The Experience of Eye Movement Desensitization and Reprocessing as a Therapeutic Approach in Healing Trauma

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THE EXPERIENCE OF EYE MOVEMENT DESENSITIZATION AND REPROCESSING AS A THERAPEUTIC APPROACH IN HEALING TRAUMA

By

Celia Naccarato

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THE EXPERIENCE OF EYE MOVEMENT DESENSITIZATION AND REPROCESSING AS A THERAPEUTIC APPROACH IN HEALING TRAUMA

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Grounded theory method was used to explore the experiences of patients suffering the effects of psychological trauma who had received eye movement desensitization and reprocessing approach (EMDR) as treatment. Saturation of the categories was achieved with the analysis of 15 interviews.

The basic social psychological process that emerged is transforming suffering and the core category is changes in perception. The three subcategories, relinquishing, presencing and emerging, form the conceptual framework for the stages of transforming suffering.

The stages of relinquishing, presencing and emerging contain concepts and their properties to guide practice. The two dimensions of processing subsumed within each stage are temporal perspectives (past, present and future) and processing fields (physical field, cognitive field and transformative field). These concepts help explain the progression of the patient to experience resolution of the trauma and/or related symptoms/behaviors.

Transforming suffering: changes in perception using EMDR is the resultant substantive theory. The implications of this theoretical framework for psychotherapeutic practice and future research are reviewed.
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CHAPTER I

INTRODUCTION

In light of recent tragic events with broad emotional impact, ranging from the September 11, 2001, terrorist attacks to the current war in Iraq, it has grown increasingly important to understand the treatment of trauma-related disorders. As such, “the human response to psychological trauma is one of the most important public health problems in the world” (van der Kolk, 2003, p. 168). The U.S. Department of Defense (DoD) considers Post Traumatic Stress Disorder (PTSD) “the most prevalent mental disorder arising from combat” (VA/DoD Guidelines, 2004, p. i). DoD guidelines state that the disorder can also strike those deployed in peacekeeping missions, responding to acts of terrorism, caught in training accidents, or victimized by sexual trauma.

DoD’s assessment is especially relevant when considering the results of a recent study of responsivity to trauma (Breslau, Chilcoat, Kessler, & Davis, 2005). After analyzing data from 1,922 participants, Breslau et al. concluded that assault (combat, rape, held captive/tortured/kidnapped, shot or stabbed, sexual assault, mugged/held-up/threatened with a weapon, and badly beaten-up) was associated with the highest risk of PTSD from subsequent trauma. Of equal importance, Breslau et al. stated:

Compared with no history of previous exposure to trauma, a history of two or more traumatic events involving . . . violence in childhood was associated with a nearly fivefold greater risk that a traumatic event in adulthood would lead to PTSD. (p. 905)

In addition, trauma from a single violent assault, whether in childhood or later in life, is associated with higher risk of PTSD.

When considering that one in four girls and one in eight boys are sexually abused before age 18 and about one in 20 children is physically abused each year, the number of
adults at risk for PTSD becomes staggering (American Medical Association, 2003). With psychological trauma so prevalent, the nursing profession faces a growing need in this area of mental health. Therefore research dedicated to understanding treatment approaches is essential to inform nurses and other health professionals who guide patients toward achieving and maintaining optimal health.

Effects of Psychological Trauma

Trauma and its effects over time continue to evolve as does the understanding of why this population has been extremely difficult to treat. “The response to psychological trauma is probably as old as human nature but the diagnosis of a traumatic stress disorder is among the newest in the diagnostic catalogue” (VA/DoD, 2004, p. i). Perception of patients who experience harsh, life-altering psychological trauma is often permanent, creating a world filled with danger and a sense of helplessness. This helplessness stems from the effect of the trauma overpowering the regulatory systems of the body to direct internal and external signals, rendering the body ineffective in maintaining internal homeostasis. Trauma evokes feelings that may include, but are not limited to, stress, anxiety, self-doubt and poor self-esteem, phobia and fears, and chronic pain (van der Kolk et al., 1996b).

A person is either directly affected by a traumatic event or is indirectly affected by witnessing the event. The trauma is not integrated in memory but is continually re-experienced as if it were perpetually in the present; in effect, “the past is relived with an immediate sensory and emotional intensity that makes victims feel as if the event were occurring all over again” (van der Kolk, McFarlane, Weisath, 1996a, p. 8).
Instead of fading in intensity over time, traumatic memories are triggered unpredictably and repeatedly which only heightens arousal and embeds them more powerfully into the brain. Hence, there is a progression of both physiological and psychological symptomatology over time. Early interpersonal traumatization is highly correlated to more complex posttraumatic psychopathology than later interpersonal traumatization (van der Kolk et al., 1996b).

**Statement of the Problem**

Given the increasing prevalence of trauma and the resulting physical and psychological effects on health, the field of psychiatric nursing faces the problem of identifying the most effective and efficient approaches in the treatment of PTSD and its associated features. The field of traumatology is beginning to understand how trauma affects the human being, and until the last decade the prognosis for victims of PTSD was poor. With the advent of increased trauma research in the 1990s, the prognosis for these victims has greatly improved with more successful treatments. Extensive research has determined two effective approaches in treating psychological trauma-related disorders, namely, Eye Movement Desensitization and Reprocessing (EMDR) and Cognitive-Behavioral Therapy (CBT). However, much controversy stemming from the comparison of EMDR to CBT has distracted some practitioners from using EMDR.

EMDR, initiated by Francine Shapiro in 1987, has been found to be equivalent to exposure and other cognitive-behavioral techniques in reducing PTSD symptoms while being more efficient (Bradley, Greene, Russ, Dutra, & Westen, 2005; Davidson & Parker, 2001; Maxfield & Hyer, 2002; Van Etten & Taylor, 1998). Despite this achievement, theoretical explanations of how EMDR might work continue to be scrutinized (Stickgold,
In addition, while both EMDR and CBT have been validated through controlled empirical research, controversy continues to surface pertaining to why EMDR research has inconsistent findings and whether EMDR is unique from other PTSD treatments (Sikes & Sikes, 2003). In contrast, Shapiro (2002a) asserts that research now needs to move forward “to identify mechanisms of action and to develop the most robust and efficient procedures for clinical use” (p. 9).

Given the uncertainty that these controversial issues evoke, it is difficult for practitioners and researchers to move forward without more clarity on the efficacy, unique mechanisms, and theoretical framework of EMDR. This reluctance to move forward in practice is exemplified by McCabe (2004) in an article warning psychiatric nursing “to approach EMDR with a degree of caution until more rigorous conclusive models of action are developed and until stringent empirical establishment of efficacy occurs” (p. 111). In conclusion, in order to assist psychiatric nursing in evaluating EMDR, this study aims to provide a social context of the interaction and experience of the patient who has experienced EMDR as a psychotherapeutic approach. This expanded view of EMDR may provide new wisdom in examining the controversial issues surrounding EMDR, more information in choosing efficient mechanisms of action in treating PTSD, and/or greater knowledge on how persons heal after trauma.

**Recognition of EMDR in the Treatment of PTSD**

EMDR is a psychotherapeutic approach that was originally designed to reduce the symptoms associated with traumatic memories and, as a result of extensive research, has demonstrated its effectiveness in the treatment of PTSD. In the 2004 *Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress*
Disorder, the American Psychiatric Association gave EMDR the same status as CBT as an effective form of treatment for ameliorating symptoms of both acute and chronic PTSD. The Clinical Division of the American Psychological Association reported EMDR as one of the three methods empirically supported for the treatment of any posttraumatic stress disorder population along with exposure therapy and stress inoculation therapy (Chambless et al., 1998). In 2000, after the examination of additional published controlled studies, the treatment guidelines of the International Society for Traumatic Stress Studies gave EMDR an A/B rating (Chemtob, Tolin, van der Kolk, & Pitman, 2000) thereby designating EMDR as an efficacious form of treatment for PTSD. Also in 2004, the Department of Veterans Affairs and Department of Defense placed EMDR in the “A” category as “strongly recommended for the treatment of PTSD in military & non-military populations” (pp. I-17-18). And finally, the National Institute of Mental Health (NIMH) sponsored Web site (www.therapyadvisor.com) lists EMDR as an effective form of therapy for PTSD.

EMDR also has become a widely accepted PTSD treatment around the world. The practice guidelines of the International Society for Traumatic Stress Studies list EMDR as “an efficacious treatment” for PTSD (Foa, Keane, & Friedman, 2000). In Israel, EMDR is one of the three methods recommended for treatment of terror victims (Bleich, Kotler, Kutz, & Shalev, 2002). The Northern Ireland Department of Health, Social Services, and Public Safety in Belfast points out that EMDR is one of two treatments of choice for trauma victims (CREST, 2003). EMDR is also one of two treatments of choice for PTSD in the Netherlands (Dutch National Steering Committee Guidelines on Mental Health Care, 2003). In a study for the French National Institute of Health and Medical Research
in Paris, EMDR was one of two psychotherapies found to be the treatment of choice for trauma victims (INSERM, 2004). In Stockholm, Sweden, EMDR was recommended as one of two treatments of choice for PTSD (Sjoblom et al., 2003). EMDR is also one of three treatments of choice in psychological therapies and counseling in the UK (United Kingdom Department of Health, 2001).

**Purpose of the Study**

The purpose of this study was to examine the experience of patients treated with EMDR approach for their trauma-related disorders. As discussed in the statement of the problem, the uncertainty evoked by controversial issues makes it difficult for practitioners and researchers to move forward without more clarity on the efficacy, unique mechanisms, and theoretical framework of EMDR. Given the extensive quantitative research and comparatively limited amount of qualitative research in EMDR, the aim of this study was to expand the knowledge related to the effectiveness of EMDR from patients’ experience of the EMDR process. In order to learn what concepts might emerge related to the recipients’ experience of EMDR, a grounded theory method (Glaser & Strauss, 1967) was applied. This qualitative method allows the data to emerge from the experiences of recipients of EMDR which may lead to new concepts about EMDR.

**Research Questions**

This study posed the following question: What was it like to experience eye movement desensitization and reprocessing as a therapeutic process? The areas explored were the following: (a) what brought the patient to EMDR, (b) what was it like for the patient to experience EMDR for the first time, (c) what did the patient find most helpful with EMDR, (d) what did the patient find least helpful with EMDR, (e) what were the
patients’ impressions after completing EMDR, and (f) what would the patient tell others about EMDR.

**Definition of Terms**

The following key terms will help the reader understand the subject:

**EMDR:** Eye movement desensitization and reprocessing is an information processing therapy using an 8-phase approach. The process includes elements of several effective psychotherapies in structured protocols that are designed to maximize treatment effects. These include psychodynamic, cognitive behavioral, interpersonal, experiential, and body-centered therapies (Shapiro, 2002c).

**PTSD:** Post-Traumatic Stress Disorder is a serious psychological condition that occurs as a result of experiencing a traumatic event (Foa et al., 2000). Complex PTSD, also referred to as Disorders of Extreme Stress Not Otherwise Specified (DESNOS), refers to alternate forms or variations of PTSD and can include comorbid diagnoses related to the stressor (van der Kolk et al., 1996a).

**SUD Scale:** The Subjective Unit of Disturbance Scale is a sliding scale from 0 to 10. The client determines the level of disturbance he or she feels when imaging the trauma. This scale was adapted from Wolpe (1990) where 0 equals *no disturbance* and 10 equals the *worst disturbance* the patient can imagine.

**VoC Scale:** The Validity of Cognition Scale is a measurement on a 7-point scale that measures how true the client rates a statement (self-belief). A 1 is considered a “completely untrue” statement and 7 is considered a “completely true” statement (Shapiro, 1989b, p. 213).
EMDR Session

In chapter II, under description of EMDR and CBT, there is a full description of all the eight phases of EMDR. However, to introduce the format of a processing session, this researcher reviews when a patient is ready for the assessment and desensitization phases (3 & 4) of the traumatic memory or associated symptom/behavior.

To begin, in phase three known as the *assessment* phase, the patient has already completed a trauma list or has a traumatic memory or associated symptom/behavior from the trauma prepared. The patient is asked the worst part of this memory or behavior and then creates a visual image of it. Following the completion of this visual image, the patient is asked what negative self-beliefs are triggered by this image and what the desired belief/s would be. Next, the client rates how true the positive self-belief feels now while visualizing the target image using the validity of cognition scale (VOC) (Shapiro, 1989b), where 1 is “completely untrue” and 7 is “completely true” (p. 213). The client combines the target image with the negative self-belief and is asked to relate the emotion that arises as well as rate the level of disturbance, which is rated using the 11-point subjective unit of disturbance scale (SUDS) (Wolpe, as cited in Shapiro, 1989a, p. 203), where 0 is “no disturbance” and 10 is the “highest level of disturbance” (Wolpe, as cited in Shapiro, 1989a, p. 203). Last, the client is asked to identify and describe the physical sensations that arise when concentrating on the targeted image.

The patient at this stage is ready to start the fourth phase—*desensitization*. The therapist and patient sit opposite each other so that the therapist can comfortably move his/her hand back and forth in front of the patient’s eyes. There are a few practice sweeps so the patient can decide the comfortable distance and speed. If the patient is not
comfortable with eye movements, another bilateral stimulation is chosen which can include: pulsars that are held in the patient’s hands and have a pulse of bilateral vibration, a light strobe bar that the patient watches as the light moves bilaterally, ear phones that the patient listens to audio sounds bilaterally or their own tapping bilaterally on their thighs. After the client is comfortable, he/she is asked to focus on the image, negative belief, and body sensations while simultaneously attending to bilateral stimulation. The patient is instructed to be an observer of the traumatic experience or associated symptom/behavior image as though watching a movie. After each set of bilateral stimulations, the client is asked, “What do you get now?” The information that arises becomes the focus of the next set of bilateral stimulations if any level of disturbance is present. When this particular branch of the original memory/image no longer produces disturbing content, the client is directed to focus on the original memory/image as he/she experiences it now. If the client experiences any level of disturbance, bilateral stimulation is repeated until no disturbing content is generated.

Summary

Trauma and the debilitating effects of traumatic memory on the human body are only in the beginning stages of medical scientists’ comprehension. Extensive quantitative research has determined two validated treatment approaches for PTSD, namely, EMDR and CBT. Much of the literature focuses on the difference or similarity between EMDR and CBT, and as a result, several controversial issues continue to surface. These issues are examined and discussed in chapter II in order to clarify the present state of controversy and to provide a comprehensive background on which to base conceptual
abstractions that emerge from this study. A grounded theory method was used to focus on data directly from the patient’s experience of the EMDR approach.
CHAPTER II

REVIEW OF LITERATURE

The review of literature in this study differs in intention due to the methodology being used to analyze the data. The method for this study is *grounded theory* and the conceptualization of data through coding is the foundation. Glaser (2004) makes a crucial point regarding the review of literature in grounded theory:

It is critical in GT methodology to avoid unduly influencing the pre-conceptualization of the research through extensive reading in the substantive area and the forcing of extant theoretical overlays on the collection and analysis of data. To undertake an extensive review of literature before the emergence of a core category violates the basic premise of GT—that being, the theory emerges from the data not from extant theory. (¶ 46)

Glaser (2004) explains that the purpose of not doing a review of literature prior to data analysis is to remain open and free to conceptualize the participant’s main concern and then discover the core category that continually resolves it. This should all emerge from the data and not from any preconceived problems from the review of literature. Glaser (2001) recognizes that there are dissertation requirements such as “standard formats of 5 chapters” that “force and constrain GT,” but adds that doctoral candidates will need to follow these requirements (p. 79).

The primary question for this study focuses on the individual’s experience of EMDR as a psychotherapeutic approach. The question is broad and comprehensive in order to allow the emergence of any conceptual abstractions, none of which may answer any specific or predetermined question. It stands to reason that the emergent conceptualizations could reflect an understanding of any number of issues related to EMDR. As noted in chapter I, one broad issue is McCabe’s (2004) warning to
psychiatric nurses to approach EMDR with caution. McCabe reviews several aspects of
the controversial issues and outlines the need for “more rigorous models of action” and
“stringent empirical establishment of efficacy” (p. 111). Two questions presented by
Sikes and Sikes (2003) that summarize the controversies surrounding EMDR are the
following: “Is EMDR effective for the same reasons as are other PTSD treatments?” and
“Why are there inconsistencies in research findings on this treatment?” (p. 169).

