work more quickly with clients than they did. At the same time, participants described going slowly and intentionally with their clients as a practice that often proved most effective.

Limitations

As a qualitative study, this study was conducted utilizing practices and philosophical conceptualizations proposed within Interpretive Phenomenological Analysis (IPA) in an area of psychology that has not been presented in the literature. While what we have learned should not lead to immediate generalization (Creswell, 2009), it extends our understanding of various ways in which those therapists that we studied think and feel as they work with traumatized clients. This IPA study's population of five subjects was intentionally small and homogenous (Smith et al., 2009). So even while we expanded our understanding of practice, this expansion remains neither complete nor encompassing.

IPA proposes interviewing as homogeneous a population as is practical, individuals who have similarly lived through the studied experience (Smith et al., 2009). Five experienced, practicing, licensed therapists were selected to participate in the interview. All participants had completed full EMDR Therapy I and II training and had recently participated in ongoing EMDR consultation support groups. They all utilized EMDR Therapy with no less than 10 percent of their clients. All participants endorsed experience using EMDR with clients who had been diagnosed with symptoms of complex trauma and/or PTSD. Additionally, all participants were white/Caucasian and situated in a middle-class socioeconomic status. All participants were also native English speakers and practiced within a community of EMDR trained therapists in the Puget Sound region of Washington State.

None of the participants was an EMDR trainer or researcher, nor were any participants newly introduced to EMDR Therapy. These exclusions were intentional for sake of homogeneity. However, they leave open potential for subsequent research.

This is a study of the participating therapists' recollections of their past experience. It is important to acknowledge that what a therapist experiences, as they are practicing, is their experience. While they are actively observing and assessing their clients, both their observation and assessment of the client will inevitably be incomplete and inaccurate, and colored by their own projection, countertransference, misinterpretation, and misremembrance (Duncan & American Psychological Association, 2014).

Finally, this is neither an efficacy nor an outcome study. Nor does it address mechanism underlying treatment effect. Our brains and the ways in which they function remain immeasurably complex (Cozolino, 2010; Damasio, 2010; LeDoux, 2012, 2014b). With all talk therapies, behavioral, cognitive, emotive, and analytical we have only inklings of physiological mechanisms of change. We cannot yet dissect or replicate a human thought (LeDoux, 2014b).

Validity and Reliability

One of the objectives of utilizing a methodology, such as IPA, is to have available best practices that can be applied to processes utilized in a study. These processes provide basic rules, assumptions, and recommendations towards the end of increased validity and reliability. Where possible, IPA based recommendations for best practices were followed in this study. These included, but were not limited to, topic selection, participant selection, use of a semi-structured interview schedule, and, most importantly, a disciplined, structured, data analysis process that involved initial analysis of all cases individually prior to the consolidation of analyses (Smith et al., 2009).

Participants in this process inhabited a similar socio-cultural-economic niche as the researcher. Therefore, consideration of hierarchical privilege differentials between the interviewer and the participants was not as important a consideration as confidentiality and protection from identification within the small population of EMDR Therapy practitioners. The focus on confidentiality was brought into project introduction conversations as well as into the informed consent review and, again into the interview introduction. Substantial efforts were made to ensure that participants were comfortable with the process before the interviews began.

Participants were given permission to review the transcripts of the interviews and invited to edit their responses or, if desired, to withdraw from the project. While all respondents were sent electronic copies of their interview transcripts, none of the transcripts was returned with changes and no requests for withdrawal were received.

Five cases were analyzed. For each case, data was analyzed by making three initial passes of the interview transcript. Each pass involved noting from a separate perspective: analysis of the data as transcribed, interpretation of the implied meanings of the participant, and development of the analyst's own views and interpretations of the topic discussed. Notes for each pass, for each case, were assigned codes associated with meaning. As needed, and continuously throughout the process of noting, additional codes were created.

Throughout the process codes were organized and re-organized hierarchically. This organizing and re-organizing eventually resulted in themes, higher order themes, and, superordinate themes. The noting and analysis incorporated multiple on-going hermeneutic circles (or cycles): that between the analyst and the data, that between the data and our current EMDR and Psychology literature, and that between the data, the analyst, his own experience, and his interpretation of the material.

IPA values the surfacing of new material accommodated by Grounded Theory (Smith et al., 2009). Development of the codes for assignment of meaning arising out of the analysis supported this value. Similarly, IPA values the importance of lived experience and the need for bracketing off of the researchers' biases provided by Phenomenology (Smith et al., 2009). The up-front documentation of positions of the author accompanied by the three differently dimensioned analysis passes of the data supported these values.

