Eye Movement Desensitisation and Reprocessing (EMDR) for trauma: A qualitative analysis of clients’ experiences.

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Abstract

This study aimed to explore clients’ experiences of receiving eye movement desensitisation and reprocessing (EMDR) as an intervention for trauma-related symptomatology, consistent with post traumatic stress disorder (PTSD). Seven outpatients who had experienced EMDR as an intervention for trauma-related symptomatology were interviewed using a semi-structured interview schedule, from which the verbatim transcripts provided the raw data for an interpretative phenomenological analysis (IPA). The themes that were extracted from the data were considered under five superordinate headings which were: ‘living with trauma’, ‘doubt and apprehension; ‘making safe and making sense’, ‘the process of ‘processing’ and ‘change’. Both active and passive processes were identified within participants’ descriptions of the process of EMDR and change. Discussion focuses on the themes in relation to previous literature and further, in respect of the unique understanding of EMDR that a qualitative phenomenological study provides. Implications for future clinical and theoretical research are suggested and the limitations and theoretical underpinnings of the study are made explicit. The conclusions drawn from the study suggest that EMDR should be viewed as a holistic approach with elements such as the development of the therapeutic alliance given equal investment to the search for the active mechanism of the bi-lateral component. Additionally, it is argued that the bi-lateral element potentially involves more than a single mechanism, particularly in relation to the enhancement of positive affect and that this would benefit from further exploration.
Statement of contribution

The author was solely responsible for the following elements of the presented research; applying for ethical approval, writing the review of literature, data collection, data transcription and data analysis. The author and Dr Steven Lilley (Clinical psychologist) were responsible for the design of the project. Dr Steven Lilley, Dass Musruck (Trauma therapist) and Steven Regal (Senior Cognitive-behavioural Therapist) were responsible for the recruitment of all participants. Clinical supervision of the project was received from Dr Steven Lilley and Dr Rachel Sabin-Farrell. Research supervision was received from Dr Roshan das Nair.
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1.0 Research paper

Eye Movement Desensitisation and Reprocessing (EMDR) for trauma: A qualitative analysis of clients’ experiences.

1.1 Abstract

Objectives This study aimed to explore clients’ experiences of receiving EMDR as an intervention for trauma-related symptomatology, consistent with post traumatic stress disorder (PTSD).

Design The accounts of seven individuals who had experienced EMDR as an intervention for trauma-related symptomatology were analysed using the qualitative method of interpretative phenomenological analysis (IPA).

Method Seven outpatients (M=2, F=5, age range 29 to 57 years) were interviewed using a semi-structured interview schedule designed for the purpose of the study.

Results Five superordinate themes were identified: ‘living with trauma’, ‘doubt and apprehension’; ‘making safe and making sense’, ‘the process of ‘processing’ and ‘change’. Both active and passive processes were identified within participants’ descriptions of bi-lateral movement and change.

Conclusion The efficacy of EMDR was initially doubted by all participants however, following engagement, all felt it had been a helpful therapeutic approach. Whilst the bi-lateral movement component was described as unique, the therapeutic alliance and the tasks associated with the early phases of therapy were also highlighted as highly valued. Consequently, it is argued that EMDR should be viewed as a holistic approach with elements
such as the development of the therapeutic alliance given equal investment to the search for the active mechanism of the bi-lateral component. Additionally, it is suggested that the bi-lateral element potentially involves more than a single mechanism, particularly in relation to the enhancement of positive affect and that this would benefit from further exploration.

1.2 Introduction

1.2.1 EMDR for trauma

Post Traumatic Stress Disorder (PTSD) is an anxiety disorder which can emerge following exposure to a traumatic physical or emotional event. (See appendix 1 for a detailed discussion of PTSD). Of the available interventions for trauma related symptomatology, eye movement desensitisation and reprocessing (EMDR) along with cognitive behavioural approaches appear to be the most effective in reducing symptoms (Bisson et al., 2007) and are recommended as first line therapies for the treatment of PTSD by the National Institute for Clinical Excellence (NICE, 2005). The primary aim of EMDR for trauma is to reduce trauma-related distress and elicit positive affect and beliefs.

The eight stages of treatment integrate elements from existing psychotherapies (Fensterheim, 1996) along with a bi-lateral movement component which usually involves the therapist moving their fingers from side to side across the client’s field of vision or gently tapping the client’s hands bi-laterally. Other forms of bi-lateral movement such as finger tapping
(Bauman & Melnyk, 1994) and auditory tones involves the therapist moving their hand or fingers across the clients field of vision or gently tapping. The initial three stages: history taking, preparation and assessment, include the development of a therapeutic alliance and coping skills and the identification and rating of negative and positive target(s) for intervention, in the form of memories, images, cognitions and physiological symptoms. Stages four to six, desensitisation, installation and body scan, involve the identified target(s) being coupled with sets of bi-lateral movements, usually in the form of eye movements, hand tapping or auditory tones. During each set, clients are asked to free associate, with the material reported at the end of each set becoming the target for further bi-lateral stimulation. This is repeated until a significant reduction in distress ratings and an increase in positive ratings are achieved. The final two stages involve the monitoring and evaluation of progress (Shapiro, 2001) (See appendix 2 for an elaboration of the phases of EMDR therapy).

1.2.2 The EMDR literature

Since its inception, EMDR has been the focus of much empirical enquiry largely centred around which components underpin its effectiveness. Investigations have attempted to find the actual mechanism of action of the bi-lateral movements (Kavanagh, Freese, Andrade, & May, 2001; Gunter & Bodner, 2008) to help clarify whether they offer any benefit over and above existing approaches or whether they are, in fact, a superfluous element of therapy (Davidson & Parker, 2001). Alternative arguments have questioned
whether the success of EMDR might be attributable to its sharing of components with existing approaches such as imaginal exposure, cognitive restructuring (Rogers & Silver, 2002) or non-specific therapeutic factors such as client expectation, effort justification or placebo (Lohr, Lilienfeld, Tolin & Herbert, 1999). It has long been posited that factors other than ‘therapeutic technique’, including the client-therapist alliance (Horvath, 2000) and client expectations (Arnkoff, Glass & Shapiro, 2002) contribute significantly to the acceptability and efficacy of therapy; however, this area has received less attention within the EMDR literature with ‘eye movements’ being at the core of most research. (See appendix 3 for a detailed discussion of the EMDR literature).

1.2.3. Clients’ experiences of EMDR

Given the level of scientific scrutiny regarding which are the active elements of EMDR, it seems remarkable that posing this question to those who have actually experienced the process has to date been neglected. This discrepancy also appears out of line with current thinking in health care where clients’ views on every facet of their care are increasingly considered in order to facilitate continuous development and shaping of the therapies and services that are offered (Department of Health, DOH, 2001). There has been an upsurge of qualitative research exploring clients’ experiences of therapy. However this is not mirrored within the EMDR literature where single case or therapeutic outcome studies appear to dominate. In a mixed methods study, Edmond, Sloan, and McCarty (2004) compared participants’
perceptions of the effectiveness of EMDR and eclectic therapy. The qualitative data revealed participants as having valued the therapeutic relationship more and as having felt more responsible for their change within eclectic therapy than within EMDR, which was described as more procedural but as more effective in the resolution of their trauma. This study highlighted factors that are often ignored within experimental studies of EMDR, such as the meaning that clients make of the therapeutic relationship. (See appendix 4 for an elaboration of the qualitative approach to EMDR). Service users offer a unique and valuable perspective on what is helpful or unhelpful within therapy and it is important that this type of information is embraced and incorporated within the existing evidence base. With this in mind, utilising a phenomenological approach, the present study aimed to gain an in-depth experiential account of the process of EMDR and explore how clients made sense of their experience, and thereby contribute further to the understanding of this therapeutic intervention (See appendix 5 for an elaboration of the rationale for the study).

1.3 Method
1.3.1 Participants

Seven participants (two men and five women) with a mean age of 44 years (range, 29 to 57) took part in the study. All participants had received EMDR as treatment for trauma related symptomatology (mean number of EMDR sessions received 7; range, 5-10). Traumatic experiences included: war, road traffic accident, physical violence, sexual abuse and a threat to the life of a relative. Symptoms had been present for a mean of 15 years (range,
The bi-lateral modalities utilised were: eye movements (five participants), bi-lateral taps (one participant) and a combination of these (one participant). (See appendix 6 for further information on participants).

### 1.3.2 Recruitment

Participants were recruited from one out-patient psychology service and two out-patient specialist trauma services in Nottinghamshire. A clinical psychologist, trauma therapist and senior cognitive behavioural psychotherapist (all male) with 4, 8 and 15 years of EMDR experience respectively, who were the treating clinicians of participants, were responsible for their recruitment.

It was not possible to identify participants at exactly the same point in therapy or after an equal number of sessions. However an attempt was made to recruit an “homogenous sample” for whom the research question was equally relevant (Smith & Osborn, 2003, p.54). Literature suggests that a client may continue to process their trauma after therapy ends (Shapiro & Forrest, 2004). Therefore at least two weeks and no more than 16 weeks separated EMDR therapy and interview in order to capture potentially important elements of the process. Before embarking on EMDR, therapists must ensure that clients are psychologically stable and able to manage their emotions safely. Therefore only clients deemed psychologically stable by the treating clinician were included. All those approached agreed to take part and provided written consent (See appendix 7 for further details of recruitment).
1.3.3 Ethical considerations

Ethical approval for this study was gained from the Nottingham Research Ethics Committee 2 in October 2007 and the University of Lincoln Ethics Committee in September 2008 (see appendix 8 for further ethical considerations and section 4.0 for copies of all ethics approval letters).

1.3.4 Interview procedure

The researcher conducted, digitally audio recorded and transcribed verbatim seven semi-structured interviews (duration, 35-75 minutes). Interviews took place at the clinics where participants had received EMDR. The questions within the semi-structured interview were developed to act as prompts to facilitate discussion whilst offering flexibility to follow the clients’ accounts; allowing their experiences and meanings to guide the data (Kvale, 1996). The general areas covered within the interview were: the impact of trauma, learning about and entering EMDR, perceptions of the therapeutic relationship and of significant or helpful and unhelpful aspects of EMDR, participants’ experiences of change (if any) and experiences post EMDR (see appendix 9 for more information on interview procedure).

1.3.5 Analytic procedure

Interpretative Phenomenological Analysis (IPA) endeavours to understand the meanings that experiences hold for individuals through a detailed analysis of how “participants are perceiving and making sense of things which are happening to them” (Chapman & Smith, 2002, p.127). As the aim of this study was to understand participants’ experiences of EMDR
this methodology was deemed most appropriate. The analysis was guided by the procedure set out by Smith, Jarman and Osborn (1999). The researcher’s initial familiarisation with the text began during transcription and through the reading and re-reading of transcripts. Texts were initially analysed ideographically with non-specific notes made regarding anything salient or of interest within each individual transcript. These were then further examined and conceptual clusters formed, which the researcher felt captured the essence of the accounts. Clusters were listed and connections identified. Across-transcript analysis was then conducted where themes reflecting psychological constructs, noteworthy language and similarities or contradictions were grouped under appropriate super-ordinate headings. Individual transcript and across transcript themes were continuously revisited to ensure that the resultant framework was representative of each participant’s narrative. Finally, a table organising emergent themes was developed (See appendix 10 for further discussion of the analytic process).

1.3.6 Validation methods

As interpretation is acknowledged and accepted as a key component of IPA (Brocki & Wearden, 2006) it was crucial that the construal of participants’ experiences reported by the researcher was evaluated against validation criteria. Transparency was maintained through the presentation of adequate raw data and through the production of an audit trail. This included a research diary detailing the pathway from data to conclusions, which was made available to an independent professional (Meyrick, 2006). Consultation within supervision was used to gain disagreement or consensus of emergent
themes (See appendix 11 for further discussion of the validation process).

1.4 Results

Five super-ordinate themes were extracted from the data: ‘living with trauma’ ‘doubt and apprehension’, ‘making safe and making sense’, ‘the process of ‘processing’ and ‘change’. Subthemes are presented under the main headings. A minor construct of ‘active and passive processes’ which permeates the final two themes is briefly considered. Despite the organisation of the themes into discrete sections, they are intrinsically linked and collectively reflect participants’ sequential journey through the EMDR therapeutic process.

1.4.1 Living with trauma

Difficulties faced by participants post-trauma were chronic and shared many commonalities. Various therapeutic trajectories were described by participants leading to their first becoming aware of EMDR. (Due to space constraints, this theme has been elaborated within appendix 12).

1.4.2 Doubt and apprehension

Regardless of previous experience of EMDR, all participants articulated disbelief as regards its genuineness or efficacy. This doubt appeared partially grounded within participants’ view of the approach as “strange”. This was compounded by the technicalities of the therapy, with the mechanics of eye movements seen as far removed from one which might
resolve trauma. As Kate\(^1\) described:

“I was really wary about it and I didn’t really think it would do a lot of good ... in fact I had a little joke with my husband afterwards...just to say I don’t know what moving your eyes about would do.” (Kate, F, 46yrs)

The reported absence of EMDR within the public and professional domain appeared to be a further cause to suspect its authenticity. Jo articulates this as follows:

“I thought it was load of rubbish...and well I’d never heard of it and I work [in a mental health setting]...so, I think it needs promoting more, coz I’ve never heard of it, like I say.” (Jo, F, 42yrs)

Within all of the accounts, a sense of fear that the therapy might lead somewhere unknown and somewhere where their control would be relinquished was conveyed. This was particularly evident within the multiple references to hypnosis, as typified here:

“I wondered...where it erm where it would lead and would you know...like hypnosis and things.” (Barbara, F, 57yrs)

Despite the cynicism communicated, all participants showed a willingness to commence EMDR. In part, this appeared to be due to the receipt of further information about the approach. In the main, however, having subjectively reached a “low point”, participants shared how they felt they “had nothing to lose”

\(^1\) Each extract will be presented with the participant’s’ name, gender and age. Pseudonyms have been used throughout to preserve anonymity
From participants' discourse, a slow shift was apparent with movement from scepticism through ambivalence to, in some cases, an underlying trace of hope. This process seemed to continue throughout the early sessions of therapy (see appendix 13 for further illustration of this theme).

1.4.3 Making safe and making sense

This theme illustrates participants' portrayals of their initial sessions of EMDR. This appeared to be a time where a sense of safety and understanding were gained, the essence of which are captured within the following three subordinate headings; ‘Therapist and trust’, ‘The reality of therapy’ and ‘The beginnings of self-expression and understanding’.

1.4.3.1 Therapist and trust

A positive therapeutic relationship was reported by all participants, with therapists described as calming, non-judgemental and as being attuned to them. Kate illuminated the importance of trust in the light of her concerns regarding the validity of the therapy and her feelings of vulnerability when about to enter an unfamiliar process:

“You’ve got to fully trust who’s doing this, it’s sort of in their hands because you don’t know what it’s about, you don’t, OK they explain things but until you do it for yourself you don’t quite know what you’re going into.” (Kate, F, 46yrs)
1.4.3.2 The reality of therapy

There was a disparity between participants’ descriptions of their expectations of EMDR, and of the actual process. The initial anxieties expressed appeared to dissipate as participants became acquainted with the therapy. Three participants reported having liked the structured nature of EMDR. Familiarity seemingly eliminated ‘fear of the unexpected’ and for some, including Shelly, facilitated mastery and goal setting:

“The third time I was ‘right let’s see what this will do for me’...because the others had been very positive...I like the fact that it is structured...because that fear is still there of my god, the unknown but because I know what I’m coming in to do...I look forward to it.” (Shelly, F, 37yrs)

1.4.3.3 The beginnings of self-expression and understanding

For five participants, the assessment phase of EMDR, which included the identification, differentiation and rating of thoughts or emotions, which had remained intangible for so long, appeared to be the catalyst for sense-making. For Clare, the labelling of her feelings helped her to crystallise her inner experiences and provided a means of communicating these to others:

“I suppose the focusing of the statements...because I was able to verbalise it that instantly gave me a lot more control because I was able to say this is the way it makes me feel and to be actually able to tell somebody and somebody to be able to recognise and understand what I was feeling.” (Clare, F, 29yrs)

It was evident that participants learnt different things from the early
sessions of therapy. For some, it was simply where the seed of change was Planted; for Jo significant change was reported:

“By the time we was nearly up to the EMDR [desensitisation]...I couldn’t believe the difference from when we started ... how my perspective in my life had changed.” (Jo, F, 42yrs)

(see appendix 14 for further illustration of this theme)

1.4.4. Active and passive processes

Observable within participants’ narratives and encapsulated in ‘The process of processing’ (describing bi-lateral stimulation) and ‘Change’ themes were two separate and opposing processes. On one hand, participants described purposeful involvement such as their facing their traumatic memories. On the other hand, a sizable portion of participants’ dialogue reflected the bi-lateral process and any subsequent change as if having had experienced them passively. Whilst not a separate theme, it seemed important to acknowledge these processes as they will be visible within many of the subsequent illustrations.

1.4.5. The process of ‘processing’

Whilst bi-lateral stimulation was the only phase of therapy clearly demarcated by participants, language able to adequately convey this experience appeared elusive and consequently participants drew heavily on metaphor, which will be demonstrated within some of the forthcoming descriptions.
Actively facing or reliving previous trauma was described by five participants. Some insightfully acknowledged the counterintuitive nature of revisiting traumatic memories when their natural instinct was to avoid these:

“You’re reliving it...you know your trauma, you’ve got to concentrate on it...coz the natural thing to do is when you see something bad, I just switch off, completely go to something totally different because you don’t want to see that again.” (Nick, M, 45yrs)

Whilst purposefully focusing on traumatic memories six participants described an involuntary recall of minute details or recalling different events altogether:

“Well it was strange because I was concentrating on one thing, which was the main reason for my post traumatic, and I was concentrating on that and yet other things came in front of it on the first session...something which probably hasn’t been resolved from years ago.” (Kate, F, 46yrs)

Participants used descriptors of the process such as ‘hitting a nerve’ to convey their sense that EMDR had precisely accessed the core of their difficulties. In finding meaning for his experience, Paul described:

“I used to do a lot of archery years ago... the only thing I can think about, as though you were shooting something and as though it’s hitting something and you’re thinking, it’s hit the point straight away, that’s how you come out of the session feeling.” (Paul, M, 52yrs)
Physical experiences were noted by five participants, some of which were described as if the body were being experienced as separate to the self. Jo saw this as a sign of the process as having effect:

“I kept burping, my stomach was making the most odd noises, it was, it was really weird and afterwards I just sat here laughing my head off giggling, it was like I was a different person, that’s when I knew it was working.” (Jo, F, 42yrs)

Around half of the participants described or alluded to the process as ‘trance like’, mainly reflecting an intense state of relaxation. However, Paul’s experience appeared to be one of disconnection with his surroundings:

“I don’t know I can’t remember what I was talking about...because you go like in a fixed trance kind of thing...I don’t even know to this day what I’ve said to him.” (Paul, M, 52yrs)

(see appendix 15 for further illustration of this theme)

1.4.6. Change

All participants described having experienced two types of change; one, quite sudden in nature, and the other, a more gradual process. These, are subsumed under the following headings; ‘within-session change’ and ‘post-session change’.

1.4.6.1. Within session change

Various transformations were described as taking place during bi-lateral movement. Reduction in the vividness and distress associated with
imagery was reported, as was reduced valence of self-referential negative cognitions that had been the focus of therapy. Shelly described this as:

“It's helped me...I suppose it's like having an, an eraser and erasing out one of those statements, you can probably just see the outline of the pencil but it's completely back there, you know in my thought process now with certain statements, with ones that we've worked on.”

(Shelly, F, 37yrs)

Four participants described having come into the therapy room ‘tensed up’ and having subsequently left feeling complete relaxation or intense positivity. For one participant, work that had entailed reliving a positive sporting experience alongside bi-lateral stimulation engaged her with the positive affect that had been felt at that time:

“And you could feel all the emotion again...everything that went with it and, and you could feel the crowd and...their sort of warmth towards you.” (Barbara, F, 57yrs)

This sense of positive change was also reported as a result of the bi-lateral mechanism itself with a few participants describing the process as relaxing. Shelly initially experienced dizziness but this moved on to a sense of comfort:

“This is why the taps worked for me coz I'm quite, I'm a tactile person anyway and...I started to feel comfort in regularity, of a repetition and it actually evened me out.” (Shelly, F, 37yrs)
(See appendix 16 for further illustration of this sub theme)

1.4.6.2. Post-session change

All participants reported change as ongoing, some of which was related to within session work but had not been experienced until weeks later:

“Well in particular, is a few weeks afterwards...all of a sudden I’m thinking where’s these flashbacks?...and I’m so used to these flashbacks and they weren’t there and then when I do get them...they don’t have the same effect as what they did before.” (Kate, F, 46yrs)

Five participants also described change within domains that had not been worked on using metaphorical accounts of the change as having spread (e.g. “ripples”, “domino effect”, “seeping”). Clare detailed how she felt that EMDR had impacted on her perception of the chronic pain that she experienced:

“That’s been a big bonus coz I’ve sort of accepted that I’m going to be in, I’ll probably be in pain for the rest of my life but I think with the EMDR, I don’t know its triggered something I’ve not consciously noticed anything but it’s all a lot better, it, it’s there but its, I’m able to deal with it better.” (Clare, F, 29yrs)

Two participants articulated feeling much worse before any respite from symptoms was realised. Paul’s experiences included an increase in traumatic imagery, anxiety, frustration and low mood:
“The two or three days after they’d done it...it was like a bull in a china shop...you was angry with yourself, very short tempered with yourself and...it just seemed to wind you up make you more tense but after like 48 hours you’d calm down a bit and you looked at things with more perspective...I was really low for a couple of days or so and I mean very low, you thought you weren’t worth nothing.” (Paul, M, 52yrs)

Four participants described EMDR as having been ‘life changing’ and as having impacted on their core self. However, sitting alongside participants’ voiced enthusiasm and praise of EMDR was a sense of realism. Whilst participants reported improvement, their difficulties had not been eradicated, with only one individual having been discharged (See appendix 17 for further illustration of this sub theme).