Keeping Glaser’s words of prudence in mind, this researcher resolved the issue of
unduly influencing any preconceptualizations of the research by covering the entirety of
the controversial issues using the two questions of Sikes and Sikes (2003) as a guide.
Since the review of literature related to these two questions consists of an extensive
amount of quantitative research with comparatively little qualitative research, this
researcher includes a separate section to cover case studies, case reports, and qualitative
research findings. The main topics are as follows: EMDR: Discovery and Controversy,
and EMDR: Qualitative Research, and Summary.

EMDR: Discovery and Controversy

The psychologist, Francine Shapiro, the originator of EMDR, in 1987, recalls
having “fortuitously discovered this technique when she found that rapid back-and-forth
eye movements reduced her own anxiety” (Lilienfeld, 1996, p. 1). Thereafter, Shapiro
applied the procedure to her own clients with PTSD and found she met with remarkable
success. Two years later, in 1989, Shapiro published a controlled study with 22 volunteer
participants (5 men and 17 women) suffering from traumatic memories and found
substantial treatment effects, but the study went essentially unnoticed by the greater
psychology community. It was not until the study was published in the Journal of
Behavior Therapy and Experimental Psychiatry (Wolpe & Abrams, 1991) that it received a great deal of attention. This attention was prompted by a footnote on the first page of the article from Wolpe, the journal’s editor and an integral figure in the foundation of behavior therapy (i.e., systematic desensitization). The footnote contained his own success using eye movement (EM) with one of his patients. Thus, began a period of criticism, controversy, and opposition.

Since Shapiro’s first observation, EMDR has evolved from a chance discovery into a sophisticated, complex treatment approach. It stands as the most extensively researched treatment for PTSD (Chemtob et al., 2000; Shapiro, 1998, 2002c). Controlled studies of EMDR surpass the body of research on any other psychotherapeutic or pharmacological treatment for PTSD (van der Kolk, 2001), and provide a considerable body of empirical validation (Perkins & Rouanzoin, 2002; Servan-Schreiber, 2000).

In the five years, since Shapiro’s 1989 article, over 100 case studies were published reporting rapid reduction of symptoms (e.g., Kleinknecht & Morgan, 1992; Lipke & Botkin, 1992; Puk, 1991; Wolpe & Abrams, 1991). However, as Greenwald (1994) noted, “while many of the case reports [did] include such features as standardized measures, behavioral indices, and long-term follow-up, most fail[ed] to meet the design standard expected of single-subject investigations” (p. 21). In numerous papers published since 1989, Shapiro was outspoken in calling for systematic, controlled, empirical studies of EMDR. Shapiro (2002c) reported “twenty controlled outcome studies have investigated the efficacy of EMDR in PTSD treatment” (p. 395).

However, these controlled treatment outcome studies had produced inconsistent findings, thereby making the efficacy of EMDR a controversial subject. The outcomes of
the controlled research involving the traditional treatment approaches and EMDR will be reviewed under EMDR: Reasons for Inconsistent Research Findings. However, it is first necessary to describe both EMDR and CBT approaches before discussing these findings. Therefore the following section will describe EMDR and CBT approaches.

**Description of EMDR and CBT**

**EMDR Approach**

The original concept of EMDR was that rapid eye movements were the integral component effecting change by accelerating information processing (Shapiro, 1995). This concept has evolved into a model of adaptive information processing attributed to the sequential and systematic delivery of the eight phases of EMDR treatment. The eight phases represent an integration of other psychotherapies such as psychodynamic, cognitive-behavioral, person-centered, body-based, and interactional therapies. Shapiro (2002c) fully describes each phase of the EMDR approach and the following is a summary.

In phase one, that is, *client history and treatment planning*, the therapist assesses client readiness, completes a full history and develops a treatment plan. Treatment planning includes deciding possible targets for processing which may include past traumatic memories, present triggers, or future templates.

In phase two, *preparation*, the therapist focuses educating the client in affect regulation and impulse control, behaviors and symptoms, and the EMDR approach. This phase is the development of personal resources for affect regulation and impulse control during reprocessing, educating the client about their behaviors and symptoms and developing goals for treatment outcomes. When client histories include significant
childhood neglect or other disruptions of early childhood attachment there are limitations in the capacities for emotional self-regulation (Damasio, 1999; Schore, 2000; Siegel, 1999). Therefore for these clients there may be substantial preparation and “likely will require resource-enhancement work combining relaxation, imagery, and EMDR” (Korn & Leeds, 2002; Shapiro, 2001). If the client does not have deficits in affect regulation or impulse control then enhancing the client’s ability to visualize/sense being in a ‘safe place’ as well as relaxation techniques will be sufficient. In addition, it is recommended that the client have an audiotape of a relaxation technique that they can use to practice self-calming between sessions. Educating the client about EMDR and the possibility of emotional disturbance during and between sessions is necessary for the client since this will dictate the approval, pace and timing of reprocessing traumatic memories. Another constraint on beginning traumatic memory reprocessing is secondary gains. “What does the client have to give up or confront if the pathology is remediated?” (Shapiro, 2001). These concerns must be addressed before any reprocessing is initiated.

Phase three, assessment, focuses on assessing the target for sensory, cognitive, and affective components. The client chooses an image that represents the worst part of the memory/image, identifies the associated negative self-belief/s followed by what the desired belief/s would be. An example might be, “I am powerless” as the negative self-belief with “I now have choices” as the desired positive self-belief. Next, the client rates how true the positive self-belief feels now while visualizing the target image using the validity of cognition scale (VOC) (Shapiro, 1989b), where 1 is “completely untrue” and 7 is “completely true” (p. 213). The client combines the target image with the negative self-belief and is asked to relate the emotion that arises as well as rate the level of disturbance,
which is rated using the 11-point subjective unit of disturbance scale (SUDS) where 0 is “no disturbance” and 10 is the “highest level of disturbance” (Wolpe, as cited in Shapiro, 1989a, p. 203). Last, the client is asked to identify and describe the physical sensations that arise when concentrating on the targeted image.

The fourth phase, desensitization, starts with the client focusing on the image, negative belief, and body sensations while simultaneously attending to bilateral stimulation such as saccadic eye movements, tapping, or bilateral audio sounds. The patient is instructed to be an observer of the traumatic experience as though watching a movie and “Let whatever happens happen” (Shapiro, 1989b, p. 322). After each set of bilateral stimulation, the client is asked, “What do you get now?” (Shapiro, p. 322). The information that arises becomes the focus of the next set of bilateral stimulation if any level of disturbance is present. When this particular branch of the original memory/image no longer produces disturbing content, the client is directed to focus on the original memory/image as he/she experiences it now. If the client experiences any level of disturbance, bilateral stimulation is repeated until no disturbing content is generated.

In phase five, installation, the targeted image can be accessed with little to no disturbance, the client is asked to focus on the image with the associated positive self-belief while simultaneously attending to bilateral stimulation. Shapiro (2001, p.74) explains, “Linking the positive cognition with the target memory strengthens the associative bond so that if memory of the original incident is triggered, its return to consciousness will now be accompanied by the new, strongly linked positive cognition”. Therefore, this linking of the targeted image and the positive self-belief using bilateral stimulation will continue until the client reports a VOC of 7.
In phase six, *body scan*, the client is asked to access the targeted image along with the positive self-belief and to scan the body for any unusual body sensations. If the client reports any tension or physical discomfort the therapist targets these sensations with bilateral stimulation until there is no discomfort reported.

Phase seven, *closure*, represents the end of the session. If reprocessing the targeted image is not complete, then the therapist will utilize relaxation techniques from phase two. Educating the client that processing continues between sessions is an important aspect of care and the client needs to know that this is a positive sign. The client is asked to keep a journal or log of any physical, emotional, or cognitive information that may arise between sessions and encouraged to use the relaxation, self-soothing techniques should their level of disturbance rise.

In phase eight, *reevaluation*, the therapist determines whether processing from the previous session has been maintained. This is accomplished by asking the client to focus on targets that have already been processed and review the client’s responses to determine if treatment effects have been maintained. The therapist can also ask the client to review any journal/log of disturbing behaviors/events related to the targets that may have arisen between sessions. If the client reports any disturbance/distress, then the therapist resumes reprocessing until the SUD level reaches 0-1 followed by the sequence of the rest of the phases.

It is important to apply the three-pronged EMDR protocol to complete the targeted image resolution, which include: “(1) the past experiences that have set the groundwork for the pathology, (2) the present situations or triggers that currently stimulate the disturbance, and (3) the templates necessary for appropriate future action”
(Shapiro, 2001, p. 76). Therefore, present triggers as well as future templates of possible triggers need to be evaluated and processed before complete resolution (Shapiro, 2002c).

**CBT Approach**

CBT approach includes cognitive-behavioral techniques such as exposure therapy (ET), cognitive restructuring (CR), and stress inoculation therapy (SIT). Some exposure therapies include cognitive restructuring, but the greater percentage of time is focused on exposure to the traumatic event (Rothbaum et al., 2000).

Exposure therapy has many variations in technique including flooding, imaginal, in vivo, and prolonged exposure. According to Rothbaum et al. (2000), the most researched exposure therapy is prolonged exposure (PE).

In PE, patients are directed to repeatedly access thoughts and triggers of the traumatic event until the anxiety reaction decreases along with PTSD symptoms. An important aspect of this approach is that the treatment is structured to focus on the traumatic event repeatedly regardless of any other associations that may arise from other content.

Rothbaum et al. (2000) note that all variations of PE usually begin by developing a hierarchy of anxiety producing segments of the trauma and then direct the client to confront these segments of the trauma until anxiety no longer is produced. These authors point out that flooding technique is extreme since it directs the client to confront the highest level of anxiety producing segments of the trauma first, and should be used cautiously with patients diagnosed with DESNOS.

Frueh et al. (1997) proposed systematic desensitization, which is commonly used for treating phobias, as an effective and safer alternative to imaginal flooding. Employing
a learning theory approach, systematic desensitization uses gradual rather than intensive exposure to stressors or trauma to diminish negative arousal. The client is exposed to the stress-provoking stimuli while induced into a physiological state that inhibits anxiety, as through deep relaxation. The authors noted that because most PTSD symptoms are related to maladaptive fear and anxiety linked with the trauma, the reduction of these negative emotions should afford substantial symptom reduction. Frueh and colleagues presented a single case study, which has been the favored method in this approach. At the same time, they argued in favor of controlled studies to examine the efficacy of systematic desensitization for PTSD.

In SIT, based on Meichenbaum (1977), clients learn anxiety management skills such as relaxation and breathing techniques, thought stopping, guided self-talk, assertiveness, and positive thinking. After these skills are mastered, the client practices applying them in the safety of the psychotherapeutic environment through role modeling and covert modeling, and then, in real life.

Cognitive restructuring (CR), described by Rothbaum et al. (2000), is a treatment that guides the patient to identify trauma-related automatic thoughts, validate the present reality of these thoughts, and change the distorted thoughts to present logical cognitions. CR educates patients to change distorted cognitions that maintain problem behaviors and to substitute more adaptive cognitions.

Having established the eight phase EMDR approach and the CBT’s cognitive behavioral techniques within the approach, the next section will re-focus on the reasons for inconsistent findings in controlled treatment outcome studies.
EMDR: Reasons for Inconsistent Research Findings

As of 2005, there were 23 controlled research studies regarding the efficacy of EMDR treatment. Several authors cited reasons for the inconsistent findings in treatment outcomes.

EMDR: Methodological Issues

The lack of adherence to the standard procedure (treatment fidelity), which relies on adequately trained therapists and assessors in the procedure, had been identified as a critical issue (e.g., Foa & Meadows, 1997; Greenwald, 1999; Maxfield & Hyer, 2002; Perkins & Rouanzoin, 2002; Shapiro, 2002a, 2002b, & 2002c). Shapiro (2002a) points out that “studies on EMDR should always include evidence that the standardized procedures and protocols are being used” (p. 14). The consequence of treatment fidelity is demonstrated by the repeated significant positive correlation between treatment fidelity and effect size supported by several authors (e.g., Foa & Meadows, 1997; Lohr et al., 1998; Maxfield & Hyer, 2002; Seidler & Wagner, 2006).

Another reason offered for inconsistent findings in EMDR research is that the number of sessions used was inconsistent for the diagnosis of the participants. The diagnostic presentation of the patient should decide the number of sessions for treatment. As established by Maxfield and Hyer (2002), the number of sessions determined to achieve the highest gold standard (GS) rating for civilian single trauma should be at least five sessions and the revised gold standard (RGS) for combat multiple-traumas should be at least 11 sessions of EMDR. Therefore, to achieve adequate results, the more traumatized the participant, the greater the number of EMDR sessions.
This presents the issue of whether the DSM-IV delineates specific criteria to address the difference between single and multiple traumas. As defined by DSM-IV criteria (American Psychiatric Association, 1994), PTSD has three basic symptoms: recurrent and intrusive feelings of re-experiencing the trauma, avoidance of event-related stimuli, and heightened arousal and problems with attention and concentration. However, a great distinction in the severity of symptoms between survivors of single traumatic events and individuals exposed to prolonged, severe trauma, for whom treatment is often initiated long after the trauma itself, caused members of the PTSD taskforce to call for a possible revision in the DSM-IV definition of PTSD (van der Kolk et al., 1996a).

The results of the DSM-IV field trial concluded that trauma, “especially interpersonal trauma, can have pervasive effects on the totality of personality and social development, resulting in chronic affect dysregulation, aggression against self and others, dissociative symptoms, somatization, and character pathology” (Luxenberg et al., 2001, p. 5). As a result, the following associated and descriptive features of PTSD were included in the DSM-IV:

Impaired affect modulation; self-destructive and impulsive behavior; dissociative symptoms; somatic complaints; feelings of ineffectiveness, shame, despair, or hopelessness; feeling permanently damaged; a loss of previously sustained beliefs; hostility; social withdrawal; feeling constantly threatened; impaired relationships with others; or a change from the individual’s previous personality characteristics. (American Psychiatric Association, 1994, p. 425)

These associated symptoms of PTSD are referred to as Complex PTSD (Herman, 1992) or Disorders of Extreme Stress Not Otherwise Specified (DESNOS) (van der Kolk et al., 1993).
Abram Kardiner (as cited in van der Kolk et al., 1996a) explains this differentiation as a “two-stage response to trauma” (p. 125). The first stage represents the core response, or what is now referred to as PTSD. The second stage represents PTSD with comorbidity, or what is now referred to as Complex PTSD or DESNOS.

Whether the reason for inconsistent findings is lack of adherence to the standard protocol, inadequately trained therapists, inadequately trained assessors, or inadequate number of sessions for the presenting symptoms of PTSD, all fit under methodological rigor. Therefore, in the next section the development of methodological rigor guidelines known as methodological standards will be discussed.

**EMDR: Methodological Rigor Guidelines**

Given these valid issues regarding methodological standards, determining which study outcomes were methodologically sound would eliminate and possibly explain and resolve inconsistent findings. Several scholars (e.g., Foa & Meadows, 1997; Hertlein & Ricci, 2004; Lohr et al., 1998; Maxfield & Hyer, 2002; Seidler & Wagner, 2006; Van Etten & Taylor, 1998) have researched and developed guidelines in EMDR research analysis.

Van Etten and Taylor (1998) conducted a meta-analysis comparing the effect size of 61 treatment outcome trials from 39 studies of chronic PTSD. The study results indicated that EMDR was an effective form of treatment for PTSD, more effective than other forms of treatment. Van Etten and Taylor also found that both EMDR and behavioral therapy had similar effect sizes in post-treatment and follow-up. EMDR was found to be a more efficient treatment because of the shorter duration as compared to lengthier behavioral therapies. However, this did not explain the inconsistent findings in
EMDR studies. Several researchers (e.g., Foa & Meadows, 1997; Hertlein & Ricci, 2004; Maxfield & Hyer, 2002; Seidler & Wagner, 2006) have taken this investigation further by developing methodological standards.