IPA also values, in the context of ideography, the study of each individual case (Smith et al., 2009). This value was supported by intentionally deferring any cross-case analysis until all cases had completed individual analysis. This practice was further supported by the Dedoose product's ability to isolate data during analysis to a particular data source. Each interview transcript was analyzed in isolation from other transcripts. The only common factor in individual case analysis was the continuously growing and shared pool of codes.

Finally, IPA values a hermeneutic acknowledgment and incorporation of the researcher's biases and the impact of surrounding culture and ideas as unavoidable (Smith et al., 2009). The IPA researcher ideally holds a hermeneutic dialectic that endorses need for suspension of prejudice while recognizing and even incorporating the unavoidable impact of researcher bias. Again, this component was supported by documentation of the positions of the author and the multiple passes applied to data analysis.

In the end, the clarity and coherence of the study is best evaluated by the reader. Are the conclusions set forth in the writing supported by the data? Do the data, in this case the selected excerpts, support the assumptions to which they are related? Do the final conclusions and recommendations make sense to the reader? Does it all add up?

Coding is a process that, while reductive, cannot be totally accurate. A many-to-many relationship between codes, notes, and excerpts involves multiple and significant subjective decisions. It results in *an* organization of the data rather than *the* organization of the data. One of my struggles, particularly in the context of completing this dissertation, was that it became clear to me as this project evolved that I could go back into the data and pull additional and different meaning from the source. That possibility, however, does not invalidate the data selected or the meanings associated with the data.

The objective of this study was to expand our knowledge specific to the experiences of five, white, cis-gendered, native English speaking, licensed, mental health practitioners, all trained in EMDR Therapy, and practicing in the Puget Sound region of the State of Washington, in the United States. And, it was to describe their lived experience of working with clients who were suffering from trauma related symptoms.

Suggestions for Future Research

As noted in *Limitations* this study intentionally excluded certain populations of EMDR Trained therapists. EMDR Consultants and Trainers would likely have differently informed views of effective ways to stabilize clients and to effectively transition back and forth between stabilization and EMDR reprocessing. Similarly, EMDR Trained therapist who had not practiced extensively, or who had not participated in recent consultation groups would likely have more divergent views than were included in these interviews. Also, while therapists specializing in particular protocols or practices, such as addiction or dissociative disorders, were not excluded, none of the participants endorsed specialty practices as such. These populations would, as would therapists with other cultural backgrounds, very likely provide different and interesting results given similar interviews.

Therapists in this study showed themselves to be self-evaluating, introspective and motivated to achieve optimal outcomes for their clients. Their presentation of the differences between Big-T and Small-t trauma and their discussion of the predominance of Small-t trauma and its more pervasive effects and more complex treatment requirements suggest a need for additional clinical study of working with complex trauma utilizing EMDR.

Additional clinical studies might include documentation of cases that involve long-term treatment of sequelae of complex developmental trauma. These could include clients with treatment resistant or refractive symptoms of mood disorders such as anxiety, depression, and bipolar disorder. Additionally, studies of clients with more pervasive treatment resistant cumulative trauma related disorders, like first responder vicarious trauma and military post traumatic syndrome disorders would be valuable. These cases could be used over time, both to refine our understanding and approaches to these hybrid treatment strategies, and to justify compensation for what are already proving to be effective and reasonable, mid- and long-term approaches to treating complex trauma related pathology.

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Appendix A:

Recruitment Flyer

Recruitment Flyer

Are you an EMDR Therapy trained therapist with 5 years of practice who regularly treats clients with trauma related symptoms utilizing EMDR Therapy?

If so, you are needed for a research study designed to help other therapists understand how you experience using EMDR Therapy with your clients and, in particular, how you resource and stabilize your clients in preparation for and during the EMDR desensitization process.

Participation is voluntary, and it will include a 1-2 hour semi-structured interview. A transcript of your interview will be available for you to review and correct, and results of the study will be made available to you after it is completed.

If you would like to share your experience and discuss the ways in which you practice

resourcing your clients, and would like to learn more about participating,

Please contact;

Ed Brendler, PsyD program

Antioch University Seattle

ResourcingResearch@gmail.com

Thank You!

Informed by (Spence, 2016)

Appendix B:

Online Prescreening Survey Content

Online Prescreening Survey Content

Page 1 - Introduction
Thank you for interest time spent participating in this this survey. Ed Brendler, a doctor of psychology student at Antioch University Seattle is looking for experienced therapists, trained in EMDR Therapy, to discuss their experience and practices around stabilizing and resourcing clients who are experiencing negative symptoms associated with prior trauma.