To summarise, EMDR was initially unwelcomed by participants but in fact went on to be “enjoyed” by this sample. Change to internal levels of distress and within their wider life was evident in all participants’ accounts. However, the majority felt that their chronic experience of trauma would necessitate a longer therapeutic course.

1.5 Discussion

Through an interpretative phenomenological approach this study gained a novel insight into the processes involved in EMDR as experienced by the client. (See appendix 18 for more detailed summary of results and
discussion of living with trauma theme).

It is claimed that client expectations and the way that they construct and understand the therapeutic process, affects treatment outcomes (Arnkoff, et al. 2002). On the whole, participants revealed negatively biased expectations about EMDR including negative prognostic beliefs as regards treatment utility and distorted views of what therapy might entail, with a fear of ‘losing control’. This failed to negate the engagement of this group of individuals or their reporting of therapy as helpful, potentially contradicting previous findings. For some, the receipt of further information appeared to regulate fear, suggesting a need for EMDR to be made more visible within services and within the public arena. Particular areas that might benefit from attention are the demystification of the mechanical component of the approach and the elucidation of the process as distinctive from hypnosis. In addition, it is not clear how much influence the therapist’s explicit and implicit suggestions might have on clients’ expectations, experiences and indeed on any subsequent change. An exploration of this factor would be an interesting inclusion within future studies. (See appendix 19 for a more detailed discussion of issues relating to the theme of doubt and apprehension).

The influence of the therapeutic alliance on therapy outcomes is well documented (Horvath 2000) and indeed, some consideration has been given to the role that non-specific factors play within EMDR (Lohr, et al., 1999). However, these elements are frequently superseded within the literature by efforts to understand the bi-lateral component. The majority of participants
reported a warm and trusting alliance as significant to their progress. It is possible that this factor moderated the negative expectations previously illustrated. The therapeutic alliance was valued less within EMDR than within eclectic therapy by participants in Edmond et al.’s (2004) study, some of which was attributed to the procedural nature of EMDR. Contrarily, the participants who acknowledged the structure in this study highly valued this factor as they felt that it facilitated a sense of control, through the eradication of the ‘unexpected’.

Meaning making within the initial sessions helped some participants to make sense of earlier life experiences or enabled them to find a vocabulary for their cognitions or emotions, which is a common difficulty for those experiencing PTSD due to a proposed failure to contextualise trauma verbally or episodically (Ehlers & Clark, 2000). Thus, for some, this shift signified a major achievement. It would be helpful if more research approached EMDR holistically so that the contribution of the less researched tasks, consistent with the early stages of EMDR, could be further investigated (See appendix 20 for a more detailed discussion of issues relating to the making safe and making sense theme).

In respect of the bi-lateral movement, most participants described having purposefully faced traumatic material and a subsequent reduction in distress or in the vividness of imagery, cognitions or physical experiences. Participants’ descriptions of having to “stay with their memory” appeared reflective of exposure, which is frequently explored as the active ingredient
within EMDR (Rogers & Silver, 2002). However, the “coming forth” of other material which prevented a sustained focus on the original target or the recounting of a relived positive experience with an accompanying re-engagement of intense positive affect do not fit well with this argument. Descriptions of reduced clarity of images or the “erasing” of statements may be understood within a dual attention hypothesis (Gunter & Bodner, 2008), where reduced vividness is thought to occur as a result of the overloading of working memory. However, other descriptions appeared counter-indicative of this such as dissociative like descriptions of being “right back in the trauma”. From the data it seemed that the experience of bi-lateral movement took a number of forms. Experiences of symptom reduction appeared qualitatively different from those involved in the intensification of positive affect despite bi-lateral movements being implicated in both. The clinical utility of the bi-lateral component within the context of inducing and enhancing positive affect would benefit from further investigation as it could potentially be a helpful generic therapeutic tool.

The paradox presented by participants of actively working within session and yet somehow passively allowing the technique or their subconscious to be responsible for change, seemingly made the process endurable by providing a protective interface between the trauma and oneself. This is interesting as clients often judge their progress in therapy by the perceived effort that has been expended in order to achieve their therapeutic goal (Lohr et al., 1999). In opposition to this, participants viewed their passivity, in some cases, as an indication that the therapy itself must be
efficacious. This ascription of ‘activeness’ to the EMDR process may indeed have been simply related to the technicality associated with the procedure. It would be interesting to see whether an alternative ‘technical’ procedure would elicit comparable experiences for clients. Change for participants seemingly took a similar form to processing in that it appeared effortful within session which passively transferred to other areas of life post-session. Whether this was a result of continued processing (Shapiro & Forrest, 2004) or merely an increase in normal activity due to an improvement in well being was not clear. The process of change as illustrated by the participants shared many commonalities with that that has been reported as occurring within other therapies and with that associated with self-recovery (Higginson & Mansell, 2008). Surprisingly, despite the abundant experiences of change reported, there was no indication of EMDR being a remarkably efficient therapy as sometimes argued within the literature, with almost all participants remaining in therapy (See appendix 21 for more detailed discussion of issues relating to active and passive processes, the process of processing and change themes).

In summary, whilst qualitative data cannot provide any conclusive answers as to the nature of each component of EMDR, the rich data within participants’ accounts have provided an alternative lens through which to consider the helpfulness of this therapy. Considering the findings of the study, the author proposes that in seeking the active properties of EMDR, the emphasis should shift from a sole focus on searching for a single technical
mechanism to a consideration of the common factors that appear to lead to common change processes within therapy. Whilst the bi-lateral component did appear to be significant to this group of participants, what also seemed of key importance was a trusting therapeutic alliance, attention to participants’ sense of safety and control, the verbalisation, sense making and integration of their traumatic experience and a focus on increasing their self-esteem and positivity. In clinical practice, not only would it be helpful to identify and further develop such factors, it is equally important that these elements do not become secondary to technical procedure.

1.5.1. Limitations and reflexive discussion

One of the limitations of this study was that only a small sample was used, all of whom were positive about EMDR. A sample that included those for whom EMDR had been unhelpful would offer an alternative viewpoint. Having engaged in previous psychological work it is possible that participants’ accounts were contaminated with experiences from previous interventions. Additionally, some clients had worked with their therapist long term which presented difficulty in the clarification of the exact number of ‘pure’ EMDR sessions they had received. However this does appear more reflective of real practice where some blurring of approaches is inevitable. Similarly, as a trainee clinical psychologist, the researcher found it difficult to step out of the role of clinician and into a detached role of researcher particularly when participants discussed their distress which seemingly necessitated validation. It is possible that this impacted on the data. However
whilst the process of ‘bracketing’ one’s prior knowledge and experience (Husserl, 1931) might be theoretically ideal, practically this is impossible. Therefore, an attempt was made to acknowledge and understand the impact of such factors on the process (See appendix 22 for more detailed discussion of the limitations, scientific underpinnings and conclusions of this research).
2.0 References


3.0 Journal guidelines for authors

Notes for Contributors

The British Journal of Clinical Psychology publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

The following types of paper are invited:

- Papers reporting original empirical investigations
- Theoretical papers, provided that these are sufficiently related to the empirical data
- Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications
- Brief reports and comments

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.
2. Length

Papers should normally be no more than 5000 words, although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

3. Submission and reviewing

All manuscripts must be submitted via our online peer review system. The Journal operates a policy of anonymous peer review.

4. Manuscript requirements

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.

- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.

- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.

- For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use
these headings: Purpose, Methods, Results, Conclusions. Please see the document below for further details:

For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.

- SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.

For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association.

5. Brief reports and comments

These allow publication of research studies and theoretical, critical or review comments with an essential contribution to make. They should be limited to 2000 words, including references. The abstract should not exceed 120 words and should be structured under these headings: Objective, Method, Results, Conclusions. There should be no more than one table or figure, which should only be included if it conveys information more efficiently than the text. Title, author name and address are not included in the word limit.
6. Publication ethics

All submissions should follow the ethical submission guidelines outlined in the documents below:

- Ethical Publishing Principles – A Guideline for Authors

7. Supplementary data

Supplementary data too extensive for publication may be deposited with the British Library Document Supply Centre. Such material includes numerical data, computer programs, fuller details of case studies and experimental techniques. The material should be submitted to the Editor together with the article, for simultaneous refereeing.

8. Copyright

On acceptance of a paper submitted to a journal, authors will be requested to sign an appropriate assignment of copyright form. To find out more, please see our Copyright Information for Authors.
4.0 Ethical approval letters

4.1 Approval from ethics committee 2

National Research Ethics Service
Nottingham Research Ethics Committee 2
1 Standard Court
Park Row
Nottingham
NG1 6GN

Telephone: 01159123344 Ext: 68575
Facsimile: 01159123300

19 October 2007

Mrs Natalie Brotherton
Trainee Clinical Psychologist
University of Lincoln
Health, Life and Social Sciences
Court 11, Satellite Building 8, Brayford Pool
Lincoln, LN6 7TS

Dear Mrs Brotherton,

Full title of study: Eye Movement Desensitisation and Reprocessing (EMDR) for trauma: A qualitative analysis of clientsaT™ experiences.

REC reference number: 07/H0408/101

Thank you for your letter of 06 October 2007, responding to the Committee’s request for further information on the above research and submitting revised documentation.

The Chair has considered the further information on behalf of the Committee.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

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<tr>
<th>Document</th>
<th>Version</th>
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<td></td>
<td>02 July 2007</td>
</tr>
<tr>
<td>Investigator CV - Natalie Louise Brotherton</td>
<td>1</td>
<td>01 July 2007</td>
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<tr>
<td>Protocol</td>
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This Research Ethics Committee is an advisory committee to East Midlands Strategic Health Authority.

The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England.
R&D approval

All researchers and research collaborators who will be participating in the research at NHS sites should apply for R&D approval from the relevant care organisation, if they have not yet done so. R&D approval is required, whether or not the study is exempt from SSA. You should advise researchers and local collaborators accordingly.


Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

Here you will find links to the following:

a) Providing feedback. You are invited to give your view of the service that you have received from the National Research Ethics Service on the application procedure. If you wish to make your views known please use the feedback form available on the website https://www.nationalres.org.uk/AppForm/Modules/Feedback/EthicalReview.aspx.

b) Progress Reports. Please refer to the attached Standard conditions of approval by Research Ethics Committees.

c) Safety Reports. Please refer to the attached Standard conditions of approval by Research Ethics Committees.

d) Amendments. Please refer to the attached Standard conditions of approval by Research Ethics Committees.

e) End of Study/Project. Please refer to the attached Standard conditions of approval by Research Ethics Committees.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nationalres.org.uk.

07/H0408/101 Please quote this number on all correspondence
With the Committee’s best wishes for the success of this project

Yours sincerely

[Signature]

Dr M Hewitt/Ms L Ellis
Chair/Co-ordinator

Email: linda.ellis@nottspct.nhs.uk

Enclosures: Standard approval conditions

Copy to:

Dr Mark Gresswell
University of Lincoln
Health, Life and Social Sciences
Court 11, Satellite Building 8
Brayford Pool
Lincoln, LN6 7TS

R&D office for NHS care organisation at lead site - NHCT
4.2 Amendment approval from ethics committee 2, December 2007

31 December 2007

Mrs Natalie Brotherton
Trainee Clinical Psychologist
Health, Life and Social Sciences
Court 11, Satellite Building B
Brayford Pool
Lincoln, LN6 7TS

Dear Mrs Brotherton,

Study title: Eye Movement Desensitisation and Reprocessing (EMDR) for trauma: A qualitative analysis of clients’ experiences.
REC reference: 07/H0408/101
Protocol number: 1
Amendment number: 1
Amendment date: 15 December 2007

Thank you for your letter of 15 December 2007, notifying the Committee of the above amendment.

The Committee does not consider this to be a “substantial amendment” as defined in the Standard Operating Procedures for Research Ethics Committees. The amendment does not therefore require an ethical opinion from the Committee and may be implemented immediately, provided that it does not affect the approval for the research given by the R&D office for the relevant NHS care organisation.

Documents received

The documents received were as follows:

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<td>Notification of a Minor Amendment</td>
<td>1 - Additional researcher and timeframe extension</td>
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Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

This Research Ethics Committee is an advisory committee to East Midlands Strategic Health Authority. The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England.
Yours sincerely,

[Signature]

Ms Linda Ellis
Committee Co-ordinator

E-mail: linda.ellis@nottspct.nhs.uk

Copy to: Dr Mark Gresswell, University of Lincoln
R&D office for NHS care organisation at lead site - NHCT
4.3 Amendment approval from ethics committee 2, June 2008

Mrs Natalie Brotherton  
Trainee Clinical Psychologist  
Health, Life and Social Sciences  
Court 11, Satellite Building 8  
Brayford Pool  
Lincoln, LN6 7TS

Dear Mrs Brotherton,

Study title: Eye Movement Desensitisation and Reprocessing (EMDR) for trauma: A qualitative analysis of clients’ experiences.
REC reference: 07/H0408/101
Protocol number: 1
Amendment number: 2
Amendment date: 06 June 2008

Thank you for your letter of 6 June 2008, notifying the Committee of the above amendment.

The Committee does not consider this to be a “substantial amendment” as defined in the Standard Operating Procedures for Research Ethics Committees. The amendment does not therefore require an ethical opinion from the Committee and may be implemented immediately, provided that it does not affect the approval for the research given by the R&D office for the relevant NHS care organisation.

Documents received

The documents received were as follows:

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This Research Ethics Committee is an advisory committee to East Midlands Strategic Health Authority. The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England.
Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

07/H0408/101: Please quote this number on all correspondence

Yours sincerely

Ms Linda Ellis
Committee Co-ordinator

E-mail: linda.ellis@nottspct.nhs.uk

Copy to:

Dr Mark Gresswell, University of Lincoln
R&D office for NHS care organisation at lead site - NHCT
4.4 Approval from ethics committee, University of Lincoln

---

**Natalie Brotherton - Trainee Clinical Psychologist**

**From:** Emile van der Zee [evanderzee@lincoln.ac.uk]
**To:** Natalie Brotherton - Trainee Clinical Psychologist
**Cc:** shtomas@lincoln.ac.uk
**Subject:** natalie brotherton: ethics approval
**Attachments:**

Dear Natalie, this is to confirm that you have ethical approval for your project on "Eye Movement Desensitisation and Reprocessing (EMDR) as experienced by the client" from today. Good luck with your project, all my best,

Emile

Emile van der Zee PhD
Principal Lecturer in Psychology
University of Lincoln
Lincoln LN6 7TS
evanderzee@lincoln.ac.uk
http://www.lincoln.ac.uk/psychology/staff/683.asp <https://email.lincoln.ac.uk/exchweb/bin/redir.asp?
URL= http://www.lincoln.ac.uk/psychology/staff/683.asp>

---

From: Natalie Brotherton - Trainee Clinical Psychologist [mailto:Natalie.Brotherton@nottsptct.nhs.uk]
**Sent:** Mon 21/01/2008 12:35
**To:** evanderzee@lincoln.ac.uk
**Subject:** Research application

Hello Emile
I submitted an application to research and development some time ago and am still awaiting a response. I wondered if you could provide me with a possible date as I have had ethical approval for a while now and would like to start my research ASAP but am still waiting on approval from Lincoln. My name is Natalie Brotherton and my study is a qualitative study investigating the client’s experiences of EMDR.
Kind Regards
Natalie


Page 46 of 170
5.1 Appendix 1

Extended background

**PTSD**

Post Traumatic Stress Disorder (PTSD) is a type of anxiety disorder that people can experience after having been exposed to a severe and traumatic physical or emotional event. Typically the trauma will have been such that it threatened the individual’s life, physical integrity or sense of safety and security, leading to feelings of intense fear, hopelessness or horror. Equally, the experience of multiple, less severe traumas can impact on an individual’s sense of agency and self-esteem, creating a real sense of helplessness (Harvey, et al. 1995). Trauma related mental health difficulties including PTSD were first classified within the Diagnostic and Statistical Manual of Mental Disorders in 1980 (DSM-III, American Psychiatric Association, 1980). Epidemiological studies estimate that between 1-15% of the population will experience PTSD at some point in their lifetime, with women demonstrating a higher incidence than men (Breslau, Davis, Andreski & Peterson, 1997).

Three main symptom clusters must exist in order for a diagnosis of PTSD to be made. The first cluster relates to the intrusive re-experiencing of the trauma and includes flashbacks and nightmares. Excessive anxiety such as hyperarousal, an increased startle response, and sleep disruption
represent the second cluster. The third involves the individual avoiding situations and internal states that remind them of the event and can include efforts to avoid talking or thinking of the event, a diminished interest in usual activities and a blunting of emotions (DSM-IV, APA, 1994). In order to meet the diagnostic criteria, these symptoms must be apparent for a period of one month and must cause significant functional impairment. Approximately half of those who experience PTSD will recover within one year regardless of treatment. However for many, the course of PTSD will be unremitting and chronic (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995) with co-morbidity common, thus adding to the distress experienced (Taylor, Asmundson & Carleton, 2006).

There are a number of theoretical models that collectively attempt to account for the development and maintenance of PTSD (e.g. Foa, Skeketee, & Rothbaum, 1989; Janoff-Bulman, 1992; Brewin, Dalgleish, & Jospeh, 1996; Ehlers & Clark, 2000). In order to provide a theory-based context for later discussions of EMDR, a number of the PTSD frameworks most commonly cited within the literature will be described.

The ‘cognitive appraisal model’ proposed by Janoff-Bulman (1992) is based on the premise that an individual holds beliefs about themselves, others and the world, which are challenged when a traumatic event is experienced. For example, an individual might believe that they are capable, that others are trustworthy and that the world is a safe place. Thus, their life
feels meaningful and secure. The shattering of these assumptions, through the experience of a traumatic event, is argued to evoke a state of hyper-arousal, hyper-vigilance or avoidance (PTSD symptomatology). Whilst this model holds some face validity it fails to offer an adequate account of the mechanisms that might be implicated in the ‘shattering’ of one’s beliefs. Furthermore, it is difficult to accommodate the findings that suggest that those individuals who have a negative attributional style might have an increased risk for the development of PTSD (McCormick, Taber & Kruedelbach, 1989) as it is doubtful that their existing belief system would be exclusively positive and thus it is improbable that it would be challenged in the way described (Dalgleish, 1999).

Drawing on Lang’s (1985) hypothesis of ‘fear structures’, Foa and Kozak (1986) proposed the ‘Emotional Processing Model’. They argued that following trauma, some individuals develop ‘fear structures’ within long-term memory which hold information pertaining to the traumatic event (stimulus), information relating to physiological, behavioural and cognitive reactions to the event (response) and also information that links the two. When associated stimuli excite these structures, intrusive symptoms such as anxiety are triggered which the individual, in turn, will attempt to avoid. They suggest that in order to resolve the trauma the information within the fear structure requires integration into the individual’s existing memory networks. This, they posit, can be achieved by evoking the ‘fear structure’ through the engagement with associated material followed by the presentation of
incompatible corrective information to modify the structure. Although this provides a reasonably coherent account of PTSD, it does not make clear why fear structures will develop in some individuals and not in others following trauma.

Perhaps the most comprehensive theoretical account of PTSD is the ‘cognitive model’ proposed by Ehlers and Clark (2000). In line with Janoff-Bulman (1992) they argue that when individuals experience a trauma, they do so with prior experiences and beliefs. They go on to explicate how these impact on their appraisal of the event and how an individual’s excessive negative appraisal of the trauma or its sequelae exacerbates their sense of current threat. Failure to contextualise or adequately integrate the event into autobiographical memory coupled with strong affective associations made in relation to the traumatic material, increases the likelihood that emotional responses will be triggered when in contact with even loosely related stimuli. In addition, the lack of adequate cortical processing of the trauma results in the absence of a memory narrative which, coupled with avoidance strategies, results in a failure to verbalise the trauma to others. It is argued that dysfunctional cognitive strategies or maladaptive behaviours, such as avoidance, fail to allow the disconfirmation of current threat and thus serve to maintain trauma related symptoms.