Maxfield and Hyer (2002) identified 10 methodological standards to guide evaluation of the effectiveness in EMDR research. These standards were an adaptation of the Gold Standard Scale (GS) developed by Foa and Meadows (1997). According to the GS, methodological rigor entails adherence to seven basic standards: GS #1: Clearly Defined Target Symptoms; GS #2: Reliable and Valid Measures; GS #3: Use of Blind, Independent Evaluators; GS #4: Assessor Reliability, GS #5: Manualized Treatment; GS #6: Random Assignment; and GS #7: Treatment Fidelity. Maxfield and Hyer revealed three deficits not detected by the GS and adapted them, resulting in the total of 10 methodological standards to guide future evaluation of the effectiveness in EMDR research. Hence, they proposed a Revised Gold Standard (RGS), adding the following: RGS #8: No Concurrent Treatment; RGS #9: Use of Multi-Modal Assessment; RGS #10: Adequate Course of Treatment.

After evaluating 12 EMDR research studies using GS, Maxfield and Hyer (2002) pointed out methodological weaknesses, strengths, and empirical findings. They concluded that (a) there were two methodological factors that performed less adequately than the others (i.e., GS #3: blind independent assessment and GS #7: treatment fidelity); (b) the GS score was directly proportional to effect size, where the more rigorous the study, the greater the effect size; (c) the mean score on the GS was 5.42, with 9 out of the 12 studies exceeding the mean; and (d) EMDR treatment fidelity was directly proportional to the effect size where the greater the score in treatment fidelity, the greater
the effect size. The resultant 9 out of 12 studies that exceeded the mean score for GS methodological rigor is included in Table 1 for analysis of the effectiveness of EMDR.

**Table 1**

<table>
<thead>
<tr>
<th>Author &amp; Year</th>
<th>Subject Criteria</th>
<th>TX</th>
<th>Sessions &amp; Minutes</th>
<th>Findings</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Devilly &amp; Spence (1999)</td>
<td>27/15F/8M PTSD</td>
<td>EMDR &amp; TTP</td>
<td>8 sessions 90-120 mins.</td>
<td>- TTP had significantly better outcome than EMDR; - Maintained at 3 month f/u</td>
<td>- No random assignment</td>
</tr>
<tr>
<td>Edmond, Rubin, &amp; Wambach, (1999)</td>
<td>59/59F Adult survivors of CSA</td>
<td>EMDR &amp; SC &amp; WL</td>
<td>6 sessions 90 mins.</td>
<td>- EMDR &amp; SC significantly better than controls post-test</td>
<td>- Tx. gains only maintained by EMDR at 3 month f/u</td>
</tr>
<tr>
<td>Ironson, Freund, Strauss, &amp; Williams (2002)</td>
<td>22/17F/5M PTSD</td>
<td>EMDR &amp; PE</td>
<td>6 sessions Unknown</td>
<td>- EMDR &amp; PE significant ↓ in PTSD &amp; depression</td>
<td>- 70% of EMDR gp. achieved good outcome in 3 sessions compared to 29% of PE gp.</td>
</tr>
<tr>
<td>Lee, Gavriel, Richards, &amp; Greenwald (2002)</td>
<td>24/11F/13M PTSD</td>
<td>EMDR &amp; SITPE</td>
<td>7 sessions 90 mins.</td>
<td>- EMDR &amp; SITPE significant improvement with = effects</td>
<td>-EMDR &gt;improvement on intrusive symptoms &amp; greater gains on 3 month f/u</td>
</tr>
<tr>
<td>Marcus, Marquis &amp; Sakai (1997)</td>
<td>67/53F/14M PTSD</td>
<td>EMDR &amp; SC</td>
<td>Unknown 50 mins.</td>
<td>Fewer EMDR sessions to diminish PTSD than in SC</td>
<td>-At 3 sessions: ↓ PTSD: 50% EMDR &amp; 20% SC; Post-tx: 77% EMDR &amp; 50% SC</td>
</tr>
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*(table continues)*
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<thead>
<tr>
<th>Author &amp; Year</th>
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<th>TX</th>
<th>Sessions/Minutes</th>
<th>Findings</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power et al. (2002)</td>
<td>72/42M/3F PTSD</td>
<td>EMDR&lt;sup&gt;10&lt;/sup&gt; + E&lt;sup&gt;1 CR&lt;/sup&gt; WL</td>
<td>Maximum 10 sessions 90 mins.</td>
<td>- EMDR effective: 4.2 sessions</td>
<td>-33 drop-outs equally distributed</td>
</tr>
<tr>
<td>Rothbaum (1997)</td>
<td>18/18F PTSD</td>
<td>EMDR WL</td>
<td>3 sessions 90 mins.</td>
<td>- After 3 sessions: ↓ PTSD: EMDR 90% vs. 12% WL</td>
<td>- Only wait-list design</td>
</tr>
<tr>
<td>Rothbaum, Astin, Marstellar (2005)</td>
<td>74/74F PTSD</td>
<td>EMDR PE WL</td>
<td>9 sessions 90 mins.</td>
<td>- EMDR &amp; PE significant &amp; = improvement at post-tx.</td>
<td>- Small sample size</td>
</tr>
<tr>
<td>Scheck, Schaeffer, and Gillette (1998)</td>
<td>60/60F 77% PTSD</td>
<td>EMDR&lt;sup&gt;12&lt;/sup&gt; AL</td>
<td>2 sessions 90 mins.</td>
<td>- EMDR improved &gt; AL</td>
<td>- Pre-tx. Measures may have influenced PE higher end-state fx.</td>
</tr>
<tr>
<td>Taylor et al. (2003)</td>
<td>60/75% PTSD</td>
<td>EMDR&lt;sup&gt;13&lt;/sup&gt; RT E</td>
<td>8 sessions 90 mins.</td>
<td>- E &gt; EMDR &amp; RT in reducing 2 scales out of 10 (avoidance &amp; re-experiencing)</td>
<td>- Lack of structured interview to assess post-tx. dx. &amp; wait-list design</td>
</tr>
<tr>
<td>Vaughan et al. (1994)</td>
<td>36/23F/1M 78% PTSD</td>
<td>EMDR&lt;sup&gt;14&lt;/sup&gt; IHT</td>
<td>3 sessions 50 mins.</td>
<td>- All: significant ↓ in PTSD compared to WL (EMDR 45%, IHT 25%, AMT 35%)</td>
<td>- EMDR not EMDR</td>
</tr>
<tr>
<td>Wilson, Becker &amp; Tinker, 1995</td>
<td>80/40F/4M 46% PTSD</td>
<td>EMDR WL</td>
<td>3 sessions 90 mins.</td>
<td>- Means in all measures normal &amp; maintained at 3 mo. f/u</td>
<td>- Lack of structured interview to assess post-tx. dx. &amp; wait-list design</td>
</tr>
<tr>
<td>Boudewyns &amp; Hyer (1996)</td>
<td>61/61M Combat Vets Chronic PTSD</td>
<td>EMDR&lt;sup&gt;17&lt;/sup&gt; GT</td>
<td>8 sessions 5-7 sessions Unknown Duration</td>
<td>- EMDR &amp; EC: superior improvement on mood &amp; physiological measures compared to GT</td>
<td>- Limited tx. time for multiple trauma</td>
</tr>
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(table continues)
Table 1 (continued)

<table>
<thead>
<tr>
<th>Author &amp; Year</th>
<th>Subject Criteria</th>
<th>TX</th>
<th>Sessions Minutes</th>
<th>Findings</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carlson et al., (1998)</td>
<td>35/35M Combat Vets Chronic PTSD</td>
<td>EMDR</td>
<td>12 sessions 60-75 mins.</td>
<td>- EMDR improved &gt; BF-RXT or SC with 78% ↓ in PTSD dx.</td>
<td>- Assessors not blind to interview process</td>
</tr>
<tr>
<td></td>
<td></td>
<td>19BF-RX SC</td>
<td>12 sessions 40 mins.</td>
<td>- On 20 IES: trauma related distress &amp; physiologic measures = significant improvement for both EMDR &amp; BF-RXT</td>
<td>- Unclear confounding conditions</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Unclear EMDR training &amp; experience</td>
</tr>
<tr>
<td>Rogers et al. (1999)</td>
<td>12/12M Combat Vets PTSD</td>
<td>EMDR E</td>
<td>1 session 60-90 mins.</td>
<td>- Both groups improved: IES</td>
<td>- Small sample</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- EMDR &gt; improvement in intrusive memory “B” rating (A-F scale) for both</td>
<td>- Limited tx. time for multiple trauma</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Greater in-session distress level drop in EMDR</td>
<td>- No fidelity checks reported</td>
</tr>
</tbody>
</table>

Note. PTSD = Traumatic event + met all DSM IV PTSD criteria; TTP = CBT (Cognitive Behavioral Therapy), SIT (Stress Inoculation Training) and PT (Prolonged-Exposure Training); CSA = Childhood Sexual Abuse; SC = Standard Care (Routine Individual Treatment for this group of adult survivors of CSA); WL = Waiting List; PE = Prolonged Exposure; SITPE = Stress Inoculation Training with Prolonged Exposure; HW = Homework; CSA = Individual Psychotherapy, Group Therapy or Medication Visit; E = Exposure; CR = Cognitive Restructuring; AL = Active Listening; RT = Relaxation Training; EMD = Eye Movement Desensitization (not eight phases of EMDR); IHT = Image Habitation Training; AMR = Applied Muscle Relaxation; GT = Group Therapy (Standard); EC = EMDR – Eye Movements with eyes closed; BF-RXT = Biofeedback-Relaxation; IES = Impact of Events Scale. Mins. = Minutes.

In a recent synthesized analysis of controlled studies of EMDR outcomes,

Hertlein and Ricci (2004) reviewed 16 empirical studies with their Platinum Standard (PS). The PS was developed from the standards developed by earlier scholars such as Foa and Meadows (1997), Lohr et al. (1998), and Maxfield and Hyer (2002). GS #5: Manualized, Replicable, Specific Treatment was expanded to include a midrange score,

GS #8: Nonconfounded Conditions was changed to include controlling for any number of confounds, and GS: #10 Length of Treatment was consolidated into one grouping with 10 sessions being the acceptable protocol for treatment. Three additional criteria were added: PS #11: Level of Therapist Training, PS #12: Use of Control or Comparison Group, and PS #13: Effect Size Reporting. Hertlein and Ricci (2004) made it clear that their review was not for the purpose of measuring EMDR’s effectiveness. However, this
researcher includes the resultant 9 out of 16 studies that exceeded the mean score for PS methodological rigor, as indicated in Table 1, for analysis of the effectiveness of EMDR.

The most recent meta-analytic study by Seidler and Wagner (2006) compares the efficacy of EMDR and CBT for clients with the diagnosis of PTSD. The authors contend that past meta-analyses did not address the a priori differences in symptom severity. As noted by Seidler and Wagner, “neglecting these a priori differences can lead to under- or over-estimation of actual symptom reduction” (p. 1516). Methodological rigor was assessed using the GS (Foa & Meadows, 1997) and the criteria for inclusion were EMDR standard protocol and manualized CBT; PTSD DSM diagnosis; random assignment; at least 18 years old; reported specific scores, rates and values from which effect sizes could be calculated; and at least one valid and reliable instrument measuring post-traumatic symptoms. After a systematic review of the literature from 1989 to 2005, only eight studies met these criteria and the authors excluded Rogers et al. (1999) because the data measured the process rather than long-term efficacy of the treatments. Seidler and Wagner concluded, “The superiority of one treatment over the other could not be demonstrated. Trauma-focused CBT and EMDR tend to be equally efficacious” (p. 1515). The resultant seven studies that passed the scrutiny of Seidler and Wagner’s criteria for methodological rigor is also included in the aforementioned Table 1 for analysis of the effectiveness of EMDR.

**EMDR: Studies that Met Methodological Rigor**

The studies that met the methodological standards (Table 1) of the following researchers, Maxfield and Hyer, Hertlein and Ricci, and Seidler and Wagner, resulted in a total of 16 studies, with one exclusion Cusack (1999), since the study did not compare
treatments. The remaining 15 studies compared EMDR to waitlist condition (control), standard care, prolonged exposure (PE), cognitive restructuring (CR), stress inoculation therapy (SIT), a combination of PE, CR or SIT, biofeedback/relaxation or another relaxation treatment. It is evident that when the studies that failed to meet methodological rigor were eliminated, the claims of inconsistent findings related to EMDR effectiveness were also eliminated. In conclusion, out of the 15 studies reviewed, as seen in Table 1, all but two studies (Devilly & Spence, 1999; Taylor et al., 2003) found EMDR to be equally effective as the other treatment.

**Unique Reasons for EMDR Effectiveness**

Lohr et al. (1998) believed the EMDR controversy lay in a misguided attempt by proponents to place EMDR above rather than within the context of existing behavioral treatments. They argued that if EMDR had been introduced as another type of existing exposure therapy, “much of the controversy concerning its efficacy and use would have been avoided” (p. 150). In order to address the unique reasons for the effectiveness of EMDR, three areas will be reviewed: EMDR Distinct from CBT, EMDR as a Psychotherapeutic Approach, and Eye Movement and Dismantling Studies.

**EMDR Distinct from CBT**

EMDR was conceived within a cognitive-behavioral format and behaviorists were the first to embrace the technique. However, Greenwald (1994) noted that “the protocol is essentially client-centered facilitating the client’s self-directed healing process in a spontaneous, unpredictable manner” (p. 30).
Studies comparing EMDR to PE. Several researchers have compared EMDR to PE. For example, Devilly and Spence (1999), Ironson et al. (2002), Lee et al. (2002), Power et al. (2002), Rothbaum et al. (2005), and Taylor et al. (2003).

Devilly and Spence (1999) compared EMDR and a cognitive behavioral trauma treatment protocol and found CBT to be more effective than EMDR. Devilly and Spence developed a treatment package combining CBT, SIT, and PE. The combination of these particular elements of CBT has not been empirically assessed. This study has been criticized as having poor treatment delivery since the treatment was provided in both conditions by the developer of the CBT protocol and from the description of the EMDR provided there was a lack of conformity to EMDR standardized procedure. Also, participants were assigned to the CBT treatment after it became evident to the authors that the more effective treatment was CBT.

Ironson, Freund, Strauss, and Williams (2002) compared EMDR and PE treatments for traumatic stress. Results indicated significant reduction in PTSD and depressive symptoms for both treatments. However, 70% of EMDR participants achieved good outcome in three sessions compared to 29% of PE participants. Of the EMDR participants, only 1 out of 12 dropped out, whereas 6 out of 12 dropped out in the PE participants.

Lee, Gavriel, Drummond, Richards, and Greenwald (2002) compared SITPE to EMDR in the treatment of PTSD. Results in both groups produced significant improvement in PTSD with EMDR being superior to SITPE in the measurement of intrusive symptoms. On follow-up, EMDR led to greater gains on all measures. Also,
participants in the EMDR group required 3 hours of homework compared to 28 hours of homework for SITPE.

Power et al. (2002) compared EMDR to (E) exposure + CR (cognitive restructuring) in the treatment of PTSD. Results in both groups produced significant improvement with EMDR efficiency requiring a mean of 4.2 sessions compared to 6.2 for E + CR group. The EMDR group did not require homework whereas the E + CR group had daily homework. EMDR performed significantly better in reducing depression.

Rothbaum, Astin, and Marsteller (2005) compared EMDR to PE in the treatment of PTSD rape victims. Results found both groups produced clinical and statistical significant improvement immediately following treatment with EMDR requiring no homework and less exposure time.

Taylor et al. (2003) compared EMDR, PE, and relaxation training in the treatment of PTSD. Results produced significantly larger reductions in two subscales out of ten, avoidance and re-experiencing. PE was found to be superior to both EMDR and relaxation at posttest and follow-up with no differences between EMDR and relaxation. In the PE group, therapists used in vivo exposure, imaginal exposure, and an hour of daily homework. In contrast, the EMDR group used only standard sessions with no homework.