This survey is the first step towards determining your eligibility for inclusion in the study. Your participation at all levels, including responses on this form, is optional and confidential and will be read only by the primary researcher, and possibly his dissertation chair. Not all therapists who take this survey will be included in the main study.

If for any reason you wish to quit this survey at any time, you can do so by closing the browser window.

If you have any questions or complaints regarding this survey please note the following contacts:

Ed Brendler, MA (primary researcher) Phone: 360-480-1012 e-mail: ebrendler@antioch.edu
William Heusler (Dissertation Chair) Phone: 206-268-4827 e-mail wheusler@antioch.edu

Page 2 – Survey
This is the first step toward determining if you are eligible for the main study. This survey contains 7 questions and should take approximately 10 minutes to complete.

1. Under what license type do you currently practice:

2. What year did you complete EMDR training I?   Training Source?:

3. What year did you complete EMDR training II?   Training Source?:

4. Do you currently participate in an EMDR consultation/supervision group? Y or N

5. Roughly what percentage of your practice involves EMDR Therapy?
   o < 10%
   o 10%-30%
   o 30%-50%
   o > 50%
6. What percentage of those EMDR Therapy clients are you treating for trauma related symptoms?
   o < 10%
   o 10%-30%
   o 30%-50%
   o > 50%

7. What is the primary theoretical foundation of your practice?
   o Integrative
   o Behavioral
   o Cognitive
   o Humanistic
   o Psychodynamic
   o Other

   Page 3 – Conclusion

8. Thank you for completing the preliminary screening interview for this study. This survey is NOT the main study: it is for determining if you meet the eligibility criteria for the main study. If you do not meet the selection criteria, are you willing and interested in being contacted by the researcher for possible inclusion in main study?
   o Yes
   o No
   o Unsure, or not at this time

1. If yes, please provide email address or phone number the researcher can use to contact you. Information will not be used by anyone other than the researcher for purposes of this study. **Provision of information implies permission to contact re: study.**

Name	
City/Town	
State/Province	
Email Address	
Phone Number	

Informed by (Spence, 2016)

Appendix C:

Prescreening Phone Interview Schedule

Prescreening Phone Interview Schedule

EMDR Therapy Resourcing Research

Introduction: Thank you for taking the time to discuss this study with me. Is this still a good time to talk? This interview will take about 15-20 minutes, and I can answer any questions you may have at the end. You will be able to end this conversation at any time. Just let me know that you would like to stop.

I am looking for experienced, licensed, mental health practitioners, who are trained in and who use EMDR Therapy to work with clients who are experiencing symptoms related to past trauma.

I'd like to start off asking some questions about your practice. Again, if at any time you wish to stop, please let me know.

1. Under what license type do you currently practice?

2. What year did you complete EMDR training I?   And what was the source of your training?

3. What year did you complete EMDR training II?   And what was the source of that training?

4. Do you currently participate in an EMDR consultation/supervision group?

5. What other EMDR training do you receive?

6. Roughly what percentage of your practice involves EMDR Therapy? Pick one of the following:
   a. < 10%
   b. 10%-30%
   c. 30%-50%
   d. > 50%

7. What percentage of your EMDR Therapy clients are you treating for trauma related symptoms? Pick one of the following:
   a. < 10%
   b. 10%-30%
   c. 30%-50%
   d. > 50%

8. What is the primary theoretical foundation of your practice?
   o Integrative
   o Behavioral
   o Cognitive
   o Humanistic
   o Psychodynamic
   o Other _____

9. Thank you for completing the preliminary screening interview for this study. This survey is NOT the main study: it is for determining if you meet the eligibility criteria for the main study. If you do not meet the selection criteria, are you willing and interested in being contacted by the researcher for possible inclusion in main study?
   a. Yes
   b. No
   c. Unsure, or not at this time

10. If yes, please provide email address or phone number the researcher can use to contact you. Information will not be used by anyone other than the researcher for purposes of this study. **Provision of information implies permission to contact re: study.**

Name	
City/Town	
State/Province	
Email Address	
Phone Number	
Text Number	

Informed by (Spence, 2016)

Appendix D:

Contact List for Participants

Contact List for Participants

This study involves only interviews with experienced behavioral health practitioners,

all of whom have graduate degrees and licensure allowing independent practice in their field.