The aforementioned models offer useful frameworks in which to
consider PTSD. The model proposed by Ehlers and Clark (2000) offers a multifactorial synthesis of many of the previously articulated theories and therefore is better able to accommodate hypotheses that attempt to delineate the responsivity of PTSD to EMDR therapy.
5.2 Appendix 2

EMDR Treatment protocol

Typically, EMDR has eight stages of therapy. The total length of therapy varies according to the unique needs of the client and the severity and chronicity of their presenting issues. In order to offer an understanding of the EMDR process a more detailed description of each stage as outlined by Shapiro (2001) is provided.

History Taking

This phase involves the therapist taking a full history including details of any previous trauma and preparing a treatment plan that considers the individual needs of the client. Consent to engage in the therapy is also gained at this point.

Preparation

During this phase the client is prepared for engagement in EMDR. This is a time when the therapeutic alliance is developed and psycho-information about EMDR and the client’s symptoms is provided. Where individual coping strategies are inadequate to deal with potential traumatic material, these must be established. Relaxation techniques alongside the development of an imaginal special/safe place are often practiced to enable the client to self soothe should they feel distressed during later phases. The available bi-lateral stimulation options are explained to the client and they are given the opportunity to select the option they would prefer. The bi-lateral component, normally, but not exclusively, takes the form of eye movements.
Other forms of bi-lateral movement such as finger tapping (Bauman & Melnyk, 1994) and auditory tones (Shapiro, 1994) may also be used. However, some forms require special equipment such as the bi-lateral tones that are played through headphones and therefore not all options are always available. The eye movement modality is the most common and involves the therapist moving their fingers or hand back and forth across the client’s field of vision, which the client follows with their eyes. Where hand taps are used, the client usually places their hands on their knees and the therapist gently taps each hand repeatedly. A stop signal that the client can use during bi-lateral movement, should they feel too distressed to continue, is agreed.

**Assessment of target for intervention**

From the memories, images and cognitions discussed within history taking, the most distressing part of the client’s traumatic memory is identified. This along with the associated cognition, physical sensations and emotions are rated on a scale of 0-10 to indicate the level of distress that such memories induce. This provides a baseline measure of what are termed ‘Subjective Units of Disturbance’ (SUD).

The client is also asked to identify an opposing positive cognition and rate this on a scale of 1-7, termed ‘the validity of cognition’ (VOC) (Shapiro, 2001), again, so that a baseline measure can be established. For instance, if an individual identified negative cognitions associated with an experienced trauma, or about themselves, such as “it was my fault” or “I am worthless”, possible opposing positive cognitions might be “I did the best I could” or “I am worthwhile”. The VOC rating would be used to indicate how strongly they
believed the positive cognition to be true.

Desensitisation

Within this phase the “information processing” (Shapiro, 2002) technique is utilised which is the bi-lateral component previously elected by the client within the preparation phase. The client is asked to focus on the disturbing identified target whilst simultaneously engaging in the bi-lateral stimulation. As bi-lateral stimulation occurs the client is asked to free associate, allowing their focus to freely follow whatever comes to mind. This lasts for around 20-30 seconds. The therapist then asks the client what they have experienced and continues with further sets of eye movements in respect of the reported images, cognitions or physical sensations. The client is monitored throughout this process in order that changes to target stimuli are noted. This procedure is repeated several times with the different memories, images or bodily sensations as they arise, followed by a return to the original target. The session usually continues until the client reports a significant reduction in the SUD elicited by the original target issue.

Installation

Using the same process of bi-lateral stimulation the positive belief is used as the target during this stage and is paired with the previously distressing target, with the aim of increasing the VOC rating.

Body Scan

Clients are asked to scan their body mentally and report any
remaining physiological sensations that they are experiencing. Bi-lateral stimulation is then used with the identified physical sensation as target, with the aim of eradicating negative physical sensations or increasing those that have been reported as positive.

Closure

Closure involves reflecting on the effort and any achievements the client has made within therapy. Where sessions are incomplete due to having not reduced SUD’s to 0 or 1, containment exercises such as the ‘special/safe place’ should be completed as described within the preparation phase.

Re-evaluation

The final stage involves evaluating whether the target issue(s) and any associated material have been activated and resolved. It also aims to assess whether the client feels able to feel at peace, and can operate, in a healthy way within the present.

5.3 Appendix 3

The EMDR literature

Since the origination of EMDR in 1989, the approach has been heavily researched, perhaps fuelled by early claims that it was a ‘unique’ therapy and that extraordinary results were often achieved via single session work (Shapiro, 1989a). Whilst such extreme claims have subsequently been replaced by more realistic suggestions such as the recommendations by the
National Institute of Clinical Excellence, (NICE, 2005) proposing that at least 8-12, 60-90 minute sessions of EMDR might be required in the treatment of PTSD, EMDR still remains a highly deliberated approach. It is important to note that this area is based almost entirely on quantitative research, which is reflective of the need for services to provide evidence based interventions (NICE, 2005). This field of enquiry will now be reviewed.

The growing body of literature pertaining to EMDR largely follows one of four lines of enquiry:

- Is EMDR efficacious for psychological difficulties other than PTSD?
- Is EMDR an efficacious treatment for PTSD in comparison with alternative therapeutic approaches?
- What components are responsible for the efficacy of EMDR?
- Are bi-lateral movements necessary for the efficacy of EMDR and if so what is their mechanism of action?

As this piece of work relates to EMDR for the treatment of trauma related symptomatology, only the latter three areas will be briefly critiqued.

*Is EMDR an efficacious treatment for PTSD in comparison with alternative therapeutic approaches?*

When a new therapeutic technique emerges not only must it be shown
to be an effective intervention, it must demonstrate its efficacy in comparison with alternative techniques. With this in mind many randomised controlled trials, meta-analytic studies and reviews have been conducted. An overview of this body of research and the findings to date will now be presented.

**Randomised Controlled Trials (RCTs)**

One of the earlier trials undertaken compared the effectiveness of twelve sessions of EMDR (n=10) with biofeedback-assisted relaxation (n=13) and waiting list control (n=12) with a group of combat veterans. EMDR led to greater post-treatment improvements than the other therapies on a number of psychometric, self-report and standardised interview measures, with PTSD eliminated in 77% of the participants. This was maintained at a three-month follow-up (Carlson, Chemtob, Rusnak, Hedlund & Muraoka, 1998). However, there were no differential effects found on psychophysiologic measures.

Vaughan, et al. (1994) evaluated EMDR (n=12) against two treatments: imagery habituation training (n=13), and applied muscle relaxation training (n=11) with a group of PTSD patients. All groups improved significantly as measured by an independent rater and self report measures, compared to the waiting list but none were found to be superior, although post hoc t-tests did go on to demonstrate a greater reduction in symptoms for the EMDR group.
An analogous study by Lee, Gavriel, Drummond, Richards, and Greenwald (2002) randomly assigned 24 civilian participants who had a diagnosis of PTSD to stress inoculation training with prolonged exposure (SITPE) (n=12) or EMDR (n=12) treatment groups. Participants were used as their own wait-list control through the administration of self report and observer rater measures prior to treatment. Both groups experienced improvement. However EMDR proved more effective in reducing intrusive symptoms and SITPE appeared stronger at targeting avoidance behaviours. The authors concluded that EMDR was a more efficient therapy as it demanded three hours of homework compared to the 28 required for the SITPE. Both Power et al. (2002) and Ironson, Freund, Strauss and Williams (2002) reported similar results with EMDR found to be equally as effective as exposure therapy coupled with cognitive restructuring, and prolonged exposure, respectively, with both studies suggesting that fewer EMDR sessions were required to achieve the same benefits.

In contrast to these studies, Devilly, Spence and Rapee (1998) compared a cognitive-behavioural based therapeutic procedure called the ‘Trauma treatment protocol’ (TTP, which included stress inoculation training and exposure) (n=12) with EMDR (n=11) with a sample of 23 civilian participants. No control group was used within this trial. Whilst both treatments proved effective, the efficacy of TTP, as measured on a battery of psychometric measures, was demonstrated as greater than EMDR for up to three months post-treatment.
EMDR has also been compared with pharmacological treatment. Van der Kolk, et al. (2007) compared the effectiveness of both treatments with a group of adult-onset trauma survivors. The participants were assessed by blind assessors with the EMDR (n=29) intervention found to be more successful than pharmacotherapy (n=30) and pill placebo (n=29) in achieving sustained reductions in PTSD and depression symptoms.

Targeting different variables to the aforementioned studies, Stapleton, Taylor and Asmundson (2006) utilised the data from a previous comparative study conducted by Taylor et al. (2003) in order to focus specifically on the effect of three therapies on the trait and trauma related emotions of anger and guilt with a group of PTSD patients. They found that prolonged exposure (N=15), EMDR (N=15) and relaxation training (N=15), as measured by structured interviews and self report questionnaires, were equally effective in reducing these emotions but added that these therapies alone may not be sufficient to reduce them, suggesting that additional intervention may be required. The finding that prolonged exposure affected anger is in contrast to Meadows and Foa’s (1998) view that purports anger to be an emotion that fails to habituate during exposure. This could indicate that alternative factors, for example, cognitive re-structuring were involved in these findings.

*Meta analytic studies*

Van Etten and Taylor (1998) analysed 61 treatment outcome trials
comparing various psychological therapies and pharmacotherapies in the treatment of PTSD. Findings indicated that whilst there was little difference in the effectiveness of the EMDR or behavioural therapy (including exposure and cognitive interventions), both were more effective than the pharmacotherapy in reducing PTSD symptomatology. However the depressive symptoms were better treated by the pharmacological treatment.

Looking at a variety of populations, Davidson and Parker (2001) investigated the outcome of 34 treatment studies. From the results of their meta-analysis they argued that EMDR was as effective as exposure therapies and more effective when compared to a no treatment control group and non-specific therapies such as relaxation. However, they found no utility for the eye movements.

Seidler and Wagner (2006) reviewed the literature that compared EMDR and trauma focused CBT. They concluded that neither treatment was superior to the other. One of the difficulties they found in conducting their analyses was that CBT treatments were far more heterogeneous than the standardised EMDR protocol, which made direct comparison problematic.

To the author’s knowledge, the most recent meta-analytic study is that undertaken by Bisson et al. (2007), which reviewed 38 RCT’s. Their findings
indicated that trauma focused CBT, EMDR, group CBT and stress management treatments were superior to a variety of alternative psychological therapies and waiting lists controls in reducing PTSD symptomatology. Whilst they highlighted evidence that trauma focused EMDR and CBT were more efficacious than the other treatments, there was no evidence to suggest a difference between the two therapies. This particular study informed the current NICE guidelines for the management of PTSD (NICE, 2005) which, recommended trauma focused CBT or EMDR as treatment for adults with PTSD.

Summarising the efficacy literature, then, it appears that EMDR is an efficacious therapeutic technique, particularly in the treatment of trauma. The evidence base for PTSD treatment is still slightly stronger for Trauma Focused CBT, although some findings are indicative of EMDR being a more efficient intervention (Kitchiner, 2000). Additionally, it has been suggested that less out-of-session homework is necessitated by EMDR than alternative approaches (Kitchiner, Roberts & Bisson, 2006). However, NICE (2005) maintain that there is not enough evidence to suggest a difference in the efficiency of the two approaches.

Given that EMDR has been shown to be effective in the treatment of PTSD, the question is raised as to the components of the therapy that might contribute to its success. Research that has sought to identify the relative
What components are responsible for the efficacy of EMDR?

Debates in this area tend to focus on whether the different components of EMDR are specific to the approach or whether they share commonalities with existing therapies, whether specific components of the therapy are efficacious or indeed necessary, and if so, what theoretical explanations might best account for their action. Neurobiological studies have begun to offer some interesting findings to this area. For example, with a sample of six individuals who were experiencing PTSD, Levin, Lazrove and van der Kolk, (1999) completed a number of measures, including single photon emission computed tomography (SPECT), prior to and following EMDR therapy. Their findings showed that the anterior cingulate gyrus and the left frontal lobe were hyperactive post-EMDR treatment relative to pre-treatment. They argued that this implied that successful treatment of PTSD did not involve a reduction of arousal at the limbic level, but rather that it enhanced the ability for individuals to differentiate real from imagined threat. However, this study used a small sample and to date the neurological literature remains inconclusive. Therefore this area is generally investigated via dismantling studies (e.g. Cahill, Carrigan & Frueh, 1999) that aim to isolate the effectiveness of each element of therapy and compare treatment protocols with and without the specific component. Again, this is a vast area and therefore just a sample of the literature will be presented to illustrate the type of work undertaken.
Imaginal exposure and cognitive restructuring are the two most frequently cited components from alternative therapies that are thought to be present within EMDR. Indeed, a number of authors have questioned whether the primary action of EMDR is in line with the components thought to be effective within traditional exposure treatments (Lee, Taylor & Drummond, 2006). Others have argued the incompatibility of the fundamental principles of imaginal exposure, such as habituation, to those implicit within the EMDR process. They have suggested that according to exposure principles, the processes used in EMDR could in fact, increase anxiety (Rogers & Silver, 2002; Welch & Beere, 2002). As Perkins and Rouanzoin, (2002, p.82) acknowledge, exposure “clearly calls for prolonged, un-interrupted and undistracted stimulus exposure rather than short bursts of attention and free association”. Indeed Foa and McNally (1996) present a similar argument suggesting that EMDR should reduce the rate of habituation due to the client being distracted from the feared stimuli. Lee, Taylor and Drummond (2006) and Lee and Drummond (2008) concur with Rogers and Silver (2002) in rejecting the proposition that the active process within EMDR is traditional imaginal exposure as findings from their studies revealed no benefit for participants’ engaging in ‘reliving’ over ‘distancing’ within the EMDR protocol.

The forming of new cognitive associations consistent with the ‘reprocessing’ phase of EMDR has frequently been compared with existing cognitive restructuring principles. This process would fit well with Foa and
Kozak’s (1986) PTSD framework as following the elicitation of the fear structure (during desensitisation where images, memories or physiological targets are brought to mind), the positive cognition could represent the correctional information required for modification of this structure. Empirically evaluating the importance of the cognitive element, Cusack and Spates (1999) conducted a study comparing EMDR with and without the development of a positive cognition. Findings indicated equal effects on all outcome measures for both procedures. However, in order to provide an equal number of eye movement sets within the ‘no cognition’ group, further sets of eye movements were given within the desensitisation phase, thereby confounding the results. Opponents of the comparison of EMDR to cognitive restructuring point out that, whereas in CBT cognitive restructuring tends to be primarily therapist led, within EMDR it is client instigated, thus suggesting the presence of a potentially different mechanism (McCullough, 2002; Rogers & Silver, 2002).

Non-specific factors

Additional questions as to the active ingredients present within EMDR have focused around the potential role of non-specific therapeutic factors. Lohr, Lilienfield, Tolin, and Herbert (1999) posit a number of components of EMDR that are shared across all therapies. For example, they query the impact that factors such as treatment credibility, the therapeutic alliance and effort justification might have on therapy or whether EMDR might be seen as an inadvertent placebo. Such factors have long been considered within the
therapeutic literature. For example, treatment outcome expectation (Arnkoff, Glass, & Shapiro, 2002), therapy acceptance (Tarrier, Liversidge, & Gregg, 2006) and therapist credibility are all thought to play a significant role in the preference and outcome of therapies. Likewise, within the general therapeutic literature, the therapeutic alliance (Horvath, 2000) has been shown to play a significant role in outcomes and drop-out rates (Schottenbauer, Glass, Arnkoff, Tendick, & Hafter Gray, 2008).

Experiments aimed at controlling for non-specific factors have generally compared EMDR with an ‘attentional control’ condition, that is where participants within the control group receive a similar content and amount of therapeutic contact to that of the experimental group, with the treatment specific factors excluded (see Boudewyns, Stwertka, Hyer, Albrecht, & Sperr, 1993; Jensen, 1994; Vaughan et al., 1994; Silver, Brooks & Obenchain, 1995). Findings from these studies have been mixed, with some showing no differential effects between EMDR and the control conditions and others demonstrating marginally better effects for EMDR. Although Lohr et al., (1999) claim that, where enhanced effects were found for EMDR, methodological flaws rendered the results unreliable and thus concluded that there was limited evidence to suggest benefit for EMDR over and above non-specific factors. This argument is inconsistent with that from Bisson et al. (2007) who posit that from the existing evidence it appears that non-specific factors are unlikely to be responsible for the effectiveness of EMDR. A further limitation of this type of efficacy literature is its frequent
failure to address clinically relevant questions. For example, it is still not clear how many individuals would need to be treated in order for the addition of bi-lateral stimulation to make a clinical difference to a single individual.

**Are eye movements or bi-lateral stimulation necessary?**

One of the most contested issues within the EMDR literature is whether the eye movements are a necessary element for therapeutic success. Results from a number of studies have suggested that the eye movements (Montgomery & Allyon, 1994; Wilson, Silver, Covi & Foster, 1996) or some other form of bi-lateral stimulation such as finger taps (Bauman & Melnyk, 1994) increase treatment efficacy and are therefore key components of intervention.

In contrast, reporting on their review of 16 RCTs that compared EMDR with alternative psychotherapies, Shepherd, Stein, and Milne (2000) were unable to offer any conclusive evidence for the efficacy of eye movements. Equally, a review by Cahill et al. (1999) suggested that eye movements or any other form of bi-lateral stimulation failed to confer any benefit over the therapy without this component. Pitman et al. (1996) found that not only were there no extra benefits gained from the eye movements, they also reported that results from the treatment without the eye movements were marginally superior. Furthermore, they cogently argued that if indeed eye movements are not required for EMDR, then any neurological argument supporting their
efficacy becomes questionable. However, this study has been criticised on methodological grounds including failure to randomly assign participants (Cahill & Frueh, 1996). The research in this area is difficult to aggregate, as the ‘no eye movement’ conditions are often fundamentally different between studies. For example they include: light tracking (Renfrey & Spates, 1994), keeping eyes focused forward whilst tapping hands rhythmically (Pitman et al., 1996), focusing on a stationary target (Lytle, Hazlett-Stevens & Borkovec, 2000), focusing on flashing lights (Devilly et al. 1998) and keeping eyes shut (Boudewyns & Hyer, 1996) and therefore they do not lend themselves well to direct comparison. Thus, findings in this area remain equivocal.

In order to clarify the arguments pertaining to the role of bi-lateral stimulation within EMDR, a number of studies investigating the possible processes underlying this component have been conducted and as a result several hypotheses regarding their mechanism of action have been proposed. These will now be briefly overviewed.

**The Rapid Eye Movement (REM) hypothesis.**

One hypothesis offered to explicate how eye movements specifically might be effective in reducing PTSD symptomatology claims that saccadic eye movements create a REM-like state through focusing attention across the midline of the brain. Stickgold (2002) theorises that during REM sleep, events that have been processed in the sensory cortices (through a perceptual
representation system) are integrated into semantic networks, becoming meaningful in light of previous experience and knowledge. Also he claims that activity is initiated that involves the interaction of episodic memories in the hippocampus with the associated affect in the amygdala. PTSD is argued to result from a failure to integrate traumatic events into appropriate memory structures in this way. The eye movement component within EMDR is argued to support the cortical integration of the trauma memories much like the process within REM sleep. Whilst this argument is appealing and has received support from a study highlighting some physiological similarities between EMDR and REM sleep (Elofsson, von Schèele, Theorell & Söndergaard, 2008), the REM sleep state, which includes body paralysis, remains a significantly different state to the waking state within EMDR. Moreover, this fails to account for the success of alternative bi-lateral modalities. Therefore, further exploration is needed before any conclusions can be drawn.

**Dual attention and working memory**

An alternative theory as regards the mechanism underlying the efficacy of eye-movements is argued to be the result of the process demanding a dual focus. From this viewpoint several hypotheses have been proposed. One line of argument suggests that engaging in a dual task whilst recalling traumatic memories might serve to distract from the negative affect thereby moderating arousal and thus facilitating reciprocal inhibition. Additionally, it has been argued that dual attention tasks ground the
individual (Shapiro, 1995) preventing dissociative states that might otherwise prevent processing of the trauma (Halligan, Michael, Clark, & Ehlers, 2003).

The elicitation of an orienting response through the dual task of eye movements is a further proposition posed within the literature. From this viewpoint, eye movements are thought to activate two processes, the first an ‘investigatory reflex’ (MacCullough & Feldman, 1996) that leads to the discernment that no current threat is present within the environment, which in turn leads to a relaxation response through the process of reciprocal inhibition. The second process, ‘reflexive exploration’ involves cognitive processes becoming more focused and flexible and is argued to result in the cognitive shifts seen in EMDR. Barrowcliffe, Gray, Freeman and MacCulloch (2004) have provided some support for this through their study that demonstrated eye movements to elicit a de-arousal effect; although theoretically, this proposal does not lend itself well to experimentation.