In summary, of these six studies, two studies of Devilly and Spence (1999) and Taylor et al. (2003) found the exposure treatment more effective than EMDR. Both these studies have questionable variants of treatment. Devilly, the creator of the CBT treatment protocol, provided the treatment in both groups and was criticized for lack of conformity to EMDR standardized procedure. Taylor et al. used additional in vivo exposure,
imaginal exposure, and one hour daily homework. The four remaining studies produced significant improvement in both treatment conditions; however, EMDR was more efficient with less overall treatment either because of less session time (Ironson et al., 2002; Rothbaum et al., 2005), less homework (Ironson et al., 2002; Lee et al., 2002), and/or no homework (Power et al., 2002; Rothbaum et al., 2005).

Essentially, the review of these studies produced overall significant improvements for both EMDR and PE. Despite EMDR and PE yielding equivalent improvements, treatment outcomes do not establish equivalent treatment process. In the next section, the differences and similarities between EMDR and PE will be discussed.

**Similarities and differences: EMDR and PE.** The similarity between EMDR and PE is that the patient is exposed to traumatic stimuli. However, the exposure process in each approach is the direct opposite of the other.

The cornerstone of habituation in PE is on the reliving of the traumatic experience (Foа & Rothbaum, 1998). This is achieved by instructing the patient to focus on as much detail as possible in the present tense. In contrast, EMDR encourages distancing (Lee et al., 2006) from the traumatic experience by instructing the patient to be an observer as though watching a movie. To encourage further distance from the traumatic experience, the patient is directed to attend to bilateral stimulation at the same time thereby creating dual attention.

Another difference in the treatment process in PE is that there is no deviation from the traumatic experience, instead, the patient is titrated up to more traumatic details until he or she can focus on the most traumatic experience aspects repeatedly from session to session. The exposure is prolonged and continuous. On the contrary, during
EMDR the focus begins with the image of the traumatic memory accompanied by bilateral stimulation. However, the resulting sequential, spontaneous content that arises becomes the next starting point for processing. The exposure is short providing breaks every few minutes. Additionally, during PE the patient is not allowed to share any associated information whereas in EMDR any associated information that arises is considered part of the memory network of trauma processing (Shapiro, 2002c).

And lastly, PE assigns patients additional homework to listen to audio-taped retelling of the traumatic event/memory and “in vivo” exposure. In contrast, EMDR requires no homework other than to notice any changes in thoughts or feelings between sessions. Contrary to the claims that EMDR is another exposure treatment (Lohr et al., 1998), EMDR is distinctly different from PE in each aspect of the exposure process.

**EMDR as a Psychotherapeutic Approach**

In a recent presentation at the EMDR International Conference, Shapiro (2006), made it clear that EMDR is not a technique or method, but, to the contrary, it is a “psychotherapeutic approach.” Shapiro stated that EMDR is “listed in the American Psychiatric Association guidelines as a psychotherapy on par with psychodynamic therapy, with cognitive-behavioral therapy” (from CD). Therefore, as opposed to EMDR fitting within the parameters of cognitive-behavioral therapy, EMDR stands apart. Shapiro’s presentation pointed out that a psychotherapy approach views the world in a particular way, with a specific model, concept of pathology, treatment for the pathology with multiple clinical applications that is distinctly different from other models. This researcher discusses each of these four defining factors in the following sections. The first defining factor is the specific model for EMDR approach.
Specific model: *Adaptive Information Processing (AIP) model*. In 2001 Shapiro formulated a specific model, namely, the AIP Model (formerly Accelerated Information Processing Model, Shapiro, 1995). This model is based on the understanding that all humans possess a physiologically-based information processing system in the brain, and like other systems in the body, “movement toward health and balance is sustained unless there is a block or repeated traumatization” (Shapiro, 2002c, p. 8). Consequently, the adaptive information processing system processes disturbing input into an adaptive resolution and a psychologically healthy integration.

It is posited that experiences are linked and stored in memory networks that contain related thoughts, images, emotions, and sensations. Learning and resolution occurs as new incoming experiences are processed resulting in linkages to more adaptive information in existing functional associative memory networks. However, when a traumatic experience is not processed, the experience and all related thoughts, images, emotions, and sensations are stored in a state-dependent form. This is called a dysfunctional associative memory network and is manifested by symptoms of PTSD or associated symptoms of PTSD (DESNOS). According to Shapiro (2002c), “A central tenet is that if distressing memories remain unprocessed, they become the basis of current dysfunctional reactions” (p. 9). What causes the disruption in the information processing of traumatic experiences will be discussed in the next section on the concept of pathology.

**Concept of pathology.** The concept of pathology follows the AIP model of EMDR approach in that the dysfunctional reactions/behaviors/feelings stem from the incomplete processing of traumatic experiences resulting in a dysfunctional memory network.
Biological explanations for the incomplete processing of traumatic experiences have been demonstrated by looking at the neurobiology of PTSD and EMDR using neuroimaging.

Rauch et al. (1996) used neuroimaging studies to determine areas of the brain affected by traumatic memories. Rauch et al. found that while patients re-experienced an original trauma through their written detailed narratives, there was a corresponding decrease in activity in the left hemisphere in the brain, specifically the left frontal cortex and particularly in Broca’s area. This, according to the authors, suggested that the part of the brain needed for cognitive analysis of an experience is not properly activated. In addition, they believed that Broca’s area, the part of the brain responsible for the ability to articulate personal experiences into language, essentially shuts off. Rauch et al. found that the only heightened activity was in the right hemisphere of the brain—specifically, the limbic system, the area responsible for emotional arousal. They also found that there was heightened activity in the right visual cortex—the area responsible for flashbacks.

Levin, Lazrove, and van der Kolk (1999) reported activation of the anterior cingulate and the left frontal cortex following EMDR treatment. The anterior cingulate function includes distinguishing between real and perceived threat. This finding led the authors to state that “our subject’s data suggest that effective treatment facilitates the differentiation of real from imagined threat” (p. 169). The increase in left prefrontal cortex activity explained why “emotion was now more comfortably experienced as a resource, rather than as an intrusive experience” (p. 169). Given that the re-experiencing of traumatic memory deactivates the left frontal cortex (Rauch et al., 1996), this finding provided evidence in support of the AIP model.
Another author in support of the AIP model, Stickgold (2002), proposes that the alternating bilateral visual, auditory, or tactile stimuli of EMDR activates brain systems much like the memory processing mode during REM sleep which “permits the integration of traumatic experiences into associative cortical networks” (p. 71). Stickgold reports that EMDR can work better for two reasons. First, at the beginning of the bilateral stimulation, the patient chooses what to hold in mind; and second, there is no interference from increased norepinephrine (NE) levels since the therapist supervises the level of fear and anxiety.

With the advent of more advanced neurobiological technology, it has become apparent that the concept of pathology in relation to the AIP model, as proposed by Shapiro, has begun to be substantiated by research. The next section discusses the third component of EMDR approach: Treatment for the Pathology.

*Treatment for the pathology.* According to the AIP model, symptoms of PTSD or DESNOS are the result of incomplete information processing of one or more traumatic experiences. As opposed to cognitive-behavioral approach that aims to inhibit the thoughts, behaviors and fear networks (Foa & Rothbaum, 1998), EMDR approach promotes the adaptive resolution of the unresolved physical storage of traumatic memory (Shapiro, 2001, 2002c). The eight stages of EMDR approach are specifically designed for the patient to have the least amount of intrusion while the dysfunctional memory network connects to associated memory networks with more adaptive information to achieve resolution that will serve to guide the patient in the future.

Imagery flooding and exposure-based therapies carry risks because repeated exposure to the thoughts related to the trauma can strengthen rather than relieve the
associated anxiety (van der Kolk, 2004). Several neurobiological studies covered under the concept of pathology have suggested how EMDR allows processing to occur while minimizing the risks. How the EMDR approach enhances information processing will follow in the next paragraphs.

The Rauch et al. (1996) study concluded that because of heightened activity in the right hemisphere of the brain and right visual cortex, the patient is in emotional hyperarousal with flashbacks and at the same time, the part of the brain responsible for putting these experiences into words is essentially turned off. With the increased activation of the right hemisphere (emotion) compared to the left hemisphere (cognition), van der Kolk (2002) suggests that when the patients relive the trauma, “they are having the experience—but lack the capacity to analyze what is going on in space and time” (p. 66). Therefore, van der Kolk (2002) goes on to say that “effective treatment should minimize the time spent reliving the past and experiencing the concomitant emotional devastation and help patients to live fully in the present, without the residual dissociation, and hyperarousal, characteristic of PTSD” (p. 68). Furthermore, van der Kolk explains that EMDR promotes the use of images and thoughts while producing only weak associations to the main elements of the trauma which allows the patient to continue processing the trauma. In contrast, traditional interventions for people with PTSD employ some form of exposure-based therapy combined with cognitive-behavioral techniques which involve intense evocation of traumatic memories over several weeks. Recalling or reliving the traumatic memory as being painful may account for the high dropout rates from treatment (Ford & Kidd, 1998; Pitman et al., 1991; Spinazzola, Hopper, & van der Kolk, 2000). Accordingly, van der Kolk (2001) referred to research on treatment
failures (Foa et al., 1995) and high attrition rates (McDonagh-Coyle et al., 1999) with prolonged exposure for persons with complex PTSD as a major reason for delineating a separate category for DESNOS. Patients with DESNOS are least likely to respond favorably to prolonged exposure and are at risk of having their condition exacerbated by prolonged immersion.

In addition, Levin et al. (1999) found that after three EMDR sessions, there was an increase in the anterior cingulate which decreases the patient’s hypervigilance and an increase in pre-frontal lobe metabolism allowing the patient to make sense of the incoming information.

According to Solomon and Heide (2005), the most effective treatment for PTSD is “biologically informed therapy” (p. 56). Biologically informed therapy parallels the AIP model in that it focuses on processing the trauma using a bottom-up treatment approach. The focus of the bottom-up approach is what is going on in the body so the state of hypervigilance and hyperarousal can be processed. This allows for the shift to cognitive processing due to increased pre-frontal lobe metabolism. The similarity to the AIP model is evident when Solomon and Heide state that, “episodic memories are processed and information transferred from the limbic system to the neocortex and filed away along with other narrative memories” (p. 57). These authors point out that even though top-down treatments inhibit problematic behaviors, feelings, and thoughts, they do not process the traumatic memory and therefore do not resolve physiological hyperarousal. In contrast, Solomon and Heide attribute the effectiveness of EMDR approach to a combination of “body-processed [bottom-up processing] and cognitive-behavioral [top-down processing]” (p. 57).
Clinical applications of EMDR. Viewing EMDR as a psychotherapeutic approach as opposed to a treatment or technique illustrates that it has applicability in many different psychological disorders and populations. In Shapiro’s (1989a) original study, a single session of EMDR alleviated traumatic memories in 22 individuals who had been diagnosed with PTSD as a result of Vietnam combat duty, sexual assault, or severe physical and/or sexual abuse. Subsequent research has demonstrated the efficacy of EMDR for treating PTSD in combat veterans from various wars (e.g., Blore, 1997; Carlson et al., 1998; Lipke, 2000; Russell, 2006; Silver & Rogers, 2001). Rothbaum (1997, 2005) confirmed the efficacy of EMDR for allaying PTSD in sexual assault survivors as did Jaberghaderi et al. (2004) for sexually abused Iranian girls. It has also been used effectively with survivors of mining disasters (Blore), and with victims of the 9/11 terrorist attack in New York (Silver et al., 2005). EMDR has successfully treated survivors of Hurricane Andrew, both in adults (Grainger et al., 1997) and children (Greenwald, 1994). While many studies focus on survivors of a common experience, others report success with diverse participants with individual traumatic experiences (Wilson, Becker, & Tinker, 1997), as did Shapiro’s (1989a) original study.

A growing body of research illustrates the use of EMDR as a form of treatment for personality disorders (Brown & Shapiro, 2006). Such applications have been used with dissociative disorders (Fine & Berkowitz, 2001; Lazrove & Fine, 1996); sex offenders (Finlay, 2002); substance abuse (Vogelmann-Sinn et al., 1998); anxiety disorders (Shapiro, 1999), including panic disorder (Feske & Goldstein, 1997), test anxiety (Bauman & Melnyk, 1994; Gosselin & Matthews, 1995); and competition anxiety (Graham, 2004); depression (Power et al., 2002); various phobias (Kleinknecht,
1993; Lohr, et al., 1996); compulsive gambling (Henry, 1996); somatoform disorders
(Grant & Threlfo, 2002); body dysmorphic disorder (Brown et al., 1997); sexual
dysfunction (Kaslow et al., 2002). In one study, EMDR was found to reduce pain as well
(Hekmat et al., 1994).

The EMDR approach is highly adaptable to the needs of different age groups and
situations. Hyer (1995) advocated EMDR as an appropriate therapy for older clients,
defining it as a “more active form of reminiscence” that “allows the client to participate
in the past as currently real and to evaluate the unfolding of the process from an observer
perspective” (p. 73). In addition, many studies have shown the efficacy of EMDR in
treating children (e.g., Chemtob et al., 2002; Fernandez et al., 2004; Greenwald, 1994,
Soberman et al., 2002; Stewart & Bramson, 2000; Taylor, 2002).

Greenwald (2000) designed a trauma-focused approach that incorporated EMDR
while targeting the problems of antisocial youth. EMDR also achieved significant
reductions in problem behaviors in boys (Soberman et al., 2002). Greenwald (2000)
attributed the more modest success rates of other treatments for conduct disorder, at least
partially, to “the failure to address trauma’s contribution to conduct disorder” (p. 146).

Eye Movement and Dismantling Studies

In 1995, Shapiro expressed that she initially overemphasized the role of eye
movements in EMDR and felt that eye movements was one of many components of
EMDR that promoted adaptive information processing (Shapiro, 2002c). The actual role
of eye movements and the mechanism that accounts for their impact remains
controversial. Several researchers tested whether eye movements were essential for
treatment success (e.g., Armstrong & Vaughan, 1996; Bauman & Melnyk, 1994; Becker et al., 2000; Dyck, 1993; Feske & Goldstein, 1997; Hyer & Brandsma, 1997; Montgomery & Ayllon, 1994; Pitman et al., 1996; Renfrey & Spates, 1994; Wilson et al., 1996). However these studies had inconsistent findings due to serious methodological problems. These problems include inadequate sample size (Devilly et al., 1998; Renfrey & Spates, 1994); the use of non-clinical populations such as college students (Becker et al., 2000); confusing comparison conditions such as eyes fixed with blinking light (Renfrey & Spates) where both conditions would be expected to engage the orienting response; finger tapping along with other conditions creating dual attention which may be more difficult in comparison to eye movements (Bauman & Melnyk, 1994; Wilson et al., 1996); or finger tapping without any control to monitor eye movement since tapping often initiates eye movements. Also, several of these studies used populations with which EMDR has not yet demonstrated efficacy such as with anxiety disorders.

More recent studies have examined the neurobiological aspects of the eye movement component. Barrowcliff et al. (2004) noted that there was a reduction in vividness, emotional valence, and electrodermal arousal when engaging in eye movements after eliciting a negative autobiographical memory. Similar findings from such researchers as Andrade et al. (1997), Kavanagh et al. (2001), Sharpley et al. (1996), and van den Hout et al. (2001) concluded greater reduction in both vividness and emotiveness of traumatic images with eye movements. Kuiken et al. (2001-2002) proposed that eye movements activate the orienting response that facilitates content transformation in traumatic memories. The results of this study determined that eye movements were superior to other control conditions. Christman et al. (2003) specified
that horizontal saccadic, not vertical or pursuit eye movements enhanced interhemispheric interaction which resulted in improvement in episodic memory.

To date, the most impressive neurobiological study is that of Rasolkhani-Kalhorn and Harper (2006). These authors found that EMDR therapy, specifically bilateral stimulation or dual attention stimulation, induces low frequency stimulation (LFS) found to depotentiate circuits in the limbic system that are potentiated during memory recall. This depotentiation modifies fear memory traces which accounts for the desensitization aspect of EMDR. This finding not only expands the myriad of the complex mechanisms of traumatic memory but gives evidence to the importance of bilateral stimulation as the main mechanism involved in trauma resolution.