If you should have any questions or concerns regarding the study you should be aware
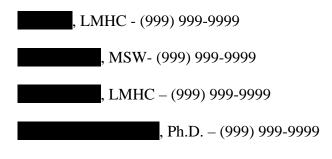
of the following resources:

- o Primary Researcher: Ed Brendler, MA, LMHCA (999) 999-9999,

  ebrendler@antioch.edu

- o Dissertation Chair: William Heusler, PsyD, (999) 999-9999

Additionally, if needed, please be aware of these contacts :

- o Antioch University Institutional Research Board 206-441-5352

- o Antioch University Seattle administration 206-441-5352

- o Washington State Psychological Association 206-547-4220

- o Washington State Department of Health – HSQA Complaint Intake - 360-236-4700

Therapy Resources in Thurston County

Consultation and/or Support

  ██████, LMHC - (999) 999-9999

  ████████, MSW- (999) 999-9999

  ████████, LMHC – (999) 999-9999

  ██████████████, Ph.D. – (999) 999-9999

Appendix E:

Informed Consent

Antioch University Seattle Informed Consent Form

The Doctor of Psychology Program supports the practice of protection for human participants in research and related activities. The following information is provided so that you can decide whether you wish to participate in the present study. You should be aware that even if you agree to participate, *you are free to withdraw at any time*, and that if you do withdraw from the study, you will not be subjected to reprimand or any other form of reproach.

Purpose of the study

This research is being completed to meet requirements of the Doctor of Psychology program at Antioch University Seattle. The researcher, Ed Brendler, is conducting a research study on the experiences of experienced therapists, trained in EMDR, with stabilizing clients in treatment of trauma. The researcher is particularly interested in ways that EMDR therapists actually conceptualize and practice both within and outside of the context of EMDR Therapy and the Adaptive Information Processing model.

You have been chosen to participate in this study because you are an experienced therapist, licensed by the state of Washington, who works with traumatized clients, and who is trained in and utilizes EMDR Therapy in their practice.

Procedures to be followed in the study, identification of any procedures that are experimental, and approximate time it will take to participate:

If you choose to participate in the study, you will be scheduled to meet with the researcher for an interview that will last up to two hours. If you practice in Thurston County, this interview will occur in-person. Depending on your practice location, or the location you wish to utilize for the interview, it will either be conducted in-person or via Skype.

No deception will be used in this study. The interview will consist of open-ended questions about your experience stabilizing clients who are being treated for various after-effects of trauma in their lives. How and whether you answer all or any questions will be your choice. And you can decline at any time to participate, either partially or fully in any part of the process. The interview will be audio recorded.

The audio recording of the session will be subsequently transcribed verbatim. Any identifying information, such as address, will be removed from the transcript. If you desire, you will be given a copy of the transcript for review. You have the right to request any or all information be excluded from the study. You also may also decide within two weeks of your interview to withdraw from the interview and have your data destroyed.

Personal data that you provide, name, contact information, location, licensure information, will be stored separately from the interview recording and transcript and will not be included in the research study. Furthermore, your information will only be available to the researcher and the supervising faculty of this study. You will be asked to provide an alias for the interview and any data specific to your interview will be stored under that alias.

No participation beyond the initial interview will be required, however, you will be offered the opportunity to read the study once it is completed.

Description of any attendant discomforts or other forms of risk involved for those taking part in the study:

You may experience increased anxiety or stress leading up to, during, or after the interview. You might be reminded of difficult clients, or of your own challenges in practice. If you experience difficult emotions that require further consultation or therapeutic support, I encourage you to speak to the researcher (myself) at any time. If needed, appropriate referrals will be available. Any charges associated with outside services, will be your financial responsibility.

When completing the interview, you may experience a question that you find unpleasant, upsetting, or otherwise objectionable. If this occurs, I recommend that you speak to the researcher at any time. Remember, you are able to decline to answer any question you choose. Your participation, at any point in this process, is completely voluntary.

Description of benefits to be expected from the study or research:

The actual interview process should prove to be an interesting, thoughtful experience. When your participation is complete, you will be given an opportunity to learn about this research, which may be useful in further understanding not only your own conceptualizations and practices, but those of other therapists. You will also have an opportunity to contribute to psychological science by participating in this research. It is possible that clinicians and other people who have had similar experiences as you will be better able to understand their situations. Finally, it is possible that this study might impact future EMDR Therapy training and protocol development.

You are welcome to ask questions of the researcher about this process or the study at any time.

Special notice to participants who are interviewed through Skype:

Using Skype will allow participation in the study when the participant and researcher are not in the same location. If Skype is used, all precautions available will be used to protect your information. Skype conversations are encrypted; however, the researcher cannot be held responsible for the security of a third-party site and cannot offer full protection of your information over Skype. The researcher will record the audio of the interview. No video will be recorded. If the interview is conducted over Skype, the researcher asks that you conduct the interview in a quiet location where you are comfortable and have little to no distractions.