There are a number of empirical studies that have concluded that bilateral stimulation disrupts working memory (Andrade, Kavanagh, & Baddeley, 1997; Kavanagh, Freese, Andrade, & May, 2001). In essence the argument proposes that when individuals are asked to hold their traumatic memories ‘in mind’ during EMDR, they are held within the visuo-spatial sketchpad, one of the theorised components of working memory. When a simultaneous task, such as eye movements, is introduced, processing
resources within working memory become overloaded which, it has been suggested, is responsible for a reduction in the vividness of imagery (Andrade, et al., 1997) and decreased emotionality (Kavanagh, et al., 2001). This empirical test of this hypothesis along with that of Gunter and Bodner (2008) both utilised non-clinical samples and therefore it is questionable as to whether the results can be extrapolated to a clinical population; although findings that have demonstrated alternative concurrent tasks to be effective in reducing imagery vividness strengthens the explanatory power of this argument (Andrade et al., 2007). However, a recent study conducted by Lilley, Andrade, Turpin, Sabin-Farrell and Holmes (in press) which used a clinical sample of individuals experiencing PTSD, found that there was something specific about visuospatial dual tasks rather than dual tasks per se in reducing the vividness of traumatic imagery. As disruption to the visuospatial sketchpad may only occur whilst the individual engages in the concurrent task during the session (Kavanagh, et al., 2001), this leaves the mechanism underlying the more durable changes reported following EMDR requiring further explanation.

Research limitations and critique

On the whole, the EMDR evidence base has attracted strong opposition. For example Lohr, Kleinknecht, Tolin, and Barrett, (1995, p.300) criticised the EMDR literature claiming that evidence often appeared more convincing than the actual effect sizes achieved and argued that there was a disparity “between the clinical popularity of the procedure and the dearth of
supporting evidence”. Contributing further to the confusion within the literature is the often inconsistently presented information (See review by Perkins & Rouzain, 2002) and the methodological limitations of many of the published EMDR studies. In fact, Herbert, et al. (2000) have described EMDR as a ‘pseudoscience’ claiming that many of the research investigations undertaken have been confirmatory exercises and not true scientific endeavours based upon falsification principles (Popper, 1965).

In line with these comments, many of the studies previously outlined, particularly the earlier RCTs, have multiple methodological weaknesses, which obviously raise problems in their evaluation and interpretation. Examples of these limitations are: failing to control for psychotropic medication effects, failing to use blind assessors (e.g. Ironson et al., 2002), comparing treatments of different durations, utilising non-validated treatments for comparison (e.g. Carlson et al., 1998), conducting multiple t-tests which fails to protect for type 1 error (e.g. Vaughan, et al. 1994) and failing to account for pre-treatment baseline differences potentially leading to inaccurate effect size comparisons (e.g. Van Etten & Taylor, 1998).

Treatment fidelity is also a point of contention within this literature (Debell & Jones, 1997), although Herbert et al. (2000) argue that proponents of EMDR often cite treatment fidelity issues in order to explicate negative findings. An issue worthy of consideration here is that whilst treatment fidelity
is essential for research purposes this is unlikely to be a reflection of clinical practice where the EMDR protocol is likely adapted by the therapist in order to incorporate it into their usual practice (see DiGiorigio, Arnkoff, Glass, Lyhus & Walter, 2004).

In response to the poor methodological quality within the PTSD literature Foa and Meadows (1997) developed seven criteria by which the methodology of future research could be evaluated, which they termed the 'gold standard'. Despite this guidance many of the previously illustrated studies fail to meet all seven criteria recommended thereby reducing the validity of this evidence base. It has been argued that, paradoxically, the more stringent the methodology employed, the higher the effect size found (Maxfield & Hyer, 2002), therefore future findings could actually be more favourable than currently reported.

To summarise the aforementioned review, there is an increasing body of evidence suggesting that EMDR is efficacious for some people and for some psychological difficulties, in particular those related to traumatic experience. The approach continues to be hotly debated with findings relating to the ‘uniqueness’ of the mechanisms underlying the efficacy of EMDR therapy remaining equivocal. Methodological difficulties contribute to the high level of criticism that is apparent within the literature.
5.4 Appendix 4

A qualitative approach to EMDR therapy

As has been illustrated, the research relating to EMDR has been almost exclusively conducted from a positivist stance. Whilst findings have highlighted efficacy issues and potential mechanisms of action of EMDR, this evidence in and of itself never really provides a full and conclusive picture. It is important that the corpus of knowledge relating to EMDR is not restricted to experimental evidence of process and outcome issues. An individual’s world is filled with manifold experiences, which are rich and meaningful and thus bring to therapy many other factors that might interplay with the process. Accordingly, despite the highest degree of scientific rigour, there will always be some nuances of therapy that quantitative data might miss or misattribute to other factors. A useful source for learning about some of the idiosyncrasies of the therapeutic process is to investigate the client’s personal experience through qualitative means. Qualitative studies, in respect of therapeutic interventions, appear to be gaining ground within the literature. A number of studies that have aimed to gain insight into clients’ perceptions of therapy include an exploration of CBT for psychosis using discourse analysis (Messari & Hallam, 2003), an investigation of clients’ experiences of psychotherapy both for an adult (Levitt, Butler & Hill 2006) and adolescent population (Bury, Raval & Lyon, 2007) and an exploration of group therapy (Newton, Larkin, Melhuish & Wykes, 2007) with all studies highlighting issues for future practice which may not have been revealed through experimental methodologies.
To date, qualitative studies relating to the process of EMDR have remained sparse. Those studies that have been undertaken are generally based on a single case (Taylor, 2002; Maxwell, 2003) or on therapeutic outcomes and effectiveness. One study conducted by Edmond, Sloan, and McCarty (2004) has provided some insight into EMDR through qualitative means. They utilised a mixed methods design to compare female sexual abuse survivors’ perceptions of the effectiveness of EMDR and eclectic therapy. The participants were a sub-clinical population and were recruited via newspaper advertisement and flyers sent to agencies. The semi-structured interviews included questions relating to the benefits that they felt that they had gained from the approach and asked them for their views on different elements of the therapy. The qualitative data presented as an adjunct to the quantitative findings suggested a difference in participants’ perceptions of the two therapies. Participants reported a sense of empowerment from the eclectic therapy through the skill acquisition and enhanced self-esteem that this approach afforded, which left the clients feeling more responsible for their personal and environmental change. These changes were not highlighted from EMDR treatment despite clients stating that they felt less likely to require any further treatment following EMDR than following eclectic therapy. Discourse suggested that clients considered EMDR to be more effective in respect of trauma resolution but viewed it as fairly procedural. Furthermore, the therapeutic relationship was valued more within eclectic therapy than within EMDR. Interestingly, Vaughan et al. (1994) asked participants to rate their therapist within their experimental comparative study of EMDR and behavioural therapies and found that the
EMDR therapist was rated as more supportive and warm than the behavioural therapist even though the same therapists were used for both conditions. Also in contrast to the Edmond et al. (2004) findings the positive therapeutic relationship was illuminated within a qualitative study that investigated how therapists of different orientation integrated EMDR into their practice, with one therapist claiming that, “EMDR improves the therapeutic relationship because clients feel that they are being helped quickly and dramatically” (DiGiorigio, et al., 2004, p.245). Whilst the Edmond et al. (2004) study provided some new and interesting insights into the EMDR process as experienced by the client it was quite narrow in its focus. Due to the scarcity of qualitative data relating to EMDR, the factors that clients raise about their experience of therapy merit further consideration. The proposed study aimed to adopt a phenomenological approach to gain an experiential account of the process of EMDR. The rationale for the present study will now be elaborated.
5.5 Appendix 5

Research question

The current study was driven by a number of factors. The previously illustrated literature has highlighted areas worthy of further investigation such as the finding that clients emphasised EMDR as procedural and valued the therapeutic relationship less than in an alternative therapy (Edmond et al., 2004). This is particularly significant when consideration is given to the proposal that the therapeutic alliance is at the core of any therapy (Beutler, Machado, & Neufeldt, 1994). Similarly, as previous research has proposed that only fifteen percent of the success of any therapeutic approach is due to the therapy itself with the remainder accounted for by external factors, placebo, expectation and therapeutic relationship (Lambert, 1992), it is disappointing that little attention has been given to how these factors are played out or developed within the protocol of EMDR. It is of course not the intention of the proposed study to find any ‘conclusive evidence’, rather this is an example of one of the issues that might be further considered via an exploratory investigation and reflected upon in light of the existing evidence base. Equally, the suggestion that information from the clients’ perspective can be useful in the evaluation of services (Department of Health, DOH, 1999) is an important issue for consideration. As Newton, et al., (2007, p.129) state “our understanding of the experiential impact of the interventions that we make still requires considerable development”.

Adopting the qualitative methodology of interpretative
phenomenological analysis, the proposed study aimed to explore the phenomenon of EMDR as experienced by the client as a psychological intervention for trauma-related symptomatology, in order to gain a unique experiential insight into the EMDR process, an area currently sparse within the literature. A secondary aim of the proposed study was to investigate the significant components and the change experienced within the EMDR process as reported by the client within their personal accounts. It was anticipated that this approach would capture rich data not achievable through quantitative methodologies, highlighting elements of EMDR which to date has been under reported. This approach also facilitated a ‘natural’ account of events, by investigating EMDR related experiences within the context of the therapeutic process.

5.6 Appendix 6

Method

Participants
The initial aim of the study was to recruit ten participants based on proposals made by Smith and Osborn’s (2003) recommendation that a sample of at least six participants be used within IPA studies. This figure also allowed for potential attrition. Within the time constraints of the research, seven participants were identified. This number of participants provided sufficient data for the research question to be adequately explored. In addition, this figure remained in line with the recommendations of Smith and Osborn (2003).
5.7 Appendix 7

Recruitment

The services from which the participants were drawn were within the Nottinghamshire region. Individuals approached to take part in the study were those clients whose mental health was such that the treating clinician deemed it safe for the clients’ mental well being to participate in the study. Two factors underpinned this. Firstly, in order to engage in EMDR, clients must be considered psychologically equipped to cope with the therapy and their emotions safely. Secondly, clinicians approached all participants at the end of EMDR therapy when they were assessing their psychological response to treatment and their suitability for discharge, or for further intervention. This informed their clinical judgement in respect of whether the client was emotionally and psychologically stable enough to engage in the study. Six of the clients had completed EMDR therapy but were going on to engage in further work with their clinician employing an alternative therapeutic approach. Again, in these cases the clinicians made a clinical judgement as to whether any remaining psychological issues might impact on the clients’ appropriateness for participating in the research. One of the participants approached had already been discharged and therefore was deemed psychologically stable enough to take part in the study. Standardised risk assessments were utilised by the consulting clinicians within the therapeutic process as standard practice in line with NICE guidelines (2005). This criterion enhanced the homogeneity of the sample, thus increasing the specificity of the research question.
The original proposal for the study had specified that non-English speaking clients be excluded due to the time and financial resources that would have been required to employ a translator, which were beyond the constraints of the present study. Additionally, it was felt that some of the intricacies of language around the clients’ experiences might be lost through the translation process. However, within the research recruitment phase, no non-English speaking clients were engaged in EMDR within the participating services and therefore this exclusion criterion became redundant.

Consulting clinicians made preliminary contact with the participants. As clients were at different stages within therapy, initial contact took two forms. For the six participants still engaging in therapy, contact was made verbally, face to face within a session at the clinic where they were receiving EMDR. In the case where the participant had already been discharged, initial contact was made by the clinician using a standard invitation letter prepared for the purpose of the study (see appendix A for an example of this document). On approaching the participants (whether verbally or in writing), the clinician provided an information sheet (see appendix B for a copy of this document) inviting participation in the study and specifying the full details of the research procedure and ethical considerations. A consent agreement document was also provided (see appendix C for a copy of this document). For those clients approached face to face, an opportunity was given within the session to work through the information sheet with the clinician and ask any questions that they had in respect of the study. Similarly for the participant contacted by letter, an opportunity was offered to either contact
the clinician by phone or to arrange an appointment if they had any questions or wanted to work through the information sheet with the clinician. The participant contacted the clinician by phone and the study was discussed. On agreeing to take part, the clinicians requested that participants complete and return a consent document following which, the clinicians forwarded these to the researcher along with the participants’ contact details. Participants were asked to respond within a two-week time frame, affording them time to adequately consider their taking part in the study. On receipt of the consent document, the researcher contacted the participants by telephone in order to give them the opportunity to ask any further questions as regards the research process and to arrange the interview appointment.

As consent was routinely required by the clinician in order for client and clinician to engage in EMDR, the participants in the study were all able to provide informed consent. On receipt of the consent form, the researcher signed the form, took a photocopy and returned it to the participant. Therefore, both participant and researcher retained a signed consent form.

The consent document and information sheet collectively detailed the nature of participants taking part in the study which included the following demographic and clinical information being provided by their clinician to the researcher for the purpose of the study. The demographic information gathered was participants’ gender and age. The clinical information gathered was; nature of traumatic experience (information given to the researcher as regards participants’ trauma was provided as a general description only and
did not include any specific details about the trauma), length of psychopathology, date of final EMDR treatment session, length of EMDR therapy, setting for EMDR therapy and type of bi-lateral stimulation used. All information was recorded without identifying information. The following details regarding the therapist undertaking EMDR were also collected: gender, occupation and length of experience of practicing EMDR therapy for trauma. The researcher informed participants verbally that if they wished to disengage from the research process at any point then their participation in the study would be terminated. It was emphasised that this would have no impact on their future treatment from the service. This information was also provided to participants within the information sheet that they were given to keep. Participant contact, recruitment and consent were piloted with the first recruited participant and feedback gained. No revisions to the documents or process were required.

5.8 Appendix 8

**Ethical considerations**

Following ethical approval, two amendments were submitted and approved in December 2007 and June 2008. The content of the amendments was to extend the time frame for recruitment from 8 weeks post EMDR therapy to 16 weeks in order to improve recruitment, which had been slower than originally anticipated, and to add two additional recruiting clinicians, again to improve recruitment (See section 4.0 for all ethical approval documentation). The primary ethical considerations highlighted within the application for approval were that the investigator remain vigilant to any signs
that the participants were re-experiencing their trauma, to remain aware of any significant disclosures from the participants and to be aware of any indication that the participants were otherwise distressed. The researcher remained attentive to these issues throughout the study. A review appointment with each participant’s treating clinician was offered to each individual following their interview in case any distress had been experienced. However, following interview, when queried, no distress was reported by any of the participants and none chose to take up the offered appointment.

5.9 Appendix 9

**Interview procedure**

The semi-structured interview schedule designed for the purpose of this study was piloted with a university tutor who is trained in, and has experienced the EMDR process. Whilst helpful, this process did not yield the degree of refinement of the schedule that had been anticipated. On reflection it was clear that as the tutor had not experienced trauma, their experience of the EMDR process (used for practice purposes only) had been different in nature to that of the participants. Following the first participant interview it became apparent to the researcher that the schedule required additional areas to be explored which were added in order to enhance the elicitation of information relating to clients’ experiences. The full interview schedule can be found in appendix D.
The sequencing of the schedule was guided by suggestions posed by Smith and Osborn (2003) who highlighted two areas of importance. Firstly, they argue that themes be approached in a logical manner and secondly, they suggest that the sensitivity of themes be considered in respect of their order. In line with this, the schedule was designed to follow a chronological narrative of therapy as experienced by the client as this appeared most ‘logical’. A secondary benefit here was that the more sensitive areas of EMDR therapy (usually the desensitisation process where client trauma is the focus) were explored after more practical questions had been presented and the participant had had an opportunity to become more at ease with the researcher. The researcher undertook all interviews. The interviews were audio recorded using an Olympus DSS digital recorder and were subsequently transcribed by the researcher using transcription notation outlined by Bannister (1994) (see appendix E). All names and identifying information were removed from the recorded data in order to protect anonymity.

5.10 Appendix 10

Analytic procedure

Interpretative phenomenological analysis has been described as “especially useful when one is concerned with complexity, process or novelty” (Smith & Osborn, 2003 p.53) and was therefore considered to be particularly relevant to the study of the clients’ experience of the ‘process’ of EMDR. Lincoln and Guba (1985) suggest that within qualitative analysis, data
sources and analytic processes be examined to confirm that the findings are grounded within the data. Accordingly, in order to make the process of analysis transparent, two of the excerpts included within the final results section will now be followed via an audit trail demonstrating the process from their transcription through to their interpretation. The researcher’s initial encounter with the text was at the transcription stage. During this process the researcher began to become familiarised with the text and also began to jot memos of thoughts or ideas about the data or personal reflection within their research diary as they occurred to them (See appendix F for an example of a memo created during the transcription stage). Memo writing within the research diary continued throughout the research process and was where the development of ideas began in preparation for write up. Transcribed data was placed into a table that separated the discourse into the chosen units for analysis (participants’ turns were used as units as they offered coherent and manageable pieces of data) with an empty column left on each side of the data for the researcher’s notes. After reading the transcripts several times, the initial analysis involved the researcher working through each turn on each individual transcript and making unfocused notes within the left hand column of the transcript relating to any significant or interesting data. Following this, each transcript was revisited and more concise notes made within the right hand column which reflected conceptual or psychological constructs (see appendix G for an example of two participants’ transcripts with analysis). The researcher then developed within participant clusters, which was an initial categorisation of ideas into meaningful chunks. In order to manage the large amount of transcribed data, initial clusters of ideas from each participant’s
transcript were placed into a table (table 1) together so that they could be more easily compared and similarities and differences identified (See section 8.1 for a sample of table 1). This data was then analysed and distilled further into appropriate super-ordinate headings in a separate table (table 2) (See section 8.2 for a sample from table 2). The analytic process was iterative with themes and transcripts continuously revisited in order to ensure clusters were representative of the data. The final part of the analysis involved the creation of a table of themes (table 3) which included participant extracts and which provided the framework for the written analysis (See section 8.3 for a sample from table 3).

5.11 Appendix 11

Validation methods

Great value is placed on objectivity measures such as reliability and validity within quantitative endeavour (Kirk & Miller, 1986). However, these constructs have different meanings within phenomenological study (Beck, 1994). Whilst the epistemology of qualitative enquiry is not in line with that of quantitative approaches (Smith, Harré & Van Langenhore, 1995) the interpretation that is accepted as a key part of the process in IPA (Smith, 1996a) must nevertheless be established as credible and therefore validation criteria must be applied. A number of authors have outlined such criteria. Smith (1996b) suggests that arguments made within qualitative research must be internally coherent and justifiable against the data. He argues that interpretation must be open to examination through presentation of sufficient raw data from the participant. Within the present study, this has been
adhered to with interpretation presented alongside verbatim transcript. Smith (1996b) also argues that validation can be achieved through the scrutiny of the analysis by the participant or an independent auditor. This is not for confirmation of ‘truth’ but instead aims to confirm that interpretation is reflective of the interview data. One of these verifications was undertaken within this study where at each stage of the process, a research and clinical supervisor inspected the work to check that what had been produced was warranted against collected data.

Reliability, in its purest form, is somewhat redundant within this study as it is not concerned with prediction (Willig, 2001), rather the primary aim is to explore the uniqueness of a given phenomenon. However, the need to provide replicable methodology demands that this study be approached in a rigorous way, which was achieved through the adherence to the IPA procedure.

5.12 Appendix 12

Extended results section

Living with trauma

The theme of ‘living with trauma’ emerged from the data and seemed to represent participants’ reflections on the way they perceived trauma as having impacted on their lives and sense of self. This theme has been included here as it provides context for participants’ EMDR experience. Although the nature of the trauma experienced by participants was divergent, descriptions of its consequence were similar. Traumatic symptomatology was
recounted as having pervaded, and in some cases destroyed, many facets of participants’ lives. Six of those interviewed detailed acute sleep disruption and lengthy periods of sickness leave or their employment as having been lost altogether. The impact that trauma had had on relationships was varied. Most participants had retained a small circle of friends or family whom they trusted and in some cases had become insulated within these, as Jo described:

“Well I never went out whereas I used to be always out, bubbly, I haven’t had a relationship for 8 years, all I did was dote on my son and that’s it... I just cocooned myself in my house.” (Jo, F, 42yrs)

Having had so much of one’s life touched by traumatic symptoms, five participants described their being in the world as no longer reflecting their old life. Rather it had become an “existence”. Paul’s account illustrated his felt loss:

“I didn’t have no life, no life whatsoever, erm (3) I would say my life was out of a scale of 100, two, there was nothing there whatsoever, (2) when somebody does something like that to you they just knock everything out of you.” (Paul, M, 52yrs)

Shelly’s story of her experiences stood out as somewhat different from the other participants. Having experienced and recovered from a breakdown over a decade ago she described how she felt that following previous therapeutic interventions she had been coping and functioning in the world, albeit superficially. Despite this, her narrative indicated that the remnants of trauma were still carried with her daily, which had often led her to engage in
unhelpful behaviours aimed at avoiding the emotional manifestations of trauma, but which in fact served to maintain their presence:

“As soon as I’ve started feeling that feeling whatever it was, er guilt for instance, erm that would then trigger all those other things, guilt coz you are this, you’re that and the other and feel shit so I would go and get pissed or, or hurt myself, whatever, whatever that would then bring up and then that’s why I would go to bed with it and that’s why I’d wake up with it.” (Shelly, F, 37yrs)

Flashbacks and nightmares were a daily occurrence for five of the participants. Paradoxically, whilst images and the co-existing emotions were frequently and powerfully relived, when an attempt was made to find the words to communicate their experiences and pain to others, a void was encountered. As Clare explained:

“I just couldn’t…find the words to, or you know express it, I could go argh, you know but that doesn’t actually tell you what’s wrong, I could it’s almost as if…the feelings were there but the sort of words and the means of expressing it, it was just like a blank, a blank sheet and you couldn’t even sort of grab a word or whatever out.” (Clare, F, 29yrs)

What was most striking from the participants’ accounts was the omnipresence of trauma within their daily living. As each individual’s traumatic experience had occurred many years ago, the symptoms and consequences that they disclosed were chronic.
Five participants had sought help previously and the therapeutic trajectories described were varied with different pathways leading to their first becoming aware of EMDR. Three participants outlined previous incomplete and unsuccessful sessions of EMDR some years earlier, two knew of someone else who had previously received EMDR and the remainder heard about the approach for the first time from their current therapist.