Several authors (e.g., Ironson et al., 2002; Seidler & Wagner, 2006; Servan-Schreiber et al., 2006; van der Kolk et al., 2005) have found the efficacy and effectiveness of EMDR approach equivalent to or greater than other traditional approaches and look in other directions for future investigation. These authors have suggested that future research in the treatment of PTSD be directed to: focusing on the full range of disordered psychological domains such as the associated features of DESNOS (van der Kolk et al., 2005); establishing which patients are more likely to benefit more from one method or the other (Ironson et al., 2002; Seidler & Wagner, 2006); and defining the aspects of treatment procedures that are most important in facilitating the best treatment results (Servan-Schreiber et al., 2006).

In conclusion, this section reviewed EMDR discovery and controversy, the reasons for inconsistent research findings in EMDR and the unique reasons for the effectiveness of EMDR approach. The following section will focus on qualitative
research including how discrepancies in outcome measures signal qualitative inquiry, case studies with excerpts of patient responses, review of the literature for qualitative studies in EMDR, purpose of this study, and summary.

EMDR: Qualitative Research

After an exhaustive search using CINAHL, PsycInfo, PsycArticles, Medline, Google, EMDR.com, and EMDRIA.org, it is clear that there is a wealth of quantitative studies on the effectiveness of EMDR. However, considering that EMDR is a rich client-centered approach, only one study by Edmond, Sloan, and McCarty (2004) has approached clients to discover what they experience during EMDR. In this study, Edmond et al. affirm the imbalance of quantitative vs. qualitative research, “In stark contrast, there is an absence of qualitative data, beyond case studies, that provide a sense of the effectiveness of EMDR as experienced from the perspective of the client” (p. 261).

Outcome Measure Discrepancies: Further Inquiry

In the first part of a mixed-method study to examine the effectiveness of EMDR in 59 adult female survivors of childhood sexual abuse, Edmond et al. (1999) found discrepancies between subjective measures and objective measures of improvement. While the SUDS and VoC scores produced a significantly higher resolution of trauma in the EMDR group (65% compared to 25% in eclectic group), the objective measures reflected no significant difference between groups. These measures included the State Anxiety Scale of the State-Trait Anxiety Inventory (STAI) (Spielberger et al., 1983), which measures anxiety related to any specific issue of concern; the Impact of Events Scale (IES), (Horowitz, Wilner, & Alvarez, 1979), which measures post-traumatic stress symptoms for any specific trauma; the Beck Depression Inventory (BDI) (Beck & Steer,
1993), which measures depression; and the Belief Inventory (BI) (Jehu, Gazan, & Klassen, 1985), which identifies and measures common distorted beliefs among adult survivors of childhood sexual abuse. In recent studies comparing EMDR with PE (Ironson et al., 2002; Lee et al., 2002; Power et al., 2002), a similar discrepancy resulted. Edmond et al. (2004, p. 264) note that this incongruence “generates questions regarding the true impact of either treatment” and signals further inquiry into how patients measure effectiveness and/or improvement. Consequently, clarification of these experiences may expand our understanding of why EMDR controlled research has inconsistent findings and what mechanisms explain how EMDR works. With this in mind, a review of patient descriptions from case studies will be followed by a review of qualitative research findings.

**Case Studies: Patient Perspectives**

In the early 1990s, within 5 years of Shapiro’s (1989a) seminal study, several case studies (e.g., Forbes et al., 1994; Lipke & Botkin, 1992; Marquis, 1991; Pellicer, 1993; Puk, 1991; Spates & Burnett, 1995; Wolpe & Abrams, 1991) explored the patients’ responses as they went through the dynamic EMDR process. Although many of these case studies reported patient perceptions, these were filtered through the lens of the therapist and not from actual quotes from patients. In the next sections, patient responses will be reviewed from a different set of case studies.

Blore (1996), a psychiatric nurse in England specializing in trauma, reviews several case studies using EMDR in the treatment of PTSD. Within each case review, Blore includes patients’ descriptive perceptions of how they felt after resolution of trauma. These descriptions ranged from “this could have happened to anyone, it’s over
now” (p. 44), to describing their images as “like watching TV with the volume off” (p. 45). In another study, Blore (1997) lists phrases describing the fading traumatic images of coalminers who had been trapped a half mile underground for 72 hours following the collapse of a coal mine. These phrases include, “It’s as though . . . a blanket of dust is covering the image,” “daylight is streaming into the picture,” “I’m looking the wrong way through binoculars,” and “the image is disappearing down the drain” (p. 92).

The patient’s experience in trauma resolution may ultimately provide greater insight into how the shift in beliefs occurs or discover what creates change. One illustration of such a shift in beliefs during EMDR is the experience of a rescue worker traumatized after the Oklahoma City bombing (McNally & Solomon, 1999). The man felt guilty over not being able to find the missing limbs of a victim and experienced additional guilt over the time it took him to find another victim whom he was able to see but could not reach. Debriefing and counseling were ineffective for diminishing recurrent, intrusive images of the event. After two months, the rescue worker received EMDR. He realized that no other worker had found the missing limbs and that the victim he had taken a long time to reach had not been calling for help as he had imagined but was already dead. His negative beliefs about the disastrous event were ultimately replaced by a common cognition used in EMDR: “I did the best I could” (p. 23), accompanied in this situation with the shift in thought and interpretation to that he and his workers had done a good job.

Exploring patient perceptions of trauma processing may provide further insight into how the patient can serve to better guide the process. In one case study of EMDR in children, it was disclosed during therapy that the trauma of one young boy was not
directly related to Hurricane Andrew but to the death of a classmate whom he had
disliked and that he subsequently believed “It was my fault,” and “I’m next [to die]”
(Greenwald, 1994, p. 93). This disclosure enabled the therapist to target the underlying
cause of distress effectively rather than focus on Hurricane Andrew.

McNally and Solomon (1999) observed failure to address traumatic stress in law
enforcement officers leading to high attrition rates, as well as possible overreaction to
perceived threats or under-reaction to real threats. Spates and Burnette (1995) described
the case of a police officer who had suffered a bullet wound to the head while pursuing a
felon in a forested area. The police officer lay on the ground for some time after being
wounded fearing he was going to be fatally shot. As a result of the experience, he
suffered intrusive flashbacks and other behavioral PTSD symptoms, including panic and
nightmares, was unable to work, and had serious marital problems. After undergoing
EMDR, he reported new insights into events surrounding the trauma and saw himself in
the hospital recovering rather than lying on the ground in fear for his life. After 12 sets of
eye movements, the man declared: “There is a feeling of euphoria; almost surrealism. It is
as if it didn’t happen to me but to someone else” (p. 54). After one additional set of eye
movements, his SUD rating dropped to zero. His experience moving from point A to
point B and what helped his transition to health could hold many lessons concerning the
specific ingredient that makes EMDR effective.

**Qualitative Research Findings**

As reviewed in Outcome Measure Discrepancies, Edmond et al. (1999) found no
significant difference between groups on objective measures of improvement but found
significant differences between groups on subjective measures. These findings resulted as
part one of a mixed-methods study and part two posed several questions to each participant through semi-structured interviews in both the EMDR and eclectic groups. The findings were reported in two categories: Client-Therapist Relationship and Nature of Change.

In the Client-Therapist Relationship category, the eclectic group fully or partially attributed the success of their treatment to the relationship with their therapist. In contrast, the EMDR group attributed success to the technical EMDR process itself. In the Nature of Change category, the eclectic group reported improvements using words such as “better,” “deal with it,” “more manageable,” “reduction,” “fewer or less” (Edmond et al., 2004, p. 267). Edmond et al. noted that “their therapy may have been a healing experience; however, they do not yet seem healed, whereas, in the EMDR group, they described making changes on a ‘deeper, more profound level’ and ‘cessation of feelings associated with the sexual abuse’” (p. 267). One participant from the EMDR group described her experience of change, “instead of working from the outside layers of an onion to reach the core inside as traditional therapy does, EMDR allows you to go straight to the core, resolve the issue, and lets the changes reverberate through the onion effecting all the outer layers” (p. 267).

Each group’s perception of change in their perception of self and other was also dramatically different. The EMDR group reported paradigm shifts such as unawareness to awareness. This paradigm shift was described as “EMDR turns on the light so you can see things clearly and see that there is nothing to be afraid of” (Edmond et al., 2004, p. 268). In contrast, in the eclectic group, there were no statements of this nature made. All the participants from this eclectic group reported that they would need further therapy
while the one half \((n = 9)\) EMDR group reported that they would not need further therapy. Of the remaining participants, 5 were unsure, and the 4 thought they would need further therapy. This study opens areas for further inquiry related to client-therapist relationship and trauma resolution.

Celiano (1996), using a process analytic approach, “examined patterns of affective information processing in successful (defined by a SUDs shift of 7 or more points) and unsuccessful (SUDs shift of 3 points or less) EMDR sequences” (p. 1). Using data from self-report questionnaires and six transcribed sessions, Celiano analyzed the change process of EMDR by coding line-by-line successful and unsuccessful sequences from a single client’s EMDR therapy. He noted that

The client’s pattern of perceptual processing was at a superficial level during the beginning phase of (S) sequences, with her attention primarily on external facts surrounding the memories. By the end of these sequences, the client engaged in a deeper, and slower mode of processing, in which she actively challenged automatic assumptions about herself and others. (p. 1)

This paralleled what Edmond et al. (2004) reported in the responses of the EMDR group who experienced a deeper, more profound level, as well as a dramatic shift in perception of self and others. Therefore, another question arises: How do we measure effectiveness? Should the emphasis be, as it was in early case studies, on subjective measures or on objective measures that are not congruent with a client’s report of significant improvement? In Sikes and Sikes (2003), the researchers felt that what a patient believes and reacts to in therapy is very important and concluded, what the patient responds to “is ample justification to use the EMDR technique” (p. 130).

McCulloch (2002) used a discovery-oriented approach to identify change mechanisms in EMDR resulting in both qualitative and quantitative data. Seven patient
responses during actual EMDR sessions were recorded along with SUD and VoC ratings. Later these responses were separated into four categories: (T) trauma response, (R) resolution response, R + T response, and (O) other/neutral response. These responses were examined for their frequencies within and across sessions as well as in relationship to the SUD and VoC ratings. The authors believed that improvement on the SUD and VoC ratings would be related to the ratio of R to T responses. However, this was not supported by the data. “The largest predictor of improvement in SUD ratings of traumatic memories was the total number of R responses” (p. 1538). Since the total number of T responses had no relation to SUD improvement, the authors concluded that T and R response variable may signify different change mechanisms.

Lee, Taylor, and Drummond (2006), using a process study, examined the responses of 44 participants who met the DSM-IV criteria for PTSD during the first EMDR desensitization session. These transcribed responses were coded with a rating system of four categories: reliving, distancing, associated, or affect. The aim of the study was to determine if more effective patient responses met the category—reliving, or the category—distancing. The category—reliving—would be consistent with the exposure based approach, whereas the category—distancing—would be consistent with the EMDR’s dual process of attention. According to Lee et al., “The hypothesis that ‘reliving’ responses would be associated with more improvement in symptoms than ‘distancing’ or ‘associated’ responses was rejected” (p. 103). In addition, the hypothesis that EMDR desensitization is comparable to imaginal exposure was also rejected. Eye movements as well as distancing were correlated with better treatment outcomes. This
study is significant in that it distinguishes EMDR as a psychotherapeutic approach and not an exposure treatment.

In conclusion, this review of patient perspectives in case studies and qualitative research findings should serve not only to inform but also to provoke interest in how often the explanations to discrepancies or controversies await discovery in the experiences of participants.

**Summary**

Since EMDR was introduced in 1989, it continues to remain a controversial therapeutic approach in the treatment of PTSD. The controversial issues center around the inconsistent findings in EMDR research and whether EMDR is an effective treatment approach for unique reasons.

In order to understand the emergence of conceptualizations of the patient’s experience of EMDR as a psychotherapeutic approach, knowledge of the history and present state of the controversial issues is important. Therefore, this chapter reviewed controlled research in EMDR for inconsistent findings within the context of methodological rigor followed by several facets of how EMDR is distinct in the successful treatment of PTSD. In addition, case studies and qualitative research findings were reviewed for their contribution to new perceptions including what constitutes effectiveness, do the measures used in research reflect improvement, what are the unique mechanisms of action and how does change or healing occur. All these questions provide a vast opportunity for future research whether it is qualitative and/or quantitative. As stated by EMDR’s originator Francine Shapiro, “the specific goal of EMDR therapy is to produce the most profound and comprehensive treatment effects possible in the shortest
period of time, while maintaining a stable client within a balanced system” (Shapiro, 1998, p. 157). Therefore to achieve this aim, Shapiro envisioned a synthesis of “all the psychological modalities and resources” (p. 157), which should include systematic qualitative analysis of the EMDR approach as experienced by the recipient.

Chapter II has addressed a comprehensive literature review of EMDR as a psychotherapeutic approach. Chapter III will address the method used to discover the emergence of conceptual abstractions resulting from this study.
CHAPTER III

METHODOLOGY

This chapter describes the research method, scholarly rigor, setting, participants, recruitment, protection of human subjects, data collection, data analysis, and summary. It begins with the research method.

Research Method

To conduct the study, the researcher used a qualitative approach based on the grounded theory method. Grounded theory refers to theory that is “grounded in social research itself” and generated from the data (Glaser & Strauss, 1967, p. viii). This social research method suited the needs of the study which explored a social process involving the interaction between patient and psychotherapist while in treatment for PTSD/DESNOS using the EMDR approach. Glaser and Strauss developed this method as a reaction against the extreme positivism that had permeated most social research. They disputed the view that theory is generated by logical deduction using a priori assumptions stemming from grand theories. The authors disputed the acceptance that there were “a sufficient number of outstanding theories on enough areas of social life to last” (p. 10) and that researchers should focus on verification followed by modification and reformulation. In contrast to logico-deductive theory, Glaser and Strauss contend that scientific truth has less to do with verification of theory and more to do with emergence of theory from the data. Glaser and Strauss proposed an organic process of theory emergence in a substantive area based on constant comparative analysis resulting in conceptual categories that fit the data identified by the participant, that explain or predict ongoing interpretations, and that are relevant to the core issues.
The aim of this study was to obtain data from individuals who had experienced EMDR approach to learn more about their experience. In the grounded theory method, the aim is not to find out the truth or answers to specific questions but to conceptualize what goes on in a social process in a substantive area, to determine the main problem of the participant, and how he or she tries to solve the problem.

The soundness of grounded theory lies in the discovery of substantive theory by following the data without any a priori hypotheses. Glaser and Strauss (1967) describe a theory that is generated through an inductive process from analyzing data collected in interviews and not by a researcher quantitatively verifying a previously stated hypothesis.

Glaser (2004) described the process this way: “The GT researcher (especially a PhD student) does GT analysis that produces a substantive, conceptual theory with general implications—not descriptive findings” (p. 18). Glaser called grounded theory research a systematic application of common sense that “applies equally to nursing, medicine, education, social work and other practicing professions as well as academic work” (p. 19). The basic features of grounded theory make it valuable in the area of nursing because of the interpersonal process between nurses and patients (McCann & Clark, 2003). By using grounded theory to explore a patient’s experience of a psychotherapeutic treatment approach, a researcher can “enable nurses to explore rich data . . . and allow interpretive understanding of what is going on” (Sheldon, 1998, p. 1). This study offered the researcher an opportunity to examine areas in which a better understanding of a patient’s experience may emerge from data through a grounded theory method.
This researcher chose to obtain study data through the interview process from individuals who had undergone EMDR treatment. Glaser and Strauss (1967) believed that conducting interviews was the key data collection technique to be used in social research. Under this approach, the researcher examines the data obtained in the interviews in a process of repeated comparative analysis. As data are collected and compared, they are analyzed line by line and coded into categories until underlying “latent patterns” begin to emerge (Glaser, 1998, p. 26).

As patterns appear, more specific questions can be asked of some participants in order to achieve a clearer understanding of the meaning of their experiences. When no new categories emerge from the data and no new information can be found to develop these patterns further, the categories are considered saturated (Glaser & Strauss, 1967). The researcher then analyzes the final patterns, allowing the data to generate a grounded substantive theory (Glaser & Strauss). This researcher followed this process in this research study and discovered the basic social psychological process (BSPP) which will be discussed in the following section.