Limits to Confidentiality

In some situations, I am required by law and/or the guidelines of my profession to disclose information whether or not I have your permission. I have listed some of these situations below.

Please note that confidentiality cannot be maintained when:

- You tell me you plan to cause serious harm or death to yourself, and I believe that you have the intent and ability to carry out this threat in the very near future. If this were to happen, I would need to attempt to keep you safe by contacting the appropriate authorities, which would generally mean that I would call emergency services (911).
- You tell me you plan to cause serious harm or death to someone else who can be identified, and I believe you have the intent and ability to carry out this threat in the very near future. In this situation, I must inform the appropriate authorities (generally by calling emergency services at 911), and I must inform the person who you intend to harm.
- You tell me you are abusing someone else (physically, sexually or emotionally). (Here "abuse" addresses the legal concepts of child and elder abuse.) In this situation, I am required by law to report the abuse to the Department of Social Services.
- You report other unethical practices.

Participant confirmation of understanding:

- I have read the above statement and have been fully advised of the procedures to be used in this project.
- I have been provided with sufficient opportunity to ask any questions I had concerning the procedures and possible risks involved.
- I understand and voluntarily assume any potential risks.
- I understand that prior to its use, the transcript of my interview will be available for me to review.
- Likewise, I understand that at any time and for any reason I can withdraw from the study without reproach.
- Upon my request, a summary of the results of this study will be made available to me for my review.
- I may contact the investigator, Edward Brendler, at ebrendler@antioch.edu or Faculty Research Advisor, Dr. William Heusler, at wheusler@antioch.edu if I have any questions.

Participant
Signature: _____   Date: _____

Witness
Signature: _____   Date: _____

I give permission to be re-contacted
at a later date for a possible follow-up: (initial next to response) Yes _____   No _____

I give permission for my interview
to be audio recorded: (initial next to response) Yes _____   No _____

Appendix F:

Project Description

Project Description

Emotional trauma impacts all of us and is one of the prime contributors to non-organic mental health related issues.

Efficacy of EMDR Therapy and the possible mechanisms of Bilateral Stimulation (BLS) have been thoroughly investigated. However, literature describing what we therapists actually do and how we experience utilizing EMDR protocols in the treatment of traumatized clients, particularly how we approach stabilization and resourcing, is sparse or nonexistent.

This project is a qualitative study of how licensed therapists who are trained and experienced in using EMDR Therapy approach stabilizing clients who are dealing with significant effects of trauma. It is also the basis for my doctoral dissertation.

The interview in which you are requested to participate will last up to two hours and will include a number of open-ended questions meant to stimulate conversation and facilitate coverage of a broad spectrum of concerns.

This study is not intending to evaluate efficacy of practice, but rather to look at how therapists actually practice. How do you conceptualize your client, what do you think of, what do you feel, and how do you actually approach your work? What do you think about and feel when you are utilizing EMDR Therapy protocols to do your work?

The study, which is qualitative, will utilize Interpretive Phenomenological Analysis (IPA) as a basis for its structure and approach to data analysis. IPA integrates concepts from Phenomenology, Hermeneutics, and Idiography, supporting the integrity of each individual interview with its unique qualities, while providing structure and direction for investigating and reporting common themes that surface in the multiple cases. It provides the investigator with

strategies for bracketing off prior biases while eventually identifying and incorporating prior experience with reactions to the interview data into the final analysis.

Six individual interviews will be utilized for this study. This number is intentionally low, placing the focus on the depth and breadth of each interview. This sample size is intentional with IPA (Smith & Shinebourne, 2012) and while it will never represent the whole of practitioners, the objective is to look at and value each case for its complexity and detail.

My hope is to develop a deeper understanding that will eventually lead to further and possibly more generalizable investigations in the future. This is just a beginning.

Appendix G:

Interview Schedule

Interview Schedule

- Tell me how you conceptualize trauma, its effects on your clients, and your approach to treatment?

- What do you feel are your strengths as a therapist?

- What kinds of feelings do you go through when you work with various traumatized clients?

- How do you approach stabilization with clients?

- What EMDR protocols/strategies do you use?

- What other approaches do you use?

- What has been the most/least effective approach to stabilization?

- What role does bilateral stimulation play in your approach to stabilization?

- What types of bilateral stimulation do you use and how does it vary between clients.

- What informs decisions you make about when, how, and where to utilize BLS?

- When do you stabilize clients?

- How has your approach to stabilization changed over time?

- What would you like to know more about, be trained in, etc.?