5.13 Appendix 13

Doubt and apprehension

Five participants articulated having initial negative feelings toward EMDR. For Jo, despite being reassured by her therapist that she would not lose consciousness, her concerns about being hypnotised were not fully overturned until she had experienced the process for herself:

“Yeah I thought, I kept thinking he was gonna like hypnotise me or, obviously he kept saying stop being silly Jo, we’ve talked about this, I’ve explained about it all but I said yes, what if you put me to sleep and I won’t know about it, but it was nothing like that.” (Jo, F, 42yrs)

Two participants described attempting to delay the commencement of EMDR as a result of their negative feelings toward it. Shelly revealed how avoidance of EMDR meant that she could continue work that fitted her view of real therapeutic endeavour, ‘talking’:

“Coz each time he brought it up I was like ‘er no I want to talk’ (laughs) ...but then avoiding it each, each session (laughs) because I wanted to fill it with other things, erm it’s because I wanted so much out my hour
that I felt that was gonna take away from what I thought was important.” (Shelly, F, 37yrs)

Likewise, Kate described having initially avoided engaging in EMDR due to her complete lack of faith in the approach:

“Well I suppose because I’ve never heard about it, never, ever, and it was totally new for me and I just didn’t see that it would really do anything...and I didn’t really want to go into it and I probably even put er, the therapy off a little bit, wavered on other things.” (Kate, F, 46yrs)

Receiving information about the approach did increase some participants’ willingness to try the therapy although it did not completely remove doubt. The information that participants received was either given by the therapist verbally, in written or diagrammatic form or using a combination of these, with differing degrees of subsequent understanding reported. Two participants supplemented the information with their own searches from books or the internet.

For three participants, it was apparent that their engagement in EMDR, in part, was as a result of compliance, seemingly going along with what they believed to be the wishes of other professionals or the therapist. As Shelly and Jo described:

“I felt that this [EMDR] was a hindrance...erm and so my feelings were ‘oh alright if you want to’ [author’s italics] type of thing.” (Shelly, F, 37yrs)
“I came the first session like I say because I felt like I was made to by
doctor, counsellor, friends.” (Jo, F, 42yrs)

For Jo, like others, having tried various alternatives with little success, she
described having reached a point where “anything was worth a try”. As she
explained

“I just wanted to see if it would work to make me feel normal again so I
thought well “why not”, I was sick of taking tablets coz they didn’t do
anything so I thought I’d give it a shot.” (Jo, F, 42yrs)

5.14 Appendix 14

Making safe and making sense

The manner of the therapist and the quality of the relationship was
reported as key for six of the participants. Jo illustrated how this factor
overrode her concerns around the nature of the therapy within her account:

“I think it was when I first met T2, well I walked in and I thought “oh
god” and I sat here like a gibbering wreck but by the time I went out
the first session I’d told him more about my life than, I think it was just
him.. Yeah and that sort of made me believe in him, not in [EMDR]...so
I think it was the tutor more than anything, not the product.” (Jo, F,
42yrs)

Similarly Barbara and Clare acknowledged the importance of a non
judgmental and helping approach to their sense of safety and acceptance, as
their following excerpts demonstrate:

“Erm (2) when I had...T2 he just, he makes you feel...comfortable, erm he makes you feel that you’re a human being that needs to be helped, and to put you back where you were,...and I, I’ve got sort of faith in that.” (Barbara, F, 57yrs)

“You know he’d put you at ease and made you feel safe and saying you know ‘no matter what, what you say, what you do it’s not gonna matter to me, it’s about looking after you.” (Clare, F, 29yrs)

It appeared that for some, the introduction of the ‘stop signal’ provided reassurance that the Journey that they may take was containable and could be kept within the confines of what they felt able to tolerate. As Barbara stated:

“If things are not right and I don’t feel comfortable you know I put my hand up and we stop...so you know while we’re doing it obviously I’m sort of full of faith that if I don’t want to do it then he’ll stop.” (Barbara, F, 57yrs)

For Clare and Shelly, being able to choose what issues they would like to bring to the session that day gave them the opportunity to begin to regain control:

“and he was very good about saying right, all this, you make the decision about how we proceed...I suppose giving me back the control I felt I’d lost.” (Clare, F, 29yrs)
“So all the other statements and self beliefs we’re working on different ones, I mean T3 lets me choose whichever, I mean he doesn’t even intrude on what it, what it necessarily is unless I...you know offer it.”

(Shelly, F, 37yrs)

Both of these elements of therapy appeared to appease participants concerns about the therapy leading them somewhere that they did not want to go and provided them with a sense of control over the direction of the session. Other tasks associated with the early stages of therapy were the identifying and rating of appropriate cognitions to be worked upon.

This was not easy for everyone interviewed. In particular, for Nick the process of beginning to bring positivity back into his life was reported as something that he initially found challenging:

“It was quite hard you know you’ve got to think of something negative and then something positive, I mean they tell you, you know think of something really positive something that’s if you like warm inside, a good feeling, you know where you are, something that’s good. That was harder to think of something like that than the negative.” (Nick, M, 45yrs)

Shelly echoed these difficulties within her account. However, unlike the majority of participants who felt that the statements that they identified were meaningful and relevant, Shelly felt that the statements that she selected were completely inconsistent with how she viewed herself. Below
she gives a picture of her initial thoughts and the difficulty she experienced when she and her therapist identified a self-referential positive cognition to work with, when actually she had full belief in the negative statement:

“Felt like a load of shit (laughs), it felt like you telling me that that’s a car (points to table)...that’s what I thought ‘this is ridiculous’ because I believed, like I believe I’m sat here...and I believed those statements so when T3 was suggesting the opposite I thought well OK I’ll go along with this game because it felt like a game.” (Shelly, F, 37yrs)

However, as the process continued and her therapist clarified that the statement could be something that she would prefer to believe about herself, Shelly’s narrative suggested that this was much more easily accommodated:

“and then he did ask ‘think what you would like to believe’ he didn’t say what was the truth which I, which helped because I believed that that was the truth.” (Shelly, F, 37yrs)

For Jo, movement began to come about through the process of identifying previous distressing memories within therapy which enabled her to gain insight into how these previous experiences had contributed to her current difficulties:

“yeah I was traumatised but other things added to that trauma that I didn’t think about before I’d had this treatment.” (Jo, F, 42yrs)

5.15 Appendix 15

The process of ‘processing’
Difficulty in verbalising the process of bi-lateral stimulation was evident in five of the participants’ accounts. Representative of this was Barbara’s comment where she recognised that something was “going on” but was unable to explain what that was:

“when we first did it, erm, just sat there and...going through the process, but...I mean obviously at the time I didn’t know...you know what was happening or what have you but it certainly did, my body and my mind definitely changed somewhat,...there was something going on but you know at that time I couldn’t have said oh you know that was so and so happening.” (Barbara, F, 57yrs)

Six of the participants recounted having experienced the coming forth of other experiences when focusing on their trauma during bi-lateral movement. One participant described an increase in detail surrounding the memory such as recalling people’s facial expressions or nuances of colour. Four, however, reported the experience of other memories ‘coming into mind’. There were two common factors within participants’ accounts of this experience which were the references to language of movement and positioning (e.g. came to the ‘fore’) and the shock and surprise expressed in respect of the emergence of this material. From participants’ accounts it appeared that the surprise expressed was seemingly due to both the content of the material, which participants had clearly not previously connected with the current trauma, and also due to their sense that they had no conscious role in its re-emergence. Confused by its spontaneous emergence, three participants attributed this to the therapeutic process as illustrated by Clare
and Paul:

“I found that it sort of triggered...things that I hadn’t thought about or considered for years and it brought a lot of things to the fore.” (Clare, F, 29yrs)

“So it must have stirred memories up what’s been locked away for years because I haven’t thought about them for years and it must have brought them all crashing down on me in one swoop.” (Paul, M, 52yrs)

Others’ accounts referred to bilateral stimulation as “strange” or “amazing” which appeared related to participants’ perceived lack of conscious activity and their attribution of action to the process itself which seemingly gave the sense that things were simply happening to them. Here Barbara described the process as one that could reach out and locate and resolve her difficulties:

“But the rapid eye movement is the one that I, (2) suits and the one that seems to me to get hold of my mind. And...physically...sort of...the feelings inside my stomach and the feelings inside my heart and it just seems to...grasp it and...sort it.” (Barbara, F, 57yrs)

In attempting to make sense of her experience of not sensing herself as consciously active, Clare provided an explanation suggesting activity at her subconscious level:

“It’s obviously subconsciously my brain’s recognised that it’s worked so subconsciously I’m, I'm not conscious of me actually thinking right
think of this and it'll work but I'll be doing it and I'll suddenly think Oh, I'm doing this and then I'll just let it sort of do whatever my brain's doing erm and then I know I'm gonna feel better.” (Clare, F, 29yrs)

Three participants described bi-lateral stimulation as hypnotic or trance like. Surprisingly, given participants previously illustrated concerns as regards a hypnotic state, their reports of experiencing something that they believed to be similar were positive. In outlining her experience Shelly reported retaining consciousness but losing some sense of her environment:

“But you’re conscious and you’re aware that something strange happens...the only thing I could think similar is like hypnotherapy because you’ve got no awareness of time or anything...and it feels quite tranced, trance like.” (Shelly, F, 37yrs)

Despite reports of reduced awareness, a sense of collaboration between the client and therapist was also communicated. In the following excerpt, Jo’s description of collaboration led her to recognise the significance of her own role in the process, albeit at a subconscious level:

“I knew that we were doing it together...I could hear him and I felt like he was helping me along, but he wasn’t, I was doing it, just without me knowing.” (Jo, F, 42yrs)

Such collaboration appeared to provide a feeling of control for some participants. Paul described the process of collaboration as part of the therapy that he enjoyed:
“He was asking the questions and I was giving the answers er that’s basically the way you can put it really, it was like team work to me.”
(Paul, M, 52yrs)

Whether employing conscious effort or engaging passively, around half of the participants reported the process as tiring and the other half as totally relaxing. The following extract is typical of those who described their experience as exhausting:

“But after you’ve had it done you’re really knackered, you’re tired you really are physically and mentally tired.” (Nick, M, 45yrs)

5.16 Appendix 16

Change

Within Session Change

The within session changes that were described were generally quite specific, and easily recognised by participants at the time of their occurrence, such as changes to imagery or levels of anxiety. Where changes to imagery were verbalised, the image itself was not reported to alter but rather its vividness decreased as did the level of distress that would normally accompany it, rendering it more tolerable, as Nick stated:

“No the image doesn’t change...It cut off the edges of it, it took the nastiness away...that certain image it can make it easier, I can relate to it and I remember while being treated...so I don’t panic so much about it although it’s still there and it still frightens the life out of me. Yeah at the time it smoothed its, smoothed it, took the harshness off it
and there was such a feeling inside you know I could really feel it from inside me." (Nick, M, 45yrs)

Six participants referred to their sense of the process as being freed or being rid of negativity that had been ‘weighing’ them down. In line with this, Jo described:

“Like I don’t know like I was being cleansed or, I don’t know and all these bad things that I’d got weren’t as bad, I could deal with them more so, it was weird.” (Jo, F, 42yrs)

Barbara described how she had experienced within-session transformation from negativity to positivity through a prolonged focus on a positive cognition about herself which had led to her becoming immersed within that statement and resulted in a real sense of well being:

“And then we’d concentrate on the...certain words which...made me feel ...more relaxed...good about myself,...my whole body...and... with doing the rapid eye movement it ...it’s like a calmer...influence I think, ...and usually when we’ve er done this you know I go out with a smile on my face, you know I come in all gloomy and I go out...feeling yeah that’s done me good today. You know I can do that and I do, do this and you know I should feel better about this and so on and you know I’ve gone out on a erm buzz.” (Barbara, F, 57yrs)

Shelly had experienced a sense of dizziness which was followed by a sense of comfort that, by the end of session, had changed to one of total
relaxation which she likened to intoxication:

“I have to say in every one of the sessions, it's that 'it's a nice feeling' (whispered), no stress', it was a very nice feeling, I said to T3 I felt pissed actually on one of them erm well in fact on a few of them I felt pissed (laughs), tipsy not pissed, tipsy, a nice, I don't know, chilled, (.) yeah at the end of them I've felt like that every time.” (Shelly, F, 37yrs)

5.17 Appendix 17

Post-session change

Consistent with all of the other participants' narrative, Clare described how change had taken different forms:

“There were some sort of small term immediate gains, more , a lot more medium term and then there's little bits that are still going on.”

(Clare, F, 29yrs)

Post-session change was also described as though it were a “knock-on” effect by Clare. She described how her ambition and sense of who she was began to slowly return:

“I'm feeling sort of my ambition and all the feelings that I felt completely cut off from and numb from, there, there seeming to be seeping back in almost, you know like water through rock, it's just coming, coming through in little bits but it's coming back and I think the EMDR has definitely sort of triggered that.” (Clare, F, 29yrs)

Some of the post-session change experienced appeared less
recognisable to participants. As a result, change was often pointed out by close others or was described in a passive way suggestive of having ‘caught themselves’ doing things differently. Jo described how her usual hypervigilent behaviour at home had ceased but she had not been aware of this until noticed by a friend:

“My friend used to come...and it was her, she said “look at your difference” and I said “oh I haven’t thought about that” and I was, I was different.” (Jo, F, 42yrs)

Two participants alluded to ‘core’ changes within themselves. For Clare this was seen as the opportunity to start afresh:

“I can sort of get on and start building, building again, it, its (3) I suppose the best way of, it’s almost as if my entire house has been knocked down and a new foundation has been laid er I suppose...in the last few weeks I’ve just been thinking I feel like I’ve got a whole new lease of life and that I can start again you know and start building on a completely fresh sort of foundation.” (Clare, F, 29yrs)

Because of this fresh start Clare saw the therapy as having been self improving as not only was she eradicating the symptoms that she experienced, she was also developing a new world view and a new self:

“Yeah, yeah, I, I feel that its (3) coz I mean [my partner] made a comment the other day that I, I mean I changed completely from the accident and he said “I’m starting to get the old you back” but...there’s been changes in the old you, you’re not, you know you’re starting to
do things differently” in that sense so, which is nice to think that I’m becoming me again but a better me.” (Clare, F, 29yrs)

Similarly, Shelly reported change as occurring at a more profound level. These changes enabled her to view herself within a totally different light:

“That’s what’s happening to me...I’m starting to feel who Shelly is and...that’s, that’s good, it’s a good, good thing, feels nice, it, I have to say, feels very nice... this so this...absolute 100% feeling is that you are a piece of shit and that you’re worthless even though this alter ego, confident, no I’m wonderful, the feeling, the actual core of me is starting to believe positive things about myself that that [trauma] isn’t who determines Shelly, it’s me, it’s who I am.” (Shelly, F, 37yrs)

She went on to illustrate how she felt that as a consequence of this core change she was beginning to experience congruence between her thoughts and feelings which was impacting on her relationships:

“I’ll tell you the biggest, the biggest change is something that we’ve not, got nothing to do with this, it’s the fact that I, er that my partner loves me, I’ve never ever, It’s tapping into other things that we haven’t even approached...I mean I know, I know she does but I’ve never believed, never even given it a thought that she actually does...and in the last fortnight I’ve caught myself going ‘my god she does love me’.” (Shelly, F, 37yrs)
Although later within the interview she went on to challenge her own previous discourse and doubt whether a fundamental change had actually been realised:

“It’s, that, that’s what I am [trauma]...and I can’t get away from it, even though I know I’m...I’m this and I’m that and I’m a woman and da, da, da, I can’t get away from it and so...feelings have changed but not necessarily er who I think I am (2) sounds a bit contradictory but.”
(Shelly, F, 37yrs)

Two participants talked of how they would draw on their experiences of EMDR in the future, as if having been equipped with skills. As Barbara demonstrates:

“The processes of going through it are...never going to leave me and if I’m feeling stressed and so on, you know all, all the sort of experience and...the erm, knowledge that I’ve picked up...sort of won’t be lost.”
(Barbara, F, 57yrs)

Only Jo had been discharged following EMDR. All other participants expected that they would go on to undertake further therapy. Barbara recognised that whilst she had made significant progress, there was still more work to be done in reshaping her life:

“You know there’s still a long way to go as a person.” (Barbara, F, 57yrs)

Nick reported having experienced significant improvements and was
exclusively positive about EMDR. However, his outlook on his prognosis was less optimistic. As demonstrated here, doubt was expressed in respect of ever experiencing a full recovery:

“It’s made it a lot easier to live with but it won’t ever go, no I still, I don’t have to think hard about it, it’ll come to me.” (Nick, M, 45yrs)

5.18 Appendix 18

Extended Discussion

Summary of Findings

This study aimed to explore clients’ experiences of EMDR for trauma and also to reflect on a clinical intervention that has to date, been studied primarily from an experimental stance. Five super-ordinate themes emerged from the data: ‘living with trauma’, ‘doubt and apprehension’, ‘making safe and making sense’, ‘the process of ‘processing’ and ‘change’. Whilst not a theme in its own right, both active and passive processes were evident in participants’ accounts and therefore these were briefly considered in terms of participants’ sense of agency throughout the process of EMDR, and in respect of the change that they reported.

The findings revealed a Journey of discovery for participants, where initial loss of hope through illness had led to cynicism, that any intervention could help them become well. Through the building of a trusting relationship with their therapist, doubt transformed to a willingness to “give it a go”, and engagement led to self discovery and change. A discussion of how this journey might be understood in terms of the current evidence base and
indeed how the findings might extend this follows.

**Living with trauma**

In attempting to make sense of the impact that EMDR might have on traumatic symptomatology, participants were asked about how trauma had affected their day to day living prior to therapy. What was revealed was a bleak existence. Trauma had bled into every area of participants’ lives. Avoidance, re-experiencing and anxiety, consistent with diagnostic and theoretical descriptions were present for most participants. What was also interesting was the difficulty that many participants had in articulating their trauma or their feelings surrounding it, describing a ‘blank sheet’ as all that verbally represented what had happened to them. This fits well with Ehlers and Clark’s (2000) model that highlights a failure to elaborate traumatic memories both episodically and verbally. Equally apparent was a new found distrust of others, people had become something to fear. Although no information was available as regards previous belief systems, one might assume that being a victim of trauma, particularly those that had involved being hurt by another human being, might have shattered one’s assumptions of people as safe or trustworthy (Janoff-Bulman, 1992). Employing a phenomenological approach was particularly helpful for understanding participants’ experiences. As Munhall (1994, p.16) argues, from a phenomenological viewpoint, lived experience “is not what is happening, it is what is perceived as happening”. For this group of individuals this was particularly relevant as despite the danger of the traumatic experience no longer being present, their felt sense of perceived danger was meaningfully
conveyed within their accounts.

5.19 Appendix 19

Doubt and apprehension

Despite having experienced various therapeutic approaches, many participants had no prior knowledge of EMDR. Regardless of each individual’s awareness of the approach, most held some negative expectations. A fear of losing control appeared common, with one participant demonstrating a real concern of being put to sleep. One speculative possibility as regards this commonality is that participants compared the eye movement component with that of the traditional hypnotic procedure as depicted within the media, where a swinging pendulum is tracked by eye. The response that one has to a traumatic incident can be exacerbated where a sense of control over what is happening is lost (Gurshuny, Cloitre, & Otto, 2003). Therefore, for clients who have experienced trauma, as had the participants’ in this study, the fear of losing control within therapy is likely to be extremely meaningful and must be seriously considered within the clinical setting.

It is important to note that the information that is supplied to clients’ within EMDR is often both written and diagrammatic with a basic theoretical explanation of the potential mechanisms underlying its action. This is a unique element of EMDR as the theoretical underpinnings of alternative therapeutic approaches such as psychodynamic psychotherapy or family therapy for example, are not provided as a matter of course. This is
potentially related to the scientific scrutiny that EMDR has faced and a response to the sense that its active ingredients should be justified (Lohr, Montgomery, Lilienfeld, & Tolin, 1999).