**Basic Social Process**

There are two types of BSPs: basic social psychological process (BSPP) and basic social structural process (BSSP). BSPPs are useful in understanding behaviors such as—becoming, shaping, and inspiring, whereas BSSPs are useful with social structures in a process such as—organizational growth, recruiting, and outsourcing. A basic social process accounts for most of the variation in change over time, context, and behavior in the substantive area. BSPs may or may not be present in a grounded theory study. Glaser (1978) makes the primary distinction between the core category and a BSP stating that,
“BSP’s are processural, or as we say, they ‘process out.’ They have two or more clear emergent stages” (pp. 96-97). Since this is a study of how patients experienced a psychotherapeutic approach in the treatment of trauma, it is clear that this study fits into the BSPP type. Consequently, BSPP that was discovered is transforming suffering which will be reviewed in Chapter IV.

The significant quantity and complexity of patterns and categories that resulted from extensive constant comparative analysis (which will be reviewed under data analysis) lead the researcher to seek a core category. The criteria for the core category will be discussed in the next section.

Core Category

According to Glaser (1978), the researcher should be looking for a core category that fits the following criteria: (a) Centrality: It must be central to the other categories and their properties. (b) Frequent Reoccurrence: It must reoccur frequently and eventually create a stable pattern as it relates more to other categories and their properties. (c) Time to saturate: In that this category relates to many other categories, it takes longer to saturate. (d) Connectivity: Connections are not forced but come easily. (e) Formal Theory: It has clear and grabbing implications for formal theory. (f) Carry-through: As a result of the core category’s relevance and explanatory power, the analysis is carried through with the core’s use. (g) Completely variable: The core category is highly variable where conditions can vary it and it is easily modifiable. (h) Dimension of the problem: The core category is a dimension of the problem, explaining itself and its variation. (i) Generate a rich core category: Prevent establishing another core that is not grounded. (j) Core category expansiveness: The ability to see the core in all relations whether grounded
or not. (k) Any kind of code: The core category can be a process, a condition, two dimensions, or a consequence, etc.

**Credibility in Grounded Theory Research**

Glaser and Strauss (1967) note that criticism of the credibility in grounded theory stems from the “canons of rigorous quantitative verification on such issues as sampling, coding, reliability, validity, indicators, frequency distributions, conceptual formulation, hypothesis construction, and presentation of evidence” (p. 224). Rennie’s (1998) explanation of Glaser’s viewpoint is that GT should not be viewed in terms such as verification, which refers to a deductive approach. In contrast, theory generation in GT is inductive with codes and categories emerging from the data which become more focused as the analysis progresses. Therefore GT can be viewed as validational, inherent through all the measures of internal consistency, reviewed later in this chapter under substantive coding. The four criteria for evaluating GT results include: fit, work, relevance, and modifiability (Glaser, 1978, 1992, 1998; Glaser & Strauss, 1967).

**Fit**

When a theory fits, then the categories fit the data and the researcher has not forced the data into preconceived slots or discarded data that does not support the theory. An example of forcing the data follows: In the beginning of data analysis, this researcher started to code with codes such as: *Phase 1* (of EMDR) or *PTSD vs. DESNOS*. This is a modification of GT used by Strauss and Corbin (1990) but it is not Glaserian GT. In essence, this type of modification is systematic and imposes other theoretical frameworks on the data. This is the importance of fit. During the constant comparison analysis, this writer realized that the systematic codes did not fit the data but only fit the preconceived
theoretical frameworks from the review of literature. Instead of the codes emerging from the data, that is, from the words of the participants, they were being forced into the data. Also indicated in the criteria for fit, the theory must fit the substantive area where it can be applied. Therefore, not only does the data analysis result in the main concern of the participants, but it also produces how the participants resolve their main concern.

**Work**

A theory works when it can explain or interpret what happened and when it can predict what will happen (Glaser, 1978). To do this, the theory must be generally understandable and make sense to those using it. This researcher found that one of the emerging concerns of the participants was different physical effects during the EMDR approach. Therefore, the emergent theory will work if the researcher, using the emerging concepts of the participants, can explain what happened, predict what will happen, and interpret what is happening.

**Relevance**

Relevance is achieved when the theory is general enough to apply to diverse situations in the area and not simply to a specific situation. In other words, with the previous example of physical effects, in order for this researcher to make the theory relevant to the substantive area, the focus would not stop at physical effects nor would physical effects be described; it becomes a focal point of understanding. Through the continued constant comparison underlying patterns or concepts related to physical effects are generated which serve to encompass diverse situations and applications. An abstraction of physical effects may become not telling the therapist, which, in turn, may become trusting the therapist.
Modifiability

Finally, a theory demonstrates modifiability when new relevant data can be compared to existing data and thereby be modified (Glaser & Strauss, 1967). GT theory does not aim to prove a hypothesis or set a theory in stone. GT concepts are subject to constant modification by constant comparisons as new data are applied and affects new emergent concepts. This modification of theory increases its power to explain and increases its applicability.

This study demonstrates credibility by theory generation through all the measures of inductive consistency contained within the generation of codes and categories emerging from the data through constant comparative analysis. However, when viewed in terms of trustworthiness from the quantitative perspective of reliability and validity, Lincoln and Guba (1985) suggest four types of criteria used to persuade this audience. These criteria are reviewed in the following section.

Trustworthiness

According to Lincoln and Guba (1985), there are four types of criteria used to ensure trustworthiness of naturalistic inquire: credibility, transferability, dependability and confirmability. These four criteria answer the basic question, "How can an inquirer persuade his or her audiences that the findings of an inquiry are worth paying attention to, worth taking account of?" (Lincoln & Guba, 1985, p. 301).

Credibility

Credibility entails that the study is believable to the readers and to the participants in the study. Lincoln and Guba (1985) recommend several techniques to achieve this goal: prolonged engagement, persistent observation, triangulation, peer debriefing,
negative case analyses, progressive subjectivity checks, and member checking. Of these, this researcher will focus on persistent observation, triangulation, peer debriefing, and member checks as used throughout the present study.

**Persistent Observation**

This technique involves the exploration of what is being studied to a deep enough level that the researcher can distinguish what is relevant from what is irrelevant. This is represented by this researcher’s credentials in EMDR, the number of years using EMDR almost exclusively in practice for 18 years, and the extensive review in literature in the preceding chapter. All these forms of persistent observation ensure depth of experience and understanding in both trauma and EMDR.

**Triangulation**

Triangulation refers to verification of findings from different data sets: multiple sources of information, multiple methods of data collection, and/or multiple investigators. In this study the researcher referred to multiple sources of information: an extensive literature review as well as years of experience using EMDR approach, being an EMDR consultant to other therapists and teaching EMDR approach in trainings. The researcher also used data collected from multiple participants \((n = 15)\) and the participants’ experiences varied since several participants underwent EMDR with different EMDR therapists. In addition, this researcher used other credentialed EMDR researchers to discuss whether the emerging codes and categories corresponded to the transcription data.

**Peer Debriefing**

This technique is "a process of exposing oneself to a disinterested peer in a manner paralleling an analytic session and for the purpose of exploring aspects of the
inquiry that might otherwise remain only implicit within the inquirer's mind" (Lincoln & Guba, 1985, p. 308). In addition to the credentialed EMDR researchers consulted, the researcher considers the chair and the entire committee peer debriefers. In addition, the researcher consulted with grounded theory coaches as well as one of the founders of grounded theory, Dr. Barney Glaser. All these peer debriefers assisted the researcher to discriminate between what the researcher thought was known and what was being communicated by the participants which directly relates to one of Glaser’s criteria for credibility, namely, the importance of fit.

**Member Checks**

This technique shares the researcher’s data, interpretations, and conclusions with the participants who provided the data. In this study, the researcher used approximately one third of the participants to give feedback on the emerging codes and categories. In each case the participant was thrilled with the data and wanted to assist in suggestions in naming the codes and categories.

**Transferability**

Lincoln and Guba (1985) state, "It is *not* the naturalist’s task to provide an *index* of transferability, but it *is* his or her responsibility to provide the *data base* that makes transferability judgments possible on the part of potential appliers" (p. 316). Transferability is facilitated by what is termed *thick description*. Thick description involves clear descriptions of the time and context in which hypotheses or theories are developed. In chapter IV, this researcher has provided a clear, full explanation of how the data fit the distinct stages of participant movement through the stages of *transforming suffering* using the EMDR approach. In addition, numerous quotes have been provided to
support the stages of the basic social psychological process: transforming suffering: changes in perception using EMDR.

**Dependability and Confirmability**

Dependability relies on the consistency and stability of the research methodology used over time. Dependability documentation used in this study includes: taped recordings and transcriptions of each interview with each participant. Also, all coding, categories, and memos were documented within the software ATLAS.ti and are available upon request to either the chair of the committee or this researcher.

Confirmability refers to the quality of the results which may be determined by reference to the literature, participant support of findings, and findings of other authors that confirm the hypotheses or theories proposed by the study. This study demonstrates all three determinants of confirmability through referencing the literature in all chapters of the dissertation demonstrating participant support of the findings through direct quotes in chapter IV along with a discussion in chapter V, while reviewing the findings of other authors in both chapter IV and V.

According to Lincoln and Guba (1985), both dependability and confirmability can be determined through one properly managed audit. Throughout this study, the chair of the committee served to audit the data, methodology, and analysis process. In addition, as stated under peer debriefing, credentialed EMDR researchers, Dr. B. Glaser and the committee overseeing this dissertation also served to audit the study.

**Setting**

The researcher interviewed the participants either by phone or in person in her office, with participant consent. The place and time of interviews were arranged in
advance to best suit the convenience and comfort of the participant. Interview sessions took approximately 30 to 60 minutes.

Each interview session was tape recorded with the consent of the participant. The researcher transcribed the tapes verbatim after each interview to ensure accuracy, confidentiality, and to familiarize herself with the data.

**Participants**

The study included 8 voluntary participants who were former patients in the private practice of this researcher and 7 voluntary participants who were former patients in the private practice of other cooperating therapists. All the therapists asked the participants to sign an authorization form for release of information, allowing the participant’s name and phone number to be sent to the researcher. The researcher then obtained a signed consent form from each participant prior to any interview (see Appendix A). The researcher and the cooperating therapists are certified in EMDR and approved as consultants in EMDR.

The researcher determined inclusion and exclusion criteria for participants. These criteria were based on several factors as reviewed in the next two sections.

**Inclusion Criteria**

In order to participate in the study, the individual had to meet the following criteria:

1. The individual had sought therapy for associated behaviors related to traumatic memory. These behaviors included depression, anger, anxiety, disturbed affect regulation, somatization, and altered relationships with self and others. These associated behaviors correlate to the associated and descriptive features of PTSD included in the
DSM-IV. The associated symptoms of PTSD are referred to as Complex PTSD (Herman, 1992) or DESNOS (van der Kolk et al., 1993). Luxenberg (2001) concluded that the results of The National Comorbidity Study made it clear that for a significant percentage of patients suffering from trauma, “the diagnosis of PTSD captures only limited aspects of their psychological problems. The combination of posttraumatic symptoms represented by DESNOS and PTSD criteria, rather than by PTSD alone, causes people to seek psychiatric treatment” (p. 376);

2. The individual was 18 years or older.

3. The individual had participated in at least 8 hours of EMDR treatment. In PTSD/DESNOS, the recommended number of treatment hours ranges from 5 to 11 hours (Maxfield & Hyer, 2002). This researcher chose the mean number of hours to support enough hours of treatment that the participant could speak to his or her experience;

4. The individual had completed treatment within 6 months of the recruitment period. (This applied only to the 10 participants selected from the private practice of this researcher to avoid ethical concerns with current patients).

*Exclusion Criteria*

The following were the exclusion criteria: If the individual met the diagnostic criteria for psychosis, active substance abuse, severe personality disorder, cognitive dysfunction, or organic mental disorder in the initial psychiatric assessment. Each of these diagnosis criteria represents a vulnerable population unable to emotionally or cognitively engage in EMDR and ultimately suffer as a result.
Recruitment

To recruit study participants, this researcher contacted other certified EMDR therapists to discuss the research and review both the inclusion and exclusion criteria for patient participation. The certified EMDR therapists were approved consultants in EMDR and were selected from a listing of the Eye Movement Desensitization and Reprocessing International Association. Discussions ensued to determine if the therapists had patients who met the participation criteria. The therapists then asked those patients if they would be interested in participating in the study. Each therapist asked each potential participant to sign an authorization form for release of information, which served as authorization to release names and phone numbers to this researcher.

An associate registered nurse from the practice of this researcher, who understands patient confidentiality and patient privacy rights, contacted each potential participant from the list compiled by the researcher. The nurse called the potential participant at home and asked to speak to the participant by name. If the potential participant was not available, the nurse stated, “This is a follow-up call from the office of Celia Naccarato. Is there a better time to reach Mr./Mrs./Ms. ______?” If the potential participant was available, the nurse explained the study and asked if the individual would be interested in participating in the study. If the individual was interested, the nurse asked the best time for the researcher to reach him or her to set up an interview and to answer any questions. In addition, the nurse informed the participants that an informed consent form would be mailed to them to be signed and mailed back in a self-addressed stamped envelope provided.
Protection of Human Subjects

Before beginning the study, the researcher submitted a study proposal that included a human research protocol form to the University of Miami Institutional Review Board for the Protection of Human Subjects in Research for review and approval. Approval was received and maintained. An explanation of the research was given to each potential participant and those agreeing to participate signed an informed consent form. The form included the project title, a brief statement of its purpose, and an explanation of how the interviews would be conducted, including the use of audiotape. For participants being interviewed by phone, a verbal consent was obtained and recorded. Then a printed copy of the informed consent form was mailed to the participant to be signed and returned to the researcher.

All participants were instructed that participation was voluntary and that they were free to answer or not answer any questions. They were also free to withdraw from the study at any time without penalty. The participants were provided the names and phone numbers of the researcher’s advisor as well as the director of the University’s Human Subjects Research Office for any concerns. All participants received copies of the signed consent form. Participants were assured confidentiality.

Participant names were collected and a list was formed that linked responses to individuals. Participant records were maintained in the locked files of this researcher, who had the only key. Tape recordings were shared only with the chair of the dissertation committee for data confidentiality.

Since it was possible that during an interview participants could have been at risk to experience feelings of anxiety while recounting experiences related to traumatic
memories, the researcher being a certified EMDR therapist was competent to offer support and to pace the responses to help them deal with these feelings. All participants were instructed that if they became distressed, a referral would be provided for them upon request. No participant requested such a referral. The researcher was also prepared if any participant was deemed to be at-risk based on the therapist’s professional judgment to refer the participant for appropriate treatment. No participant was deemed to be at-risk, and no referrals were made.

**Data Collection**

This researcher was the primary instrument for data collection. The interviews were semi-structured with an interview guide (see Appendix B). In order to maintain theoretical sampling, the researcher intentionally adjusted the semi-structured interviews of what & why into open, conversational exchanges; engaged in constant coding and analysis; and created new categories and concepts which generated additional questions to help saturate the categories. This flexibility in using a semi-structured interview guide is part of GT’s method, because the actual process of interviewing should lead to a “change [in] the subsequent questions as the researcher samples for data in different aspects or directions,” thus grounding the research in the social reality of the participant (Glaser, 2001, p. 174).

**Data Analysis**

Under Glaser and Strauss’s (1967) constant comparative method of qualitative analysis, the analysis of data occurs concurrently with collection. From the very first interview and transcript, the researcher constantly compared each phrase, each line, and each stated thought with the phrases, lines, and stated thoughts of every other interview.
On the interview transcriptions, codes were put next to key words, phrases, or sentences in the text. This coding was conducted using ATLAS.ti software package (Muhr, 2005), which is uniquely suited for computer-assisted analysis using the grounded theory approach. Computer-assisted software needs to fit the method, if not the researcher runs the risk of manipulating the data to fit the software program. To this end, ATLAS.ti has several major advantages, including that the researcher is free to choose and change the text segment (called quotation) to be coded at any time. In this respect, it resembles the manual cut-and-paste or highlighting-to-code of text segments. Unlike other software programs, the researcher is not bound by the original codes, categories, or selected text since these can be changed at any time. Therefore, ATLAS.ti enables the creation, renaming, removal, and merging of codes and categories so that the analysis does not become locked into any initial conceptual frameworks.

MacMillan and Koenig (2004) found that grounded theory is the dominant method for computer-aided qualitative data analysis software (CAQDAS). In their evaluation of CAQDAS use in qualitative research, they found that the important issue was not if CAQDAS should be used by qualitative researchers but how CAQDAS is to be used. The authors believed that researchers must take care in explaining how they used the software because several factors can be misleading. Misrepresentation of the software function is a common error, with researchers stating that the software analyzes data or builds theory. In fact, what the software does is expedites the organization and management of data, thus rendering more rigorous the conceptual aspect of data analysis. Another frequent misunderstanding is that building theory is completed by arranging the data into hierarchical categories within the software program. This view mistakenly treats
coding as an end in itself, when, in fact, it is simply a means to an end; namely, the
discovery of an emerging theory.

**Preparing Data for Analysis**

In preparation for data analysis, this researcher attended two ATLAS.ti training
sessions to become proficient in using the program. To obtain data from the participant
interviews the researcher transcribed the tapes. The transcriptions were reviewed
repeatedly to maintain accuracy. The transcriptions were then saved in Rich Text format
and imported into ATLAS.ti for coding.

**Data Analysis: Substantive Coding**

According to Glaser (1978), the researcher generates categories that fit and work
in the area being studied. To do this, the researcher begins with open coding. Six rules are
used so that the researcher using grounded theory follows a systematic agenda in coding
consistently from one interview to the next. Glaser indicates the researcher do the
following:

1. Ask the following throughout the analysis of data and starting
during open coding:
   a. What is the data a study of?
   b. What category does this incident indicate?
   c. What is actually happening in the data?
2. Analyze the data line by line.
3. Do his or her own coding.
4. Always interrupt coding to memo the idea.
5. Remain within the confines of his or her substantive area and the field
   study.
6. Not assume the analytic relevance of any face sheet variable such as
   age, sex, social class, race, skin color, etc., until it emerges as relevant.
   (Glaser, p. 57-60)

The researcher analyzed the data line-by-line, creating open codes in the right side
of the text using ATLAS.ti (see Appendix E). This line-by-line analysis of the data was
used to name and categorize by systematically comparing for similarities and differences and asking questions about the phenomena in the form of memoing. The coding at this stage was derived from the participant’s own words, thus helping the researcher to not impose preconceived notions onto the data (Donovan, 1995). The researcher began open coding with the first seven interviews, which resulted in 254 codes. The realization that a core category was to emerge from these codes was overwhelming. It was at this point the researcher understood the importance of memoing.

During the process of building and exploring relationships among the codes and categories, writing memos was essential for delimiting categories that did not fit the emerging theory and for explaining the conceptualizations in the remaining core categories. This process not only kept the emerging categories grounded in the data, but it also moved the analysis to a new level of abstraction. The researcher then began identifying any emerging patterns in the open coding, including patterns of similarities or differences.

Data Analysis: Theoretical Coding

As categories were related, they began to collapse into fewer larger categories, becoming integrated through constant comparisons and resulting in themes, hypotheses, and theory. Glaser (1978) explains that these codes implicitly conceptualize how the substantive codes may relate to each other as hypotheses to be integrated into a theory. Incidents articulated in the data are analyzed and coded, using the constant comparative method to initially generate substantive categories and later generate theoretical categories.
The essential relationship between data and theory is a conceptual code. A code gives the researcher a condensed, abstract view with scope of the data. Substantive codes conceptualize the substance of the area of research. Theoretical codes give the researcher an expansive, integrative scope with a conceptual perspective. Therefore, the codes guide the researcher to maintain the conceptual level in writing about concepts and their relationships.

Feeling the pressure to find the core category to guide all the significant quantity and complexity of emerging categories, it was noted earlier that this researcher found interpretations of the data in the early stages of coding and categorizing to be assumptions made by the researcher. However, due to the rigor of constant comparative analysis, theoretical coding, and memoing, those assumptions were eliminated as conceptual abstractions from the data that emerged. An example is the original code *separation from the experience*. After comparing *separation from the experience* to other codes and patterns that emerged, it became apparent that this processed out as a core category. The codes and patterns that created this deduction and caused verification to fail, were cultivating the witness and changes in perception. Cultivating the witness could easily correlate to separation from the experience as witness; however, it did not encompass the extra-sensory piece that participants expressed which is seen in the following example (incident):

P1: All of that is, uh, for me that sensory piece, that, that, that extra-sensory piece, really uh, really moves something, like it’s not just in my head, it really brings my whole body.

This quote denotes something central to the person and to their experience of wholeness while processing trauma. The essence of this quote could not be captured within
separation from the experience which led this researcher back to constant comparison for a core category that could subsume the stages of processing.

Another participant expressed a change in his perception of reality over time which could not be incorporated into the code separation from the experience:

P2: What I perceived as the problem was making life difficult more than reality.

Therefore, as a result of constant comparison with the data, separation from the experience was demoted to a substantive code in search of a category. However, further constant comparison of other relevant codes brought the researcher to a core category that is more densely grounded in the data. The emergence of the core category, namely, changes in perception, marked another beginning of more selective and theoretical coding.

**Data Analysis: Selective Coding**

Selective coding was used to relate the categories to each other and to allow the core category to develop. Glaser (1978) advised that “it often seems wise, given human finiteness, to delimit the theory to one core variable” (p. 61). To accomplish this requires the researcher to selectively code for the core variable and to halt open coding with this core guiding the subsequent coding. Concepts or categories that have little or no relationship to the core category are not considered. As a result, selective coding delimits the research and fosters greater guidance and less confusion.

Glaser (1978) described how grounded theory emerges from a “concept-indicator model” (p. 62) in which the analyst constantly compares indicators to indicators and then, as a concept emerges, compares indicators to the emerging concept. In following this advice, this researcher gave each concept a label, such as focusing with the body, and
identified its properties. As coding continued, each incident (indicator) related to this concept would be assessed for whether the meaning fits, is relevant to and works within the concept as a property. When no new patterns or codes arose in subsequent interviews, this concept was considered saturated. Glaser summarizes this process by stating,

> As the analyst gets deep into the data, he discovers that all data can be subsumed as an indicator of some category in the analysis. Later in the study nothing occurs as a surprise, after constantly comparing, analyzing and generating, sufficient codes to handle differential emergents. (p. 60)

In the next section, this researcher illustrates the generation of three levels of concepts using the “concept-indicator model,” as described in the preceding paragraph. It is important to understand that the following illustration of constant comparative method is only a minute fraction of the enormity of data being compared to substantiate theory.

**Constant Comparative Concept-Indicator Model**

Hundreds of codes lead to the BSPP of transforming suffering and the core category of changes in perception. These codes were all directed toward relief from suffering and separating from the pain of the traumatic experience. However, through constant comparison of indicators to concepts over and over, these codes evolved from the concepts of wanting relief or wanting to get rid of the suffering to the concepts of becoming present for themselves and changes in perception that come with this awakening.

Three stages of transforming suffering became evident from the indicators that emerged from the data. However, in this section, for the sake of illustration the emergence of only the first stage—relinquishing—will be reviewed with the concepts that are subsumed under it (see Figure 1).
As Figure 1 shows, within the hierarchy, relinquishing subsumes increasing awareness; and increasing awareness subsumes the properties of being vulnerable and sensing feelings. The concepts under increasing awareness are called properties and will be discussed within the increasing awareness analysis. In order to proceed with discussing the constant comparison of these three levels of concepts, this researcher will begin with the subcategory of the BSPP, namely, *relinquishing*.

Relinquishing was derived from repeated references to levels of attachment/repulsion to the problem, behavior, or symptom. This is identified in the following incidents:

**Incident #1:** Probably another reason that I was more anxious was because I know how addicted I am. And, and uh, all the reason why, uh . . . there, there were a lot of feelings involved. There were feelings about success and failure. All the, my history about trying to quit, and the emotional and physical and, and stress that was involved. So that stress alone did not really help me, I don’t think. Uh . . . and also like I said, uh, it was uh, very, uh, involved process. I’m not even sure that uh when we were working on it that I actually worked on all the right, uh . . . I don’t know how to call it . . . cues, or issues, or, uh…

**MEMO:** The degree of attachment to the behavior equals the degree of resistance which may present as anxiety, anger, projection, defense mechanisms, etc. Therefore, resolution can be longer since preparation will involve affect awareness, affect regulation, etc. Decreasing hyperarousal will increase cognition or else there is cycling.
Incident #2: My mind was so full of myself and, you know, my problem, and what was going on . . . the whole process was new to me, not just the EMDR, but everything . . . and, I was just kind of just following along, and had, you know, in so much pain that I couldn’t even identify the pain, you know, I could be in pain and not even know it. . . . You know, sometimes it’s hard to focus on doing something positive, or a solution to solve it.

MEMO: Clearly this client did not have the proper amount of preparation with knowing feelings, being able to separate from the pain, use affect regulation at this point. Client is talking about hyperarousal and the inability to think clearly or self-soothe. Yet, on the other hand, she is also talking about not knowing she is in pain, which refers to the defense of turning off. The degree of repulsion from the pain is not high due to her ability to deny it.

Incident #3: Cause, you know, because we’re human beings and, and the same, if it’s something that’s abusive, you know, and it’s happening again and again, it makes perfect sense that it would, just because you had EMDR about something that happened last week . . . It’s not going to erase the fact that it’s happening today . . . the whole true event. And then, of course, the issue of how much do, does the person really want to change their life comes up, which with any therapy, if the person is not committed to that change, then no therapy uh will change it. Well, and, that brings up another interesting thought because I remember in my situation . . . Um, looking back at it, the only times I think that I’ve really used EMDR is, is to get out of a painful . . . to erase something that has been very painful for me. But, as I look back on that whole situation, when you and I were working together, the thing I needed to do was to remove myself from the relationship and I did not feel, that was like . . . back in those days that felt, it felt was impossible (exasperation).

MEMO: Seems that levels of repulsion can act as motivation or obstacle. Preparation includes being able to take steps toward detaching from the old ways of seeing things, living your life and making a commitment for change.
This researcher could derive from these indicators that the first stage of transformation was to separate from the experience and to let go of the attachment to the existing trauma or pain. Therefore, in the initial stage of relinquishing, the patient is guided to loosen the hold on, or attachment to, his or her past perspective of the trauma (perceptions, interpretations, beliefs, feelings and images). How this was accomplished was determined through the constant comparison of incidents from the data. Several concepts arose that led to the concept of increasing awareness.

Prior to deciding on the label for the concept of increasing awareness, the meaning of the concept was constantly changing with each indicator within each interview. Examples of indicators came under several codes in the beginning of the study such as being initially unsure, impeding factors, no prior knowledge, degree of attachment/repulsion, degree of commitment, being comfortable, orienting, trusting the therapist, and not knowing feelings. Indicators in this study would be quotes from the participants. As an example, this researcher originally interpreted unsure of the process as an impeding factor that might later illuminate a need to orient patients to EMDR more effectively. Logically, this could create another concept under relinquishing, namely, orienting to EMDR. However, this concept never emerged since being unsure of the process would not earn its way into becoming a code.

In an article by Heath and Cowley (2004), the authors reiterate what Glaser originally postulated. While induction is the key process of emerging codes and patterns, “deduction and verification are the servants of emergence (p. 144).” Memoing records the creative insights and deductions of the researcher; however, unless verified for fit, relevance, and workability with the core category, the data is considered forced. The
following incidents will show the change in the meaning of the initial code _unsure of the process_: 

Indicator #1: My first impression was, uh, I don’t get it, but I’m open to it. (laughter) I didn’t really see, I didn’t understand . . . It seemed kind of funny. And, uh, I remained open, open to it, and we progressed with my sessions. Now, looking back on that, I can totally see the difference. But myself, my first initial reaction was “I’m not sure what it’s all about.” I think it’s allowing yourself to be vulnerable with a therapist, or if you’re working in a group, or whatever your setting is, that you don’t feel silly. Cause some people I think instantly feel kind of silly and that this is goofy, and if they would just kind of get over that and not worry about how it looks, or, you know, just trust. And know I’m supposed to be vulnerable, then, I think, at least for me, that was what it was for me, in the first session, I felt a little silly, but I said, you know what, this gal is highly recommended, she knows what she’s doing. I’m going to just, I’m going to give this 110 percent.

MEMO: Processing seems silly, allow being vulnerable with therapist, supposed to be vulnerable, trust.

Indicator #2: A little frightening and confusing. Uh, I’m trying to remember, uh. I didn’t know what was expected of me. . . So there wasn’t anything that I was scared of my life. But I didn’t know what the right answers were. Right being in quotes. And I wasn’t sure if my answers were right, so I was unsure of myself.

MEMO: Frightening, confusing, unsure of self not of the process, therefore, also vulnerable to being wrong.

Indicator #3: Uh, you know, I had, I had visions of a hypnotist or something when it started, although it was explained nicely . . . I, uh, and I had some knowledge of it ahead of time . . . but it did seem kind of silly the first time there, I’m sure some of it was me resisting because it was a little scary. . . . uh, knowing what I knew of it at the time, uh, I was afraid of it being, sort of, uh, very mentally invasive, you know, like I was going to be something was going to be revealed that, uh, I didn’t know, about myself even, possibly . . . or maybe something I didn’t want the therapist to know about me was going to be revealed.

MEMO: Silly, scary, mentally invasive, fear of exposure fits being vulnerable.

Therefore, instead of _unsure of the process_, being the property of the concept _orienting to EMDR, being vulnerable_ earned its way into the concept _increasing awareness_. Glaser (1998) states, “Through constant comparing, saturation and theoretical
sampling categories and their properties earn their way into the theory as relevant to its working. If they didn’t emerge they would not earn their way into the theory” (p. 198).

The importance of this difference has everything to do with moving toward change. If unsure of the process earned its way as a property of orienting to EMDR, then more effective orientation to the process would become a focus. However, the participants made it clear that being vulnerable was part of being in this stage of the process and attention to tolerating the vulnerability would make sense as part of the treatment. Upon further comparison, the same participants reported that in the cognitive field (mind), trusting the therapist acted as a resource for security since their sense of vulnerability kept them from being present for themselves.

However, in conjunction with becoming aware of their vulnerability, participants expressed the realization that they did not know how to sense what they were feeling. This property arose when participants reported being unable to distinguish one feeling from another in their body and thought that most of their feelings came from their “head.” Consequently, the property sensing feelings describes this discrepancy between knowing their feelings (head) and sensing their feelings (body).

In reviewing these three levels of concepts, it becomes clear that each quote alone may, but does not necessarily, illustrate a concept. The quotes gain importance for the researcher through the constant comparison and analysis not only of the words but of the meaning being conveyed. This rigorous analysis allows the truth of the concepts to emerge.
Summary

In this study, the researcher used grounded theory method to examine how 15 patients experienced the EMDR treatment approach. Grounded theory, as first described by Glaser and Strauss in 1967, is grounded in social research and generated by the data through coding and constant comparison analysis. Accordingly, grounded theory does not test a hypothesis; it seeks to find a theory that accounts for the social situation. Thus, the aim of this study was to expand the knowledge related to the effectiveness of EMDR from the patient’s experience of the EMDR process. The resulting concepts and substantive theory will enhance future patient care for those suffering from trauma-related disorders.

The researcher approached the study with an open mind, collecting data through interviews by asking the participants seven partially or totally open-ended questions. In the data analysis stage, key categories developed and substantive theory emerged following prescribed coding techniques.

The next chapter identifies the results of grounded theory analysis including the BSPP of transforming suffering and the core category of changes in perception using EMDR, in relation to the three stages of processing trauma, relinquishing, presencing and emerging as the subcategories. The final chapter discusses the results and their implications to practice, including recommendations for further research based on this study’s findings.
CHAPTER IV

RESULTS

The grounded theory method suited the needs of this study which explored a social psychological process involving the interaction between patient and psychotherapist while in treatment for PTSD/DESNOS using the EMDR approach. When treating PTSD and/or DESNOS, an EMDR session may be processing the actual trauma and/or the associated symptoms/behaviors resulting from the trauma. Therefore, when the word trauma is used in the following chapter to describe the target, image, or what is being processed, it will mean trauma and/or associated symptoms/behaviors.