In spite of the provision of this additional information, participants’ doubt was only partially appeased. Fortunately, this did not lead to disengagement within this group of individuals, although two did describe having purposefully avoided EMDR therapy initially and others reported having engaged through compliance or because they had reached a felt low point. It is important to consider whether distorted expectations might prevent other individuals from accessing a potentially helpful intervention, particularly given that individuals experiencing trauma related difficulties might be hypervigilent to danger from others, or the environment and may find it difficult to trust. Collectively, these issues raise the question as to whether anything can be done to raise the profile of EMDR and to improve the initial encounters clients have with this approach. The most relevant literature within which to consider these issues falls under the rubric of ‘client expectations’. The expectations that clients hold as regards therapy have been suggested to affect the development of the therapeutic alliance (Constantino, Arnow, Blasey & Agras, 2005) and treatment outcomes (Arnkoff, et al., 2002). These are not new propositions with early work by Frank and Frank (1973) suggesting the augmentation of positive expectation and hope to be central components of the healing process. Greenberg, Constantino and Bruce (2006) propose a number of clinical strategies for improving client expectations, for example, providing results of efficacy
studies to clients and being clear about how many sessions they might expect, both of which the EMDR protocol already incorporates. Along with the general information given, perhaps it would be helpful to provide excerpts from previous clients describing their experiences which may reassure potential clients. It is possible that this might be more readily taken on board given that the information would be generated by someone who has experienced a similar situation. Tarrier et al., (2006) conducted a study with a university student sample that gathered data on their preferences for 14 different treatment approaches for PTSD. Treatments were rated according to ten variables including prior knowledge of treatment, treatment credibility and expectation of positive benefit from treatment. EMDR was ranked as the least preferred out of all 14 therapies. Given this result, along with the findings from this study, it appears that an increased presence of EMDR within services and within the public domain would be highly beneficial.

5.20 Appendix 20

Making safe and making sense

As has been illustrated elsewhere within this piece of work, the study of eye movements within the EMDR literature is greatly disproportionate to that of non-specific factors. In fact in a number of experimental studies comparing treatment effects between EMDR and other therapies, often the EMDR sessions include the bi-lateral elements but not always all of the additional proposed treatment components (Devilly, Spence, & Rapee, 1998). Likewise, the original myth of EMDR as a one-session treatment (Shapiro, 1989b) promoted the idea that EMDR was devoid of relationship or
skill building. The present study was not immune to this difficulty, where the recording of the number of sessions of EMDR that each participant had attended was, in some cases, initially misunderstood to imply just the sessions of bi-lateral movement.

However, what was clear from participants’ accounts was the significance of the factors associated with the early sessions of EMDR therapy. One of the valued elements, the therapeutic alliance, was experienced as warm, helpful and meaningful to participants’ progress. The importance of the relationship appears intuitive given participants' low expectations of therapy and, in some cases, their sense of others as untrustworthy. It is disappointing therefore that more research has not been directed toward augmenting the clinical understanding of how the therapeutic alliance might develop within EMDR and whether the time given to this endeavour differs within EMDR to that within alternative therapies. This need is made more significant by Edmond et, al., (2004) where their qualitative findings revealed that within eclectic therapy, clients reported a good relationship and attributed therapeutic success to this factor, whereas in EMDR therapy, not only did clients value the relationship less, they also failed to associate even part of their progress to this. This contradicts the current findings where one participant had stated that success was a result of “the tutor and not the product”. Either way, the findings suggest more scientific endeavour would be helpful in this area.

Other factors associated with the early sessions of EMDR were highlighted as equally important by participants. Although Lohr, et al., (1999)
has considered non-specific factors in relation to EMDR, it is not clear whether all of the experiences reported by participants during these phases could be contextualised in this way. Certainly factors such as the collaboration highlighted by participants would fall within this category. Collaboration is a prominent factor within the CBT literature however it is less visible in the evidence base relating to EMDR. Nonetheless many clients were vociferous in their descriptions of how throughout the process they had felt that they had been given choice and control. Again, with this group of clients who may have felt out of control during traumatic experiences it appears instinctive that this factor would be relevant within therapy.

In particular safety and control were highlighted as being facilitated by the stop signal and through the self election of material to be used within session. Having an internal locus of control has been argued to impact on how one copes with aversive stimuli (Averill, 1973) and on psychological well-being (Ryff, 1989). Therefore, the nurturing of this element within therapy potentially contributed to therapeutic engagement and progress for some participants. The structure inherent in the EMDR protocol also afforded control. Having knowledge of what was to be expected from sessions allowed clients to gain a sense of mastery. The salience of this factor is reflected within the therapeutic literature where facilitating experiences of success and mastery have been suggested as one of therapists’ primary aims within psychotherapy (Frank & Frank, 1991).

Finding a language to express one’s feelings and thoughts regarding
the trauma was also an important facet of the early therapeutic stages for participants. Consistent with Ehlers and Clark’s (2000) model, many participants experienced an inability to articulate a trauma narrative and, where thoughts and feelings were verbalised, they were on the whole, negatively biased, with some participants experiencing real difficulties in generating positive statements in respect of the self. Participants described the process of identifying statements and how, whether they considered them to be meaningful, or not, they provided a vehicle through which they could express themselves. What was interesting about these accounts was that from the literature it would seem that these types of process are argued to take place during bi-lateral movement. For example, the REM hypothesis suggests that eye movements facilitate the integration of the trauma memory. However, it appears from participants’ experiences that the building of verbal associations began before bi-lateral movement took place. Taken together these findings demonstrate manifold processes occurring within participants’ initial stages of EMDR therapy. Within the general therapeutic literature, Ilardi and Craighead (1994) have posited that a substantial percentage of patient improvement tends to occur within the first four weeks of therapy. Therefore, it is important that these clinically relevant issues are capitalised upon in order that this therapeutic approach be continuously improved. Furthermore, it has been estimated that only eight percent of psychotherapy outcome is based on the specific ingredients of interventions (Wampold, 2001) which might suggest that collectively the remaining factors potentially account for a larger proportion of therapeutic movement than that of the bi-lateral mechanism. Whilst it is of course important to acknowledge the eye
movement component, it is equally important to acknowledge the process of therapy within which they sit, which in and of itself appears to be helpful to clients. In making this point, Hyer and Brandsma (1997, p.521) argue that EMDR is a sound therapeutic approach regardless of the eye movement component stating that “we believe that the methods of EMDR are important, whatever the eventual merits and impact of its component parts”

5.21 Appendix 21

Active and passive processes

Despite participants’ descriptions of the value of all elements of therapy, the bi-lateral movements were delineated by all as remarkably distinctive. Experiences were varied and included feelings of intense relaxation, exhaustion and surprise. What was universal was a difficulty in articulating this experience. Some of the participants’ narrative suggested their recognition of being involved in the process but sensed that this was at a subconscious level. The general consensus is that human beings have two types of mental processing systems, explicit and implicit (Kirsner, et al., 1998). Explicit processes are thought to be: voluntary, easy to verbalise, slow, and reflective, whereas implicit processes are argued to be: difficult to verbalise, fast, affect driven, involuntary, and sensitive to specific cues such as facial expressions. Although speculative, it could be argued that some of the descriptions given by participants regarding their experiences of the bi-lateral movements are indicative of processes occurring at the implicit level which might explain their inability to adequately convey these verbally. Without a language with which to describe this process, some participants
made meaning of their experiences by referring to it as “magic” or “strange”. This finding demonstrates the role of language in the meaning making of phenomenon. Language is argued to both generate and constrain the life world of individuals (Heidegger, 1962) which was evident in this study, where in the absence of appropriate descriptors to convey this experience, meaning was made through an alternative hermeneutic. There was some ambivalence evident as regards participants’ feelings towards the nature of the process. Whilst they had clearly stated their fear of losing control, the sense that the bi-lateral movement was the active tool or that they were engaging without conscious volition actually seemed to provide a sense of pleasure, almost as if the difficult conscious work had been taken out of their own hands. It could be speculated that these types of experiences make EMDR more easily tolerated than other therapies for PTSD such as exposure, as has been suggested within the literature (Pitman, et al. 1996; Poole, de Jongh, & Spector, 1999). Although this proposal has not been evident within other studies (Tarrier, et al. 2006) and there appears to be little evidence to suggest a difference in drop-out rates between PTSD related therapies (Hembree, et al., 2000).

The process of ‘processing’

Certainly, engaging in the bi-lateral movement, although described as effortful and tiring, appeared to moderate distress levels for some participants. In facing their traumatic memories, one participant stated that EMDR “helped me to do it”. Another talked of how images were “smoothed” or had their “edges cut off” taking the nastiness away. This account, along
with other similar descriptions, fits well with the working memory hypothesis suggested by Gunter and Bodner (2008). The difficulty in understanding participants’ experiences from this viewpoint lies in the accounts that suggest change as ongoing. The descriptions of one participant that involved images and distress increasing for several days after the EMDR session, following which an improvement in symptoms was experienced, challenges this account as it has been suggested that the dual attention benefit is only enjoyed during the concurrent activity (Kavanagh, et al., 2001). However, this specific in-session benefit of dual attention moderating distress might explain the account of “core change” that was recounted by one participant which, on reflection, during interview, was doubted and questioned as having actually occurred.

Others experiences of the bi-lateral process included descriptions of a sense that memories were being made past; that they were still there, but that there had been a realisation that they could no longer hurt them. This could be contextualised within Ehlers and Clark’s (2000) framework where they argue that the significant element implicated in maintaining PTSD is one’s focus on current threat. Although, how this process would facilitate the sense that memories had become past, is unclear. One possible suggestion is that the memory, through the introduction of positive corrective information, in the form of the chosen positive statement, modifies the ‘fear structure’ and incorporates the information into existing memory networks as suggested by Foa and Kozak (1986). This model appeared to be potentially relevant to a number of participants’ descriptions. Firstly, when concentrating on specific
material, many participants’ relayed their experience of other memories coming to mind. Participants expressed surprise by their emergence but did acknowledge to some degree that the memories must be related, unresolved issues. It could be speculated that this process facilitated access to the fear structure which, in turn, elicited other associated materials within that structure. This was also apparent in participants’ accounts of experiencing associated physical and sensory sensations during the process. Presumably, having accessed the fear network, all connected modalities of experience might have been triggered. Finally, potential evidence of this process was also apparent in a number of participants’ accounts of EMDR as having “hit the spot” or having the ability to “grasp and sort” their trauma related difficulties. Such comments possibly reflected that by concentrating on one aspect of their trauma, the participants’ were able to immediately and precisely, access their fear structure within semantic memory.

Of course, these ideas are speculative and are not aimed at finding a definitive truth. They do demonstrate however, how qualitative enquiry that explores participants’ experiences can provide valuable data through which to consider proposed frameworks. The main conclusion that this type of evidence appears to highlight is that a reductionist approach aimed at finding a single mechanism that is able explain the manifold experiences associated with this phenomenon may be too limited in its focus. For example, a number of participants described the process of bi-lateral movement as “trance-like” or “relaxing”. It is doubtful whether an intense sense of relaxation could be explained using an exposure hypothesis. However, considering participants’
use of this terminology it is worth consulting the evidence base as regards any commonalities that might exist between EMDR and hypnosis. In essence, the literature exploring this area appears to have reached the conclusion that there are some distinct differences between these two therapeutic processes. For example, it is argued that whilst reaching a relaxed state is an intended goal within hypnosis, in EMDR it is not. Additionally, one of the proposed effects within hypnosis is that clients experience a reduction in their generalised reality orientation (Shor, 1959) whereas in EMDR a general goal is to help the client remain grounded. Whilst participants were not intentionally hypnotised, whether any similarities existed between the mental experience of being hypnotised and the mental state that they experienced remains unclear.

One possible explanation for this state of relaxation could be through the elicitation of an orienting response as proposed by McCullough and Feldman (1996). Their argument suggests that this response is facilitated by eye movements, although within this study one of the participants who described intense relaxation and being “evened out” by bi-lateral movement used the modality of hand taps only.

A small number of those interviewed described experiences of reduced awareness, and in one case, what seemed to be dissociation. What was interesting was that despite this, this individual went on to experience some improvement in symptomatology following their engagement in EMDR. This challenges previous proposals that posit that dissociation can hinder
therapeutic work relating to traumatic material (Halligan, et al., 2003).

Also difficult to make sense of in light of the extant EMDR literature are the participants’ illustrations of intense positive experiences. The degree to which participants talked of experiencing positivity and “nice feelings” was an unexpected finding. The majority of the literature pertaining to the active mechanism of bi-lateral movement focuses on the desensitisation phase, and not on installation. One argument that could be made is that installation facilitates the integration of corrective information into the fear structure (Foa & Kozak, 1996), reducing the distress of the traumatic memory through reciprocal inhibition. However, the findings from this study seem to point to more than a reduction in distress through this process. Participants described experiencing intense positivity and the re-experiencing of positive affect associated with past positive memories. How the process of bi-lateral movement might contribute to the continuous enhancement of positive affect as measured by the VOC rating is unclear. The use of imagery techniques within psychotherapy are long standing and ubiquitous (Schorr, 1974). For example, Gilbert (2005), drawing on Buddhist philosophy, describes how a focus on compassionate thoughts, emotions and imagery can lead to an enhanced sense of compassion for the self and others. It seems obvious that within EMDR, engaging with positive imagery activates sensory and emotional experiences associated with that memory. It would be interesting to explore whether bi-lateral movement actually augments this process. A few participants highlighted how they had re-experienced the feelings of positivity whilst at home, through recalling their memory of their experience.
within session, or by focusing on their previously identified positive cognition. This is indicative of them having developed the skill of eliciting positive affect through the engagement of positive stimuli. Whilst demonstrating the helpfulness of imagery based interventions clinically, this does also appear to potentially negate the need for bi-lateral movement. Research investigating the installation phase of EMDR specifically would help to further clarify the role of eye movements as utilised within this process.

Change

An all inclusive descriptive or theoretical account of therapeutic change is not currently available. This study revealed change as taking different forms, from immediate changes in distress levels within session, to longer term changes in the way participants perceived and made sense of themselves and the world around them.

A recent qualitative study by Higginson and Mansell (2008) utilised IPA to analyse interviews from six participants who had experienced, and recovered from various psychopathologies, one of which included trauma. The aim of their study was to explore the process of change as experienced by the client, three of whom had received psychotherapy and three of whom had not. There were a number of findings within their study that are comparable to the current findings. Participants similarly recounted change as both a sudden and gradual process. Likewise, participants in some instances described change as having ‘crept up’ on them which might be compared to the passive process of change that was identified within this
research. Furthermore, participants in the Higginson and Mansell (2008) study talked of having gained a new perspective on life and of becoming a new self; a better person. A number of participants described similar experiences following EMDR. Narrative included descriptions of building on “new foundations”, “reinventing” one’s self and, as viewing the world in a new light. Participants’ experiences of change appear remarkably similar within both studies. Consequently, the findings from this qualitative data raises the question as to whether the change reported by participants within this study is unique to the process of EMDR or indeed whether this is reflective of change processes associated with all therapeutic approaches and with those associated with self-recovery. Indeed findings do not appear to support an argument for a sole active mechanism or a process of change specific to this approach. Rather, it is hypothesised that a number of different mechanisms (many of which are common to alternative approaches), dependent on individual presentation and need, collectively facilitate the common processes of change associated with all psychological recovery.

Regardless of the types of change experienced and reported it was clear that the therapy, to-date, had not resolved all of the difficulties that participants were experiencing. These findings are in opposition to those of Edmond, et al (2004), who in their study, found EMDR to be considered successful in resolving trauma by most participants. Participants’ expectations of the amount of change that they might experience were often offset against the chronicity of their traumatic symptomatology. Their sense was that they were unlikely to experience complete and rapid remission
where trauma had been part of their daily living for, in some cases, decades. To conclude, it appears that despite many similarities across participants’ accounts it seemed that how each individual experienced EMDR and the change that they derived from this process was idiosyncratic and involved many factors such as the nature of their trauma, the chronicity of their symptoms and the relationship that they held with their therapist.

5.22 Appendix 22

Research limitations

As has been previously stated, it was not possible to recruit participants at exactly the same point in therapy or after an equal number of sessions, therefore participants were at different stages therapeutically, with one participant discharged from therapy and the remainder going on to do further therapeutic work, which could have impacted on their perceptions of the therapy and the therapist. Whilst all participants were positive about EMDR, it had not resolved trauma for most. This could simply be reflective of this group only and may not be representative of a wider population. Also as participants had experienced symptoms chronically, and had experienced different therapeutic histories, it is probable that previous psychological intervention would also have influenced their experiences. Additionally, therapists are often trained in a number of different therapeutic approaches and, whilst primarily operating within a specific theoretical model, probably draw on a number of different techniques as part of their normal practice. Of course the aim is to achieve as much homogeneity as possible, however it is unlikely that empirical studies can ever be truly free of interference from the
therapist or clients’ previous experiences consistent with suggestions by Heidegger, (1962) that argue that our histories inevitably effect our interpretation of events. Finally, the participants were not involved in the validation process in respect of the resultant themes. Requesting consent from participants to allow them to be contacted post-interview was inadvertently omitted from the participant information sheet and from interview and therefore it was inappropriate to introduce this aspect later in the study at the point of theme construction.

**Analysis of reflexivity**

EMDR is a therapeutic approach that appears to involve a plethora of cognitive, emotional and physical experiences for those who experience it. To date, the study of this therapy has primarily aimed to find objective truths as regards its underlying active mechanisms. One of the limitations of quantitative endeavours is that in the process of falsifying hypotheses, clinical data that does not fit with the statistical findings can often be overlooked and the process of discovery circumscribed (Rescher, 1978). A hermeneutic phenomenological stance was adopted within this study in order that EMDR be approached from a different viewpoint that allowed new insights regarding EMDR to be added to the existing evidence base.

Heidegger’s (1962) ‘relational view’ of the person suggested that society, language, culture and history not only impact on a person, but make meaningful what it is to be a person. Therefore, any situation is entered with a ‘background’ which informs one’s meaning making of that experience, the
expression of which, relies on interpretation and language. Furthermore, Heidegger (1962) argued that meaning is generated through a process of social engagement. This idea is particularly relevant to therapy as this is not an individual activity but rather an interactional process. This approach acknowledges that a person cannot be separated from their context thereby affording a holistic view. As IPA is an approach with a double hermeneutic, in that the participant interprets their own experiences and then the researcher interprets the participants’ interpretation. The position of the researcher should be acknowledged and explored.

In line with this, it has been argued that instead of striving to eliminate researcher effects, we should embrace them and endeavour to make sense of them (Schuman, 1982). Indeed, this is the aim of personal reflexivity. This was achieved through a research diary where personal reflections afforded potential areas where the researcher might have impacted on the data to be acknowledged and recorded so that they could be incorporated within the write up (See appendix F for copy of researcher reflection from research diary).

Epistemological reflexivity analyses issues related to methodology choice and research question and how these impress on the type of knowledge that can be derived (Willig, 2001). These will now be considered. Selection of EMDR as the area for exploration was clearly motivated by the researcher’s current role of trainee clinical psychologist. This provided advantages in that the researcher had previous experience of EMDR and
therefore could follow and understand the content of participants’ narrative. However, this knowledge also meant that the researcher entered the process with expectations and biases. Steps were taken to minimise the influence of this position on inquiry direction. Semi-structured interviews were utilised allowing for issues that arose from the participants to be followed rather than the interview being solely researcher led. For instance, although issues were partially pre-conceived to create interview schedules, some areas transpired as irrelevant. For example, questions addressing the ending of therapy became redundant, as for most participants therapeutic contact was to continue. In contrast, the enhancement of a sense of positivity within EMDR arose as salient to participants’ experiences, which had not been considered by the researcher.

IPA is a data-driven methodology. Therefore, whilst the EMDR literature was consulted prior to the study, it only partially guided the direction of the study and additional relevant literature reviews were completed following analysis so that the study was responsive to the new findings within the data. Finally, in thinking about cultural and value system differences that could have impacted on the data, there was potentially a power differential between researcher and participants as participants were, or had been, part of the mental health services, and the researcher was a member of staff. It was hoped that as the researcher was not a treating clinician for the participants, this may have afforded a different relationship to that of client and therapist. However, it is improbable that in this kind of setting, power differentials can be eradicated completely and therefore this must be
acknowledged as potentially influencing factors such as demand characteristic.

5.23 Appendix 23

Conclusions

This study offers insight into the process of EMDR as experienced by clients as a treatment for trauma related symptomatology. Such an account provides a broader awareness of: how clients make sense of their engagement in this process, what factors they feel are helpful, and of the change that clients experience during and following this therapy, adding depth to what is at present, almost exclusively an experimental evidence base. Findings have highlighted the need to move away from a sole focus on the bi-lateral movement component of therapy and rather to a view that considers the approach holistically so that important areas such as the development of the therapeutic alliance are not overlooked. The different experiences of bi-lateral movement described within this study were reflective of a number of different processes and might suggest that the search for a single mechanism underpinning this component may present an unachievable challenge.
6.0 References – Extended paper


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**Word count extended paper: 21,350**
Dear

I am writing to you with details of a research project that is being undertaken in respect of the experience of receiving EMDR as a therapy for trauma. As you recently completed a course of EMDR, I wondered whether you might be interested in taking part. Enclosed is a participant information sheet that provides all of the details of the research. There is also a consent document to be completed should you decide that you would like to take part. Please read the information carefully and take your time to decide whether you would like to participate. If you have any questions on the information sheet, or about any other aspect of the study, please feel free to call me or make an appointment with me where I will be happy to help. If you would like to take part, please complete the consent form and return it to the researcher. Her contact details are on the bottom of the information sheet.

Yours sincerely

Clinician Details
7.2 Appendix B – Participant information sheet

Participant Information Sheet

Eye Movement Desensitisation and Reprocessing (EMDR) for trauma: A qualitative analysis of clients’ experiences.

We would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it will involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. These sheets will provide you with details of the purpose of the study and what will happen to you if you take part. They will also provide detailed information about the conduct of the study. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the research about?

The research is to learn about what it is like to experience Eye Movement Desensitisation and Reprocessing as a therapy for trauma. It is also interested in discovering which parts of the therapy (if any) stand out as most significant for you.

What is the purpose of the research?

The researcher will be undertaking the research as part of her personal and professional development as a Clinical Psychologist. The study will form part of her Doctorate degree at Lincoln University. It will also allow us to gain an understanding of EMDR therapy and how it affects clients.

Why have I been invited to take part?

You have been invited to take part because you are receiving or have already received EMDR as a therapy for trauma related symptoms and we are interested in your experience of this. We are hoping to interview a total of ten participants.

Do I have to take part?

It is up to you to decide whether you take part or not. We will describe the study and go through this information sheet, which you can keep. We will also answer any questions that you may have. You do not have to take part and this will not affect your care in any way. If you decide to participate you will be asked to sign a consent form to show that you have agreed to take part.

What will I have to do if I take part?
If you decide to take part the first thing that will happen is that you will be asked to complete the consent form and return it to the researcher with your contact details. The researcher will then contact you to answer any more questions that you have about the study and to arrange an appointment for an interview. The interview will take place at the same clinic that you attend/attended for EMDR therapy. The interview will be asking about your experience of EMDR for example, whether it was helpful and what you felt were the most useful parts. The interview will be recorded onto a mini disc, which will later be typed. Your travel expenses for attending the interview will be refunded to you on the day of attendance. Please bring details of your travel expenses with you, for example, bus tickets. The interview is anticipated to take between one and one and a half hours. As part of the study your EMDR clinician will need to access your case notes and pass on relevant information to the researcher in order that they can record some demographic and clinical information.

The demographic information that will be requested will include your gender, age and ethnicity. The clinical information that will be requested will include the nature of the trauma on which you have been working (your clinician will only provide this information to the researcher in the form of a coded category and will not include any specific details), the length of time that you have experienced the psychological difficulties that are the focus of the EMDR therapy, the length of the EMDR therapy, where you received the EMDR therapy and the name of the therapist with whom you worked. However, you are under no obligation to provide this information so may withhold this if you so wish. Should you provide this information it will be used for the length of the study. The study will last for three years until September 2010 although you do not have to do anything else after the interview.

What happens to the information about me and to the written research?

All information that you provide or that is accessed from your files during the course of the research will be kept strictly confidential. The interview will be recorded onto mini-disc. This recording will be labelled with a code number that will link it to a master file that will hold any identifiable information. The master file will be kept in a locked filing cabinet at the clinic that you attend/attended. The code number will allow the researcher only to recognise your recording file when they take it from the clinic to type up. Any information about you that leaves the clinic will have your name and address removed so that you cannot be recognised. Likewise, no identifying information will be kept with the typed information. Again, a code number will be used for identification by the researcher. When the research is finally written up or presented no one will be able to tell who you are as no identifying information will be included.

What will happen to the results of the research study?

At the end of the project the researcher will prepare a brief summary of her findings. If you would like this, or any other information about the project, then this will be forwarded to you on completion. The final written project may be published in a psychological or related health Journal. No personal information will be included and you will be referred to by a different name to protect your anonymity.

Are there any possible benefits of taking part?

There are no personal advantages of taking part. However, your involvement will help us to gain a greater understanding of EMDR and how clients' experience this. This type of information can be helpful for our thinking about treatment processes that we might undertake in the future.
Are there any possible disadvantages of taking part?

The study will be investigating the process and experience of EMDR as a therapy and will not be focusing on the trauma itself. Therefore, it is not envisaged that you will experience any distress through taking part. However, it is acknowledged that the EMDR therapy will have been related to a potentially sensitive area for you. Therefore a review session with your EMDR clinician will be available following the interview if you would like this. If the researcher has any concerns that you have experienced any distress then with your consent she will notify the treating clinician.

Will my taking part in the study be kept confidential?

Yes, we will follow ethical and legal practice and all information about you will be handled in confidence. The procedures for handling, processing, storing and destroying your personal data will be in line with the Data Protection Act 1998. When the researcher has finished the project the recorded discs will be destroyed. The written transcripts will be kept in a locked filing cabinet and destroyed after seven years. You have a right to see all information that is held about you.

What if I want to withdraw from the study?

You are free to withdraw from the study at any time, without giving a reason. A decision to withdraw or not to take part will not affect the standard of your health care in any way.

What if there is a problem?

Any complaints that you have about the way that you have been treated will be addressed. If you have a concern about any aspect of this study, you should contact the researcher who will do her best to answer your questions (Tel: 01522 886029). If you remain unhappy and wish to complain formally, you can do this by contacting the researcher’s supervisors. The contact details are: Steve Lilley (Tel: 01777 274449) or Nadina Lincoln (Tel: 0115 9515315).

Who is organising and funding the research?

The research is to be funded and organised by the University of Lincoln.

Who has reviewed the study?

All research within the NHS is looked at by an independent group of people called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed by an NHS Local Research Ethics Committee.

Researcher Contact Details:
Research Consent Form

Eye Movement Desensitisation and Reprocessing (EMDR) for trauma: A qualitative analysis of clients’ experiences.

Researcher: Natalie Brotherton

Please initial each box and sign at the bottom

1. I confirm that I have read and understand the information sheet dated October 2007, Version 2, for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without my care or legal rights being affected.

3. I understand that relevant sections of my medical notes as specified on the information sheet will be looked at by my clinician and passed on to the researcher. Where it is relevant to my taking part in this research, I give permission for these individuals to have access to my records.

4. I confirm that I am willing for the interview to be recorded.

I agree to take part in the above study.

Name of patient  Signature  Date

Name of person taking consent  Signature  Date

Researcher Contact details:
7.4 Appendix D – Semi-structured interview schedule

Learning about and starting EMDR

Q1. Can you start by telling me approximately how many sessions of EMDR you have had in total?
    Prompts: assessment, treatment, when was your last session?

Q2. I’ve got some questions about EMDR but what would be helpful would be for you to tell me about your experience of EMDR as you see it and then I may follow up with some questions if that is OK?

Q3. What did you know about EMDR before you started?

Q4. What information was given to you?
    Prompts: was it helpful, which bits? Did feelings change when told about the process?

Q5. How did it feel to enter therapy initially?
    Prompts: expectations, Positive/negative, engage, decision to engage, did you feel it risky?

Q6. What would it have meant to you not to have started EMDR?
    Prompt: Did you feel any other therapy was helping? What did you want/hope to get out of EMDR?
Q.7 Without giving specific details can you tell me how your difficulties affected you and your life before you began therapy?

EMDR therapy and change

Q.8 How did you find the process of identifying an image, SUD’s, pos cognition, VOC etc.?

Prompts: easy, meaningful, did it feel related to your experience

Q.9 Did you experience any change throughout therapy? If so can you describe the changes that you have experienced?

Prompts: in stages/gradual/sudden change, physical, emotional, thoughts, what did those changes mean to you? Surprised? Quicker/slower than anticipated? Same/different process/feeling than anticipated?

Q.10 Did you notice any changes to the memory that you were working on?

Prompt: How did that feel? What did it feel like was happening?

Image/sensory/cognition/physiological

Q.11 How do you think these changes have affected you and the way you live your life?

Prompts: work, relationships, routine activities, sleep, coping skills

Q.12 Did you feel different in yourself at different stages of therapy?

Prompts: How? Emotionally, physically, did you behave differently?
Q.13 What did the therapeutic relationship feel like within therapy?
   Prompt: was this different at different stages, different to other therapies?

Q.14 Did the therapy feel collaborative?
   Prompts: self-insight, doing together, done to you?

Q.15 What were the most helpful or unhelpful aspects of EMDR?
   Prompts: In what way?

Q.16 What personally did you feel had the greatest impact on change?

Q.17 When you think about the experience of EMDR are there any significant elements of the process that stand out for you?

Q.18 Are there any other changes that you are aware of within yourself since engaging in EMDR?
   Prompts: made a difference to the way you see yourself? Physically, psychologically, confidence, emotionally

Q.19 Is EMDR comparable to anything else you have ever experienced?

**Endings**

Q.20 How did the ending of therapy feel for you?

Q.21 Have you thought about the process since?
Prompt? What did you think?

Q.22 Have you needed to find a meaningful explanation – search for answers of what happened/what worked and why?

Q.23 Do you consider EMDR to have been successful?

Prompts: Continuing with other therapies, resolution of issues attained?

Q. 24 If you were asked to describe EMDR to a friend, perhaps who might be attending sessions in the future, what would you tell them?
7.5 Appendix E – Transcription notation as outlined by Bannister (1994)

(.) pause

(2) two second pause (number indicates duration)

xxx untranscribable

(XXX) indistinct/doubtful transcription

word underline emphasis
### 7.6 Appendix F - Example of memo from research diary completed during transcription

<table>
<thead>
<tr>
<th>Date</th>
<th>Observation/Reflection</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/07/2008</td>
<td>Interview with participant 2</td>
</tr>
</tbody>
</table>

**Observations within interview**

Client still reasonably withdrawn and therefore interview process requiring lots of questioning to elicit information – more turn taking and speaking on my part than anticipated

**Personal reflection**

Found it difficult to step out of role as clinician and into role of researcher particularly as I felt I needed to be responsive to the client when she was talking about something difficult. Perhaps fearful of re-traumatising as raised in ethics. Wonder whether this is positive in that she would have felt validated and able to feel safe and share her story or I wonder whether this might have replicated a client-therapist relationship and, in so doing, exacerbated power differentials? How might this have impacted on the data?

**Personal reflection**

Surprised by the level of focus that P2 had on positivity. It seems like her experience of EMDR was much more about increasing positive affect than decreasing negative. This goes against my initial assumptions about EMDR which perhaps viewed it as primarily reducing traumatic symptoms, probably related to my limited experiencing of practicing EMDR

**Links with theory**

Thinking about the reported positivity and particularly her description of her having relived a positive sporting experience which had led to the re-experiencing of the positive feelings that she had at that time. Curious as to how this fits with the evidence base that suggests that EMDR is exposure? If the eye movements also increase positive affect through reliving how can an explanation of habituation or reciprocal inhibition explain this element?
### 7.7 Appendix G - Sample of transcript and researcher’s analysis notes for participant 5 (pg 21)

**Note:** The red text in the following examples is text incorporated within the results section and demonstrates an audit trail from transcript to the final theme table.

<table>
<thead>
<tr>
<th>Initial Analysis</th>
<th>Turn no.</th>
<th>Participant</th>
<th>Participant/Researcher narrative</th>
<th>Secondary analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dealing with making past, past process of organisng distanci ng assigning capacity to process of EMDR as able to 'make realise' control -- starting to have belief -- able to manage immediate anxiety</td>
<td>182</td>
<td>[CLARE]</td>
<td>I think it was the EMDR, just the dealing with the bad things but knowing that (.) even though these things have happened years ago it’s (.) not necessarily gonna impact, it’s not gonna hurt you, it’s just sort of like you said the unpleasantness of, of dealing with it but (2) that by dealing with it you can change the way it influences you, the control, I think is given, given back because I think a lot of it was a lack of control (..) and I think realising that I’ve got the control back and that these things are in the past and it’s just a case of sorting them out in your head and then not allowing them to, they’re there but not giving them the power to influence you, I think that’s sort of the biggest sense of control knowing that because you’re in control and I think the EMDR has (.). sort of made me realise, you know because you know you hear people say you know you’re in control of your destiny, you’re in control of the way (xxx) and I’ve never felt that, whereas since the treatment I’ve felt more in control and I think I’m getting, even though I know you’re gonna feel reactionary and stuff it’s just sort of dealing with the aftermath</td>
<td>Making past – letting go, Facing it, Passivity of process, Control</td>
</tr>
<tr>
<td></td>
<td>183</td>
<td>[R]</td>
<td>Yeah</td>
<td></td>
</tr>
<tr>
<td></td>
<td>184</td>
<td>[CLARE]</td>
<td>As such</td>
<td></td>
</tr>
<tr>
<td></td>
<td>185</td>
<td>[R]</td>
<td>So when you say EMDR, which part of it do you think impacted on that change?</td>
<td></td>
</tr>
<tr>
<td>Language as power/control understanding self able to communicate feelings to others</td>
<td>186</td>
<td>[CLARE]</td>
<td>I suppose the focusing of the statements, I think a lot of that because I was able to verbalise it that instantly gave me a lot more control because I was able to say this is the way it makes me feel and to be actually able to tell somebody and somebody to be able to recognise and understand what I was feeling</td>
<td>Words as control, Making sense of self – self awareness and understanding</td>
</tr>
<tr>
<td></td>
<td>187</td>
<td>[R]</td>
<td>Yeah</td>
<td></td>
</tr>
<tr>
<td>Language as power/control others as support gaining direction – able to convey needs to others understanding what her own needs are</td>
<td>188</td>
<td>[CLARE]</td>
<td>I think gave me a lot of, a sort of sense of control and power over my own feelings because I could verbalise it and I think a problem shared is a problem halved and being able to say that and then saying right I don’t want this, I actually want this as well being able to identify where I want to go to because before I could just say I don’t want to be like this anymore but I couldn’t tell you what I wanted to be like</td>
<td>Language as control, self awareness and understanding</td>
</tr>
</tbody>
</table>
### Initial Analysis

<table>
<thead>
<tr>
<th>Turn no.</th>
<th>Participant</th>
<th>Participant/Researcher narrative</th>
<th>Secondary analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust and information as important to engagement Try anything</td>
<td>50</td>
<td>CLARE</td>
<td>Yeah its when I’d got the confidence and the trust in them and they explained what could happen, the benefits, anything to get it out of my head, try anything just to get it out of my head</td>
</tr>
<tr>
<td></td>
<td>51</td>
<td>R</td>
<td>That makes sense, definitely. So what information did they give to you, can you remember what kinds of things they told you?</td>
</tr>
<tr>
<td>Verbal and written information rec’d Finding out for self Making sense of process</td>
<td>52</td>
<td>CLARE</td>
<td>They just explained it and they gave me some paperwork on it and I took that home and read it erm we looked a bit up on the computer me and wife did to see what just what it entailed and it was basically just what they’d said and things like that</td>
</tr>
<tr>
<td></td>
<td>53</td>
<td>R</td>
<td>So did, was that, what kind of, what was your experience of that information, then, was that helpful or?</td>
</tr>
<tr>
<td>Information as helpful – reducing fear Movement – beginning to believe it could help – believing in therapists</td>
<td>54</td>
<td>CLARE</td>
<td>Erm it helped me, oh I think I’d say it actually calmed me down a bit because up until then I was still frightened about it erm reading what they gave us and how they explained it and looking on computer with wife, I think it, something inside clicked a little bit and thought well if it’s going to help do, so that’s the way I looked at it because nobody else has helped as much as what they have</td>
</tr>
<tr>
<td></td>
<td>55</td>
<td>R</td>
<td>So (2) what would it have meant to you not to have started EMDR</td>
</tr>
<tr>
<td>Black days Feels uncertain of progression without EMDR Increased change process - momentum Overwhelmed by emotions, frustration Worse before better Making sense of experiences Recognising elements of old self Support from family</td>
<td>56</td>
<td>CLARE</td>
<td>What would it have meant, Black days that’s the way I look at it, black days because I don’t, I don’t even know if I hadn’t done anything like that, I don’t even know where I would have, where I would be now with it, erm I was coming along well with people but it seems, it seems to have picked things up a little bit, it’s like a stone going downhill it seems to have gained more momentum, at first when I had it, the two or three days after they’d done it, er it was like a bull in a china shop, you weren’t angry but you was angry with yourself, very short tempered with yourself and erm it just seemed to wind you up make you more tense but after like 48hrs you’d calm down a bit and you looked at things with more perspective like I used to years ago and it was a bit better but they said it affects people different ways but er the biggest support I’ve ever had is from my wife anyway er she helps me all the time</td>
</tr>
</tbody>
</table>
8.0 Tables
8.1 Sample taken from table 1 to demonstrate the preliminary clustering of ideas following an excerpt from Participant 5

Note: In the following examples the researcher’s initial analysis comments have been taken from the transcripts and clustered. They are shown with the corresponding participant turn number

<table>
<thead>
<tr>
<th></th>
<th>P1</th>
<th>P2</th>
<th>P3</th>
<th>P4</th>
<th>P5</th>
<th>P6</th>
<th>P7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>to be worked on 18, 26</td>
<td>Identifying 174</td>
<td>Making sense of 116, 162, 178, 204</td>
<td>Self elected what to work on – 140</td>
<td>List as facilitating expression of what feeling/making concrete/labeling – 78, 90, 92, 94, 96, 98, 102, 172</td>
<td>Statements as truthful/hitting what believes – 100</td>
<td>List as facilitating expression of what feeling/making concrete/labeling – 78, 90, 92, 94, 96, 98, 102, 172</td>
</tr>
<tr>
<td></td>
<td>Meaningful 104</td>
<td>Identifying truth 100</td>
<td>Facilitating focus 112, 174</td>
<td>Therapist guiding – 178</td>
<td>Facilitates identificatio of pos – 90</td>
<td>Communication as control – 186</td>
<td>Communicating own needs &amp; aims – 188, 190</td>
</tr>
<tr>
<td></td>
<td>Being monitored 108</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Would like to use list in daily life - 192</td>
</tr>
</tbody>
</table>
Sample taken from table 1 to demonstrate the preliminary clustering of ideas following an excerpt from Participant 6

<table>
<thead>
<tr>
<th>P1</th>
<th>P2</th>
<th>P3</th>
<th>P4</th>
<th>P5</th>
<th>P6</th>
<th>P7</th>
</tr>
</thead>
<tbody>
<tr>
<td>During the process</td>
<td>Active participation versus passivity - Concentration g/purposeful activity</td>
<td>Increased worse Process 134, 288 realisation changes 104, 118, 120, Seeking, 140, 142</td>
<td>During the process</td>
<td>Movement /positioning - 52, 124, 134</td>
<td>No control - no awareness of what saying/trance like</td>
<td>During the process</td>
</tr>
<tr>
<td>Layering/positioning of imagery – 96, 100 “fog” - 100 “Blocking” 110</td>
<td>(protection) Arriving/opening up 112</td>
<td>Realising one has a choice what to believe – 142</td>
<td>Letting go/erasing - 144</td>
<td>Passive/unconscious – catch myself – 64, 66, 68, 128, 154, 162, 182, 198, 208, 236</td>
<td>Increased emotionality – 56, 112</td>
<td>Active participation versus passivity - Concentration g/purposeful activity – 96, 106, 110, 120, Seeking, 140, 142</td>
</tr>
<tr>
<td>v Letting go/release – 212/4/6/</td>
<td>Difficult looking at neg - 242</td>
<td>sudden change – 138</td>
<td>No awareness of time – 172, 314</td>
<td>Tiring – 124, 168</td>
<td>structure as presenting a challenge/task – 110</td>
<td>(increased emotionality) / difficult process before better</td>
</tr>
</tbody>
</table>
8.2 Table 2 - Sample taken from table 2 to demonstrate the initial forming of themes following an excerpt from Participant 5

<table>
<thead>
<tr>
<th>P1</th>
<th>P2</th>
<th>P3</th>
<th>P4</th>
<th>P5</th>
<th>P6</th>
<th>P7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Making safe and making sense preparedness - 102</td>
<td>Making safe and making sense - 102</td>
<td>Making safe and making sense - 102</td>
<td>Making safe and making sense</td>
<td>Making safe and making sense - 102</td>
<td>Making safe and making sense</td>
<td></td>
</tr>
<tr>
<td>relationship/Trust, 244,248, 258, 260, 262, 264, 266</td>
<td>- 102</td>
<td>- 102</td>
<td>- 102</td>
<td>- 102</td>
<td>- 102</td>
<td></td>
</tr>
<tr>
<td>Collaboration - 154, 272</td>
<td>Done to - 244</td>
<td>Pacing – 244, 248</td>
<td>Therapist in control 134/136</td>
<td>Therapist guiding 178</td>
<td>Experiencing process as whole package - 294, 296 effect 236/294/296</td>
<td></td>
</tr>
<tr>
<td>Self as in control 128/130/132</td>
<td>Experiencing attunement from therapist 140</td>
<td>Timing 22, 24, 30, 34, 38, 54, 64, 212</td>
<td>Therapist responsiveness 186</td>
<td>Therapist guiding 178</td>
<td>Timing 120 to be worked on 18, 26</td>
<td></td>
</tr>
<tr>
<td>Therapist in control 134/136</td>
<td>Pacing 120</td>
<td>Identifying 174</td>
<td>Monitoring 178</td>
<td>New experience - awareness of how feel “New language” - 180, 182, 186</td>
<td>Lists – 84</td>
<td></td>
</tr>
<tr>
<td>Experienceing process as whole package - 294, 296 effect 236/294/296</td>
<td></td>
<td>Making sense of 116, 162, 178, 204</td>
<td></td>
<td>Facilitates identification of pos – 90</td>
<td>Making sense/concretet et 86/96/236/240/ 248</td>
<td></td>
</tr>
<tr>
<td>Timing 120 to be worked on 18, 26</td>
<td></td>
<td>Negative bias 92</td>
<td></td>
<td>Communicatin g own needs &amp; aims – 188, 190</td>
<td></td>
<td>Meaningful Pieces of jigsaw 108</td>
</tr>
<tr>
<td>Lists – 84</td>
<td></td>
<td>Understanding purpose 94</td>
<td></td>
<td>Would like to use list in daily life - 192</td>
<td></td>
<td>Being monitored 108</td>
</tr>
<tr>
<td>Making sense/concretet et 86/96/236/240/ 248</td>
<td></td>
<td>Identifying old pos mem 96</td>
<td></td>
<td>Communicatio n as control – 186</td>
<td></td>
<td>Meaningful Pieces of jigsaw 108</td>
</tr>
<tr>
<td>Meaningful 104 Pieces of jigsaw 108</td>
<td></td>
<td>Identifying truth 100</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being monitored 108</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Sample taken from table 2 to demonstrate the initial forming of themes for audit trail following an excerpt from Participant 6 - text highlighted for audit trail

<table>
<thead>
<tr>
<th>P1</th>
<th>P2</th>
<th>P3</th>
<th>P4</th>
<th>P5</th>
<th>P6</th>
<th>P7</th>
</tr>
</thead>
<tbody>
<tr>
<td>The process of processing</td>
<td>The process of processing</td>
<td>The process of processing</td>
<td>The process of processing</td>
<td>The process of processing</td>
<td>The process of processing</td>
<td>The process of processing</td>
</tr>
<tr>
<td>Seeking, 140, 142</td>
<td>Facing it 178</td>
<td>Letting go/erasing - 144</td>
<td>Hard work/facing get dizzy/trance turbulent - 90, 168, 178, 182</td>
<td>Hard work/facing</td>
<td>Like a diff person/not there/unsconscious/us/unaware – 57, 130, 134, 210</td>
<td></td>
</tr>
<tr>
<td>“fog” – 100</td>
<td>Increase in detail, nuance of experience 178, 180, 186, 200, 338, 340</td>
<td>“go along with game”</td>
<td>V/gradual/esp/vising through – 124, 164</td>
<td>“go along with game”</td>
<td>“go along with game”</td>
<td>Making sense of self/experience s/becoming aware of selflife – 92, 94, 146</td>
</tr>
<tr>
<td>Ariving/opening up 112</td>
<td>Making safe 204</td>
<td>Sudden within session change 296 &amp; gradual change – 196</td>
<td>Breaking down Reliving – 122, 124</td>
<td>Difficult focusing on neg</td>
<td>Difficult focusing on neg</td>
<td>Making sense of process – raising client self awareness – 14, 148</td>
</tr>
<tr>
<td>Reliving/Holding on facing it - 134, 222/4/6,232</td>
<td>sudden change – 138</td>
<td>Core change – 212</td>
<td>No control/awareness over what saying/trance – 122, 174</td>
<td>Difficult focusing on neg</td>
<td>Difficult focusing on neg</td>
<td>In session change - 174</td>
</tr>
<tr>
<td>sudden change – 104, 118, 120</td>
<td>tiring - 144, 148</td>
<td>Hard work/made dizzy – 234</td>
<td>Worse before better – 168</td>
<td>Difficult focusing on neg</td>
<td>Difficult focusing on neg</td>
<td>Feeling it inside - 196</td>
</tr>
<tr>
<td>Sudden change (within session) 20/28/100/136/ 148</td>
<td>Sudden change (within session) 20/28/100/136/ 148</td>
<td>Hard work/made dizzy – 234</td>
<td>Not the same/different from distress – 138, 140</td>
<td>Hard work/made dizzy – 234</td>
<td>Not the same/different from distress – 138, 140</td>
<td>Delving – 124, 142</td>
</tr>
<tr>
<td>20/28/100/136/ 148</td>
<td>20/28/100/136/ 148</td>
<td>Hard work/made dizzy – 234</td>
<td>All the same – 138, 140</td>
<td>Hard work/made dizzy – 234</td>
<td>All the same – 138, 140</td>
<td>Process as totally draining/tiring</td>
</tr>
<tr>
<td>Gradual</td>
<td>Gradual</td>
<td>Gradual</td>
<td>Gradual</td>
<td>Gradual</td>
<td>Gradual</td>
<td>Increased headaches-238</td>
</tr>
</tbody>
</table>

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8.3 Sample taken from table 3 to demonstrate the final theme table including participant extracts following an excerpt from Participant 5

<table>
<thead>
<tr>
<th>P1</th>
<th>P2</th>
<th>P3</th>
<th>P4</th>
<th>P5</th>
<th>P6</th>
<th>P7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Making safe and making sense</td>
<td>Making safe and making sense</td>
<td>Making safe and making sense</td>
<td>Making safe and making sense</td>
<td>Making safe and making sense</td>
<td>Making safe and making sense</td>
<td>Making safe and making sense</td>
</tr>
<tr>
<td>Relationship/T                      - Trust, 244,248, 258, 260, 262, 264, 266</td>
<td>Relationship/T                      - Trust, 244,248, 258, 260, 262, 264, 266</td>
<td>Relationship/T                      - Trust, 244,248, 258, 260, 262, 264, 266</td>
<td>Hard to identify positive 92</td>
<td>Self elected what to work on/control – 140</td>
<td>Communicati on as control – 186</td>
<td>Trust in therapists/rel – 164</td>
</tr>
<tr>
<td>“You’ve got to have trust and you’ve got to be, you’ve got to fully trust who’s doing this, its sort of in their hands because you don’t know what its about, you don’t, OK they explain things but until you do it for yourself you don’t quite know what you’re going into, yeah and he was very gradual with me which helped, he gave me all the information I needed and I had trust for him and I think then you’ve got all the motive for it to work... I’m sure its not something you can walk into a room and say right you’re having this treatment, I don’t think it can be done like that, you’ve got to trust the person who’s doing it... you can’t do that sort of thing with a stranger... It wouldn’t, I’m sure it wouldn’t”</td>
<td>“It was quite hard knowing you’ve got to think of something negative and then something positive, I mean they tell you, you know think of something really positive something that’s if you like warm inside, a good feeling, you know where you are, something that’s good. That was harder to think of something like that that’s the opposite”</td>
<td>“I suppose the focusing of the statements, (.) I think a lot of that because I was able to verbalise it that instantly gave me a lot more control because I was able to say this is the way it makes me feel and to be actually able to tell somebody and somebody to be able to recognise and understand what I was feeling”</td>
<td>“Yes I have, er T1 &amp; T4 I’ve had a good relationship with them T4 has been very good but so it took a lot of confidence first to get to know em a long time er but since I’ve got to know em, I can open up now with T1, I really trust him, well I think personally it’s a good relationship”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapist 114/116</td>
<td>Therapist 264, 266</td>
<td>Therapist 114/116</td>
<td>In control 224 “but it doesn’t matter who it would have been if it had enough I would have said look that’s it I’ve had enough and that would have been it we would have stopped, no problem, you know”</td>
<td>Untrue, “ridiculous” “load of shit” – 156/8/160</td>
<td>Accepted/not judged/in control/choic e – 116</td>
<td>Collaborative/teamwork-172</td>
</tr>
<tr>
<td>“Erm (2) when I had er T2 he just, he makes you feel (.) comfortable, Erm he makes you feel that you’re a human being that needs to be helped, and to put you back where you were, em and I, I’ve got sort of faith in that”</td>
<td>“Felt like a load of shit (laughs), it felt like you telling me that that’s a car (points to table)... That’s what I thought ‘this is ridiculous’ because I believed, like I believe I’m sat here... Erm and I believed those statements so when T3 was suggesting the opposite I thought well OK I’ll go along with this game because it felt like a game (laughs)”</td>
<td>“Oh yeah, yeah and he was very good at putting me at ease erm and (.) I don’t know it’s almost as if (.) he was like a grandfather or somebody like that or a father figure who, you know he’d put you at ease and made you feel safe and saying you know ‘no matter what, what you say, what you do it’s not gonna matter to me,”</td>
<td>“It was working together, T1 was doing the hand movements and I was doing the eye movements, he was asking the questions and I was giving the answers or that’s basically the way you can put it really, it was like team work to me, er I used to love that before, its, it makes it better when its somebody you can trust,”</td>
<td>“Making sense 90, 92”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self as in control and understandin g process as =safe128/130/132</td>
<td>Familiarity/Tr ust/safety 210,212. 214 “because, you’ve got to trust people haven’t you, it’s just hard, it”</td>
<td>“I’m sort of erm, (2) erm (2) sort of erm (.) full of confidence in”</td>
<td>“I’m sort of erm, (2) emr (2) sort of erm (.) full of confidence in”</td>
<td>“Because, you believe me now (.) you’re (.) it’s just hard, it”</td>
<td>“Making sense 90, 92”</td>
<td></td>
</tr>
<tr>
<td>“I’m sort of the, (.) full of confidence in”</td>
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</tbody>
</table>

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work and You wouldn’t be able to sit there... and they've got to know the full story /I think../ because you are doing it together because he’s picking things up from you, he’s picking things up from me and going through it, he's taking the lead from me, he took the lead from me each time and went through that so its very much er something you do together really’

what he’s doing which makes me er feel more relaxed. Erm, if, if things are not right, I mean I suppose you’ve done this, if things are not right and I don’t feel comfortable you know I put my hand up And we stop and things like that so you know while we’re doing it obviously I’m sort of full of faith that if I don’t want to do it then he’ll stop, you know if I’ve got a problem and I’m not concentrating then we’ll stop erm... the more, the more times gone on and I’ve sort of understood where its leading to’

Jigsaw – 108 “Erm and you know it weren’t just for the sake of doing it, it was sort of (2) where I am on the process of mending erm its erm you know it’s helpful, helpful to me and plus it helps T2 to erm (2) you know (2) work out the next piece of the jigsaw so to speak”

depends on what’s happened to you, your trauma, what it’s about but sometimes it’s hard you know I just can’t, I can’t explain to everybody what’s happened... It’s very hard to open up with something like that its very hard, I think you’d have to know someone a little bit, you know, a few, a few sessions with them and you know... you know... Yeah you couldn’t, you couldn’t just go in like that I don’t think coz you would clump you know coz, obviously you’re talking about something personal in your life, whatever it could be, you talking to a stranger at th’e end of the day you don’t know

Making sense of process 94 “I could understand where they were coming from in the end, you know 0-10,”

Making sense of 178 “You know and the end results, but when you opposite of that and didn’t give it any thought until we started to do the work and then getting images that associate with that and helping me have a strong thought’

‘Would like to believe’ not ‘truth’ as helpful - 168 “and then he did ask ‘think what you would like to believe’ he didn’t say what was the truth which I, which helped because I believed that was the truth”

Making sense - New experience – awareness of how feel “New language” - 180, 182, 186 “and that’s, that’s good to actually for the first time to look into how I actually feel... and how I’ve got to that feeling... Something completely new to me something as new as a new language”

Making concrete – 252 “So that, the EMDR I don’t know how else to call it erm... I allowed me, it was like putting an...

it’s about looking after you you know and if you don’t feel happy or you don’t feel safe then just raise your hand and say stop you know, you know and he was very good about saying right, all this you make the decision about how we proceed, you know I make the decision, you know I suppose giving me back the control I felt I’d lost, I found that really, really good you know and sort of ‘don’t worry, I’m not gonna hurt you’ or anything like that so I found that very helpful”

List as facilitating expression of what feeling/making concrete/labe lling – 90, 92, 94, 96, 98, 172 “I suppose being able to identify the positive, because my outlook on life got rea, so negative it was kind of difficult to see any of the positives and stuff like that and I mean it was difficult with the image and stuff because I mean it automatically brings, sort of challenge/tas k – 110 “Good because I like a challenge, that was part of my job, er solving.. problems what other people couldn’t do and I was fetched in to solve a problem and to me it was like going back to work, it was good because (2) it was sort of another task where you thought well they can’t solve it so you’ve got to try and solve it, work it out for yourself and it helped in that respect, very well, I enjoyed that’

one of my friends just said JO lets do it, we’ll do it together and once we’d started I mean I only had a little piece of paper at first and by the time I’d finished there was all these pieces of paper stuck together (laughs)... Coz there were loads that you just don’t think about and I mean really at the end of it yeah I was traumatised but other things added to that trauma that I didn’t think about before I’d had this treatment”

Statements as truthful/hitting what believes – 100 “Truthful, erm, everything I said was truthful, erm was meaningful as well but I must say more than anything most of the statement’s like I am weak and things like that I think most of the time it was 100% you believe it”

Wondering about relevance – 176 “I don’t think there was anything that
break it down slowly coz otherwise you know you can say oh this happened, that happened
encyclopedia of all that I wanted to
the associated feelings but I suppose in some respects was really unhelpful, ern it all, it all basically counted for different parts of it, ern I wouldn't say
Sample taken from table 3 to demonstrate the final theme table including participant extracts following an excerpt from Participant 6

<table>
<thead>
<tr>
<th>P1</th>
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<td>The process of processing</td>
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<tr>
<td>“There was like fog in front of it and it was something else, it was really strange”</td>
<td>“but it sort of gets hold of you and it get, it (3) erm you know psychological and physiologically erm it hits a nerve sort of thing, you know and you can feel it in different parts of your body. Erm, erm, (4) and its as though its there all the time, its happening. Erm (5) and before I even started (xxx) erm (4) I hadn’t even thought of it”</td>
<td>“but obviously with this EMDR its you go, or more detail, it’s the only way to describe it, its hard to describe... Yeah, its really (.) you go really deep, I don’t know how to word it properly really”</td>
<td>“fog” positioning of 162/178, 20192</td>
<td>“felt a bit vulnerable because there was know stuff was starting to come to the surface and I kind of thought well ‘how is him moving his fingers gonna make any ‘found that it sort of triggered erm (.) things that I hadn’t thought about or considered for years and it brought a lot of things to the fore”</td>
<td>“at first when I had it, the two or three days after they’d done it, it was like a bull in china shop, you weren’t angry but you was angry with yourself, very short tempered with yourself and erm it just seemed to wind you up make you more tense but after like 48hrs you’d calm down a bit and you looked at things with more perspective like I used to years ago and it was a bit better but they said it affects people different ways”</td>
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<td>Active participation versus passivity – 96, 96, 104, 106, 110</td>
<td>Using language ie grasp it to get hold of it – 32</td>
<td>“You know and the end results, but when you break it down slowly otherwise you can say oh this happened, that happened quick as that but you know when you break it down other, then you, you, thing is I was coming out with details that I remember (.) but I never told the staff before and they never, I could remember and of course when you break it down you come out with more details, how things</td>
<td>Hard work/facing neg 90, 168, 178, 182 was difficult with the image and stuff because I mean it automatically brings, sort of the associated feelings but I suppose in some respects it was good because I could say this is, 162/178, 20192</td>
<td>“When I went, every time I had the session I went away and I was really low, every time, I was really low for a couple of days or so and I mean very low, you thought you weren’t worth nothing erm it drained you, really drained you, you can’t believe that just”</td>
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<td>Right, erm well it was strange because I was concentrating on one thing, which was the main reason for my post traumatic, and I was concentrating on that and yet other things came in front of it on the first session erm (.) something which probably hasn’t been resolved from years ago... and that sort of</td>
<td>transforming 26</td>
<td>“we’d sort of er</td>
<td>Passive/unconscious – catch myself – 64, 66, 68, 162, 182, 198, 208, 236 working through that and sometimes I’ll</td>
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came out as (.) sort of like the image that I was trying to get to... But it did shock me how the very first session something else came up... And then eventually I got to the image that I was trying to get to

Reliving/Holdi ng on/facing it -

22/4/6, 232

"And I got really quite upset but I held on to that sort of... Its really hard, the therapist worked through with me, for me to hold on to the actual real problem, I had to hold it, the picture it my head, but I think it was really helpful, it was like exposure therapy and the erm, you know that as well... It was harder because it like you’re straight back into the trauma, its like you, you’re straight in there, if you’re doing it properly and its working for you you’re straight in there, (.) yeah and it felt for me as if I

pick out all the good things. Erm (2) and the things that we wanted to get rid of erm (2) like erm (2) not feeling good about myself and we, we tried you know we try to erm talk about why, why I wasn’t feeling good about myself and so on and forth and then turn it round."

reliving positive 148/150/152/6/8

"Yeah, erm (3) sometimes its you know as we’re going and erm same as I said sometimes its erm you know shall we make this stronger erm for example a few weeks ago I wanted to be positive about myself... so we were looking at images that were positive about me you know it could be at present or in the past and so on... So we looked at me as a hockey player... Anyway we were talking about goal scoring and, and the happened” Exposure – more say more get 266

"and I mean the more you can come out with the way I looked at it anyway in my one, the more I came out with, the more they’d be able to help me, because if they haven’t got quite that detail you know they’re not magicians, they can’t pull nothing out of a hat unless they know so that was, but once that’s done then obviously as I say you count down then, but you’ve got it out of your system then they bring you back down and afterwards you feel like you’ve achieved something."

Reliving/facin g it – 144

"I don’t know because you’re watching the fingers and they’re asking the questions and your eyes do get a bit heavy actually, you know a bit tired watching it and everything but you can always stop have a drink of this is good, I like this, I like, I like what this is doing and then I’ve not given it any thought and since but then I’ve not had the daily waking up thinking and believing that so its been gr, amazing actually, it is amazing”

Difficult to concentrate – 170

“because my eyes are closed so as you know whenever you close your eyes you can wander and erm so I was a bit concerned about that, it took me some time to actually clear”

No awareness of time – 172, 314

“My thoughts because, alongside that I’d obviously got the doubts, scop, (mutters) type thing erm but (.) and the time flew, I couldn’t believe the time it was like we’d been sat there five minutes and he goes we’re nearly (xxx)”

“I’ve never been hypnotised, never watched anyone being hypnotised really but I can catch myself and I’ll be thinking of the good feeling and thinking of the fingers and then sort of, things seem to slot (.) finding that, I’m sort of catching myself when I’m wanting to avoid stuff I’m actually thinking no its alright, just go ahead it probably won’t be as bad as you I don’t know its triggered something I’ve not consciously noticed anything but its all a lot better, its there but its I’m able to deal with it better its, to me that, its Organisation – slot into place – 64, 154, 182

"of the fingers and then sort of, things seem to slot into place and its all sort of unravelled or sort themselves out, I find I’m doing that autom, without even thinking about it, I’m thinking back to, to sort of that and kind of triggers, things are in the past and

Hits point – 206

“there’s nothing you can compare it to, not in my lifetime anyway, erm and I’ve seen and done a load of things before this happened, I’ve tried going through my employment, through my history of what I used to do, my sports what I used to do (2) erm, the only thing that we did touch on once erm....I used to do a lot of archery years ago I used to be in a club, (XXX) and the only thing I can think about was when you was letting flight with the arrow with a bow, letting it go and then going into the target, it was just, it was just like that as though you were shooting something and as though its hitting something and you’re thinking, its hit the point straight away, that’s how you come out of the session feeling, when you’ve had the session... you think about it, you think how silly that is that moving hands couldn’t tell you what I was laughing at, I was, I was just laughing and then gormless and then tired and then I went home and I felt good about myself, more confident, not a nervous, gibering wreck like I’d been”

Being cleansed – 138

“Like I don’t know like I was being cleansed or, I don’t know and all these bad things that I’d got weren’t as bad, I could deal with them more so, it was weird, I mean I still don’t really understand how it worked on me because like I say a year ago I’d have laughed at you, well I couldn’t have been sat here, no way Relaxation 130, 134, 174, 186, 198

Unconscious self as agent – 194, 204

"I don’t know probably because I trusted him, but I was relaxed but I could hear him if you knew what I mean, I could hear him so I wasn’t on my own, it, I knew that we were doing it together but...