In chapter IV, the results of the grounded theory research question, what is it like to experience eye movement desensitization and reprocessing as a therapeutic approach, are discussed. In addition, how these results lead to the generation of substantive theory is reviewed. In the final chapter, chapter V, the results reported in this chapter and their application to practice and the processing of trauma will be discussed.

Participants

The final number of participants totaled 15. Out of these 15 participants, 11 were females and 4 were males. The age range was between 25 and 55, but most of the participants were in their late 30s or early 40s. Although this researcher did not document the exact diagnoses of the participants, all met the criteria for PTSD and/or DESNOS. The predominant precipitating factor for seeking EMDR approach related to relationships with others and/or relationship with self. Most of the participants reported having had prior experience with some form of psychotherapy.
The predominant type of trauma (even in those participants who suffered acute PTSD) was childhood trauma. Childhood trauma ranged between abandonment and/or neglect to actual physical/verbal abuse. As discussed in chapter II, the person who has suffered from early childhood trauma is at a much higher risk for PTSD with traumatic experiences in later life and is likely to present in therapy with behaviors/symptoms that meet the criteria for PTSD and/or DESNOS. As stated previously, this was true of the participants in this study. A discussion as to the discovery of the basic social psychological process (BSPP) will follow in the next section.

**Basic Social Psychological Process**

According to Glaser (1978), the basic social psychological process displays certain characteristics. BSPs “process out” at least two emergent stages that “differentiate and account for variations in the problematic pattern of behaviour” (p. 97); are suited to qualitative studies where the researcher observes the evolution of a process over time, and are labeled by a gerund which reflects their evolving nature.

As presented in chapter III, the grounded theory method began with the interviewing process, transcription, and then the initiation of coding. This rigorous and constant comparative analysis resulted in pinpointing the problematic pattern of behavior. The main concern of the 15 participants in the study was derived from the code: presenting issue/main concerns. In total, there were 58 quotes related to the participant’s main concern or issue. In summary, the responses ranged from “not understanding what was holding me back” to “actually move things on a more permanent basis than talk therapy.” Some participants expressed the belief that “I just had never been able to get past it” and wanting to find a way “to be able to cope” or “to get rid of it.” Since each
participant involved in this study had experienced a traumatic event, it referred to the pain and suffering of trauma. In addition, most of the participants had been in psychotherapy before and as a result, knew the experiences that they did not want repeated. For this reason, participants explained that “to get rid of it” meant resolution without “delving into the whole story,” “without analysis,” and “without reliving it.”

The resulting basic social psychological process (BSPP) was transforming suffering. Although transforming suffering could be delineated into stages, the substantial quantity and complexity of patterns and categories that arose lead this researcher to find a central point. Therefore, in order to generate theory, the researcher needed to continue the constant comparative analysis for a core category and delimit the study around it. In the next section the core category analysis will be discussed.

**Core Category**

The core category “has the prime function of integrating the theory and rendering the theory dense and saturated as the relationships increase” (Glaser, 1978 p.93). Therefore the core category is the central point for the theory connecting all other relevant emerging categories and accounts for most of the variation in pattern and behavior. The emergence of the core category requires the adherence to the constant comparative analysis process comparing incident to incident, then incidents to categories followed by categories to categories. This process takes a great deal of time since the core category requires verification through saturation, relevance and workability.

The study began with the researcher interviewing the participants, transcribing the interviews, and then downloading them onto ATLAS.ti software. Use of the software made organizing the data and memos more efficient. As open/substantive coding progressed, it became clear that there was little to no direction of the codes. Initially, this
researcher coded for all incidents in the data which yielded hundreds of codes and concepts. After coding seven interviews, 254 substantive codes were generated. With the guidance of memoing and constant comparative method, the researcher began to merge, rename, and modify the substantive codes into theoretical codes. This higher level of abstraction yielded 23 theoretical codes from the 254 substantive codes. Using these 23 theoretical codes, this researcher continued to analyze the remaining eight interviews using selective coding.

Although it is suggested to evolve the interview questions to match the evolving nature of the codes and categories, the researcher chose not to change the original questions. This choice stemmed from the researcher’s concern of biasing or leading the participant to answering the question in an affirmative for the secondary gain of approval. Instead, the researcher learned other ways to abstract more information from the responses of the participants.

Ultimately, the core category emerged as changes in perception. In the following section, how changes in perception using EMDR transforms suffering will be delineated into subcategories, concepts and the properties of the concepts.

**Transforming Suffering: Changes in Perception Using EMDR**

After extensive substantive coding, comparative analysis, and theoretical coding, the results suggested that EMDR approach creates multiple layers of processing which are sequential and simultaneous and support the participants’ desire to relieve their suffering without analysis and without reliving it. The subcategories of the core category, changes in perception, are contained within movement over time in three stages of transforming suffering. In order to clarify the evolution of transformation, changes in
perception in two dimensions of time and space are represented by temporal perspectives and processing fields (See Figure 2).

**TRANSFORMING SUFFERING: CHANGES IN PERCEPTION USING EMDR**

![Diagram]

*Figure 2. Substantive theory model.*

The processing fields that emerged from this study are the physical (body), cognitive (mind), and transformative (inner-self). The physical field relates to the senses of the sensory system in the body, such as sight, sound, smell, taste and touch. The cognitive field relates not only to the perception of what is sensed but also to the choice of what the patient decides to bring into consciousness. The third field, transformative, relates to the inner self. This is where the choices made in the physical and cognitive fields determine the changes in how one experiences past trauma, ranging from suffering to a profound, deepening experience of self.

Temporal perspective relates to the way a person views and interprets the experience of past, present, and future. When past trauma invades the present moment, it
deprived of clarity in the present but also of potentiality in the future; the construction and preservation of the person’s perspective of the trauma changes during EMDR processing. This is accomplished by changing the positioning of the person’s temporal perspective. Hence, participants reported that viewing and sensing past trauma from the position of being grounded in the present (witness stance) was a powerful tool in processing the trauma.

The stages in which the transformation of suffering occurs are relinquishing, presencing, and emerging. These stages, experienced as successive and simultaneous, change not only the person’s perception of the trauma but the perception of self. However, evidence from the participants shows that for this progression to occur, each stage compels a specific re-focusing of the temporal perspective with the body and the mind in order to invoke the emergent nature from within the inner self. In addition, it became evident that the level of emergence from the inner-self depends on the level of completion of the stages in the mind and body. Therefore, the three stages of transforming suffering, relinquishing, presencing, and emerging become the subcategories of transforming suffering.

Hence, each stage of processing trauma (relinquishing, presencing and emerging) presents concepts and properties in each field of the body, mind, and inner-self which will illuminate the changes in perception in the temporal perspectives and the processing fields. In the following section, the stages of transforming suffering in relation to the temporal perspectives will be discussed.
**Stages of Transforming Suffering: Temporal Perspectives**

The three stages of relinquishing, presencing, and emerging apply to the processing fields of the physical (body), cognitive (mind), and transformative (inner-self) as well as the temporal perspectives of past, present, and future. Through the dimensions of the processing fields, the changes in temporal perspectives are delineated at each stage of transformation (see Table 2).

<table>
<thead>
<tr>
<th>Stages of Transforming Suffering: Processing Fields and Temporal Perspectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical (Body) + Cognitive (Mind) + Transformative (Inner-Self)</td>
</tr>
<tr>
<td><strong>Emerging</strong> → Present-in-Present, Present-in-Past &amp; Present-in-Future</td>
</tr>
<tr>
<td><strong>Presencing</strong> Past Experience-in-Present Perspective → Present Perspective-in-Past Experience →</td>
</tr>
<tr>
<td><strong>Relinquishing</strong> Past Experience-in-Past Perspective → Past Experience-in-Present Perspective →</td>
</tr>
</tbody>
</table>

**Stages and Temporal Perspectives**

In the initial stage of relinquishing, the patient is guided to put aside the repetitive, habitual stream of thoughts and feelings about a minimally charged disturbing thought or memory. To facilitate relinquishing the hold on or attachment to the past perspective of the thought or memory (perceptions, interpretations, beliefs, feelings and images), several concepts are distinguished within the processing fields of the body, mind, and inner-self. Consequently, it is within this stage that the patient begins to delineate between what is in the past from what is in the present as well as the difference between their present experience of a disturbing thought or memory from their past perspective of it.
In the next stage, presencing represents the combination of two words: presence and sensing. Therefore, it is within this stage that processing is concerned with how to achieve and maintain the patient in the present perspective (as witness) while sensing the past traumatic experience. It is within this stage that bilateral stimulation takes place.

In the final stage, emerging, the goal is to support the patient in embracing what is emerging from the place of transformation, the inner-self, as changes in perception. This change may present itself as new perceptions, clarity of vision, sense of freedom, and release from pain or conflict which had been experienced for a long time. This sense of emergence creates a feeling of openness and sometimes timelessness, freeing the person to harness the power of the senses and use them to be in and maintain a higher state of consciousness. The end result is the ability of the patient to achieve and maintain the present perspective in the past, present, and future realms of experience.

In the following section, each stage is discussed in relationship to the processing fields and temporal perspectives. The first stage of processing trauma, namely, relinquishing, will initiate this discussion (see Table 3).

**Stages of Transforming Suffering: Dimensions of Processing**

**Relinquishing**

The relinquishing stage is reflected in the physical field (body), the cognitive field (mind), and transformative field (inner self). Throughout this stage, the goal is for the person to loosen the hold on and attachment to a traumatic memory (target). In each person’s life there are memories that at the time of occurrence the person thought they would “never get over it” or “never live it down.” At the time the emotional and physical charge from this occurrence would be a 8-10 on a scale of 10. Yet years later, the same
person, if asked about this past occurrence could look back on it and smile knowing it taught them something about themselves or others. This is an example of present perspective in past experience and the remaining emotional and physical charge is 0-1.

In PTSD/DESNOS, the patient cannot look back without reverting to the physical and emotional feelings of the time of the trauma and in essence, loses the sense of themselves in the present moment. Needless to say, the emotional and physical charge is high (often the same charge as the time of the trauma). Therefore, relinquishing in each field (physical field, cognitive field, and transformative field) will be accomplished when the patient is able to remember a minimally charged disturbing thought or memory and stay in the temporal perspective of the present while re-focusing on the body, mind, and inner-self.

In order to introduce the patient to this transformation, the therapist assists the patient to choose a thought or memory that is minimally charged. During the initial sessions the patient is asked to list any events, incidents or memories that they think/feel were traumatic to them. This list can go as far back as the patient can remember. It is imperative that the patient only list the trauma not write about it. Therefore the list is made up of one to three words that act as cues for the therapist and the patient to refer to. The therapist and patient review the list and score each trauma for the level of disturbance (or charge) that is triggered when the patient brings it up to mind.

The temporal perspective in this stage is relinquishing the past perspective in order to open to a present perspective. It is the beginning of focusing on the release of the attachment to the past experience-in-past perspective, in order to transform to past experience-in-present perspective.
<table>
<thead>
<tr>
<th>Processing field (Body)</th>
<th>Concept</th>
<th>Property</th>
<th>Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical field</td>
<td>Increasing awareness</td>
<td>Being vulnerable</td>
<td>Cause some people I think instantly feel kind of silly and that this is goofy, and if they would just kind of get over that and not worry about how it looks, or, you know, just trust. And know I’m supposed to be vulnerable...</td>
</tr>
<tr>
<td>Sensing feelings</td>
<td></td>
<td></td>
<td>I don’t remember the feeling part… because I had a lot of trouble back then with feelings…And, I was just kind of just following along, and had, you know, in so much pain that I couldn’t even identify the pain, you know, I could be in pain and not even know it…</td>
</tr>
<tr>
<td>Cognitive field (Mind)</td>
<td>Fostering resilience</td>
<td>Trusting the therapist</td>
<td>None of the three were unsure people, even the ones who brought it to me the first time. They’ve been very confident in it, and that has brought confidence to me in trusting that, because they were people I trusted. That was very helpful.</td>
</tr>
<tr>
<td>Changing feeling states</td>
<td></td>
<td></td>
<td>I can’t remember all of it specifically, but I know it was in my upper chest, and it was, um, it was a way of when uh, I was very agitated to soothe myself, and it had to do…it was a blue color…And it was, I don’t remember if it was, um, it was a blue like a cloud or a softness or, not a cloak …but a blue space that I could recall and pull up to my upper chest to calm me.</td>
</tr>
<tr>
<td>Transformative field (Inner-Self)</td>
<td>Becoming separate from the experience</td>
<td>Recognizing the self</td>
<td>Um, it's just again for me, it's just really a feeling like I can do this, I've been doing it. It's in me, it's part of me, uh, it's sort of a feeling of power, and then a feeling of, ahhh, you know,okay. If they [thoughts] came into my conscious mind in the daytime, or whatever, I would try to reframe them, you know, push the thought out, like it's a thought that it's dark and I'm alone and I'm scared and I'm fearful, I would try to reframe that into okay, you are, but you are not alone, and I can handle this.</td>
</tr>
<tr>
<td>Noticing</td>
<td></td>
<td></td>
<td>I can get distance on it, and it doesn’t feel like I’m in it any more, you know</td>
</tr>
</tbody>
</table>
Relinquishing stage: physical field (body). In the physical field of the relinquishing stage, the goal is to isolate the physical experience of a disturbing thought or memory from the cognitive experience of the trauma. This process allows the patient to separate out their present physical experience from the past perceptions of a disturbing thought or memory. This required a certain degree of awareness of their body which was a new experience for many of the participants. However, this awareness was an important preparation for the next process (in the presencing stage) of focusing on the physical experience with a present perspective. Consequently, the concept for the physical field of the relinquishing stage is increasing awareness. The concept of increasing awareness includes the properties of being vulnerable and sensing feelings which will be reviewed in the following section.

In the relinquishing stage, the first property of the concept, increasing awareness is being vulnerable. Being vulnerable refers to a number of indicators: being unsure of the process, not knowing what to expect, being afraid of something being revealed, looking silly and the fear of doing it [EMDR process] wrong. A strong indicator of a person’s level of resilience in the face of challenge is his or her level of vulnerability (McFarlane & Yehuda, 1996) and the primary factor related to emotional stability was the perception of self (Friborg et al., 2005). Therefore, the person’s ability to become aware of this state is an important factor in evaluating the degree of strengthening resilience in the next processing field of cognition. The awareness of feeling vulnerability was not something that participants found easy to tolerate or admit; however, the capacity to sense this happening in the body is a beginning of distancing or separating from the disturbing thought or memory:
P1: a little frightening and confusing. Uh, I’m trying to remember, uh... I didn’t know what was expected of me... So there wasn’t anything that I was scared of my life. But I didn’t know what the right answers were. Right being in quotes. And I wasn’t sure if my answers were right, so I was unsure of myself.

P2: I had some knowledge of it ahead of time... but it did seem kind of silly the first time there, I’m sure some of it was me resisting because it was a little scary. …uh, knowing what I knew of it at the time, uh, I was afraid of it being, sort of, uh, very mentally invasive, you know, like I was going to be ...something was going to be revealed that, uh, I didn’t know, about myself even, possibly...or maybe something I didn’t want the therapist to know about me was going to be revealed.

In the relinquishing stage, the second property of the concept increasing awareness is sensing feelings. Sensing feelings refers to the practice of becoming aware of what you are feeling and being able to describe it. The patient begins by focusing on learning about the senses and about the feelings generated by the senses using only memories that are minimally charged or, the term as used in EMDR, memories that have a low subjective unit of discomfort level (SUD level).

The patients begin with locating where they sense the emotional feeling in the body, followed by naming it and then describing it. During this stage, participants realized how little they knew about the sensed experience of the memory. Much of the time spent with the past memory was either re-living it or trying to deny it in the mind. However, the experience of sensing their physical feelings in the present which were being triggered by a past memory opened patients to the experience of being in the past-in-present.

Hence, in the relinquishing stage in the body, the temporal perspective is in the past (past-in-past) with the beginning of awareness that there is a present perspective. This awareness of the temporal perspective of the present is precipitated first, by re-
focusing the patients on the body and this, in turn, empowers them with not only a sense of achievement but a sense that more of oneself is present for the processing. One participant explained this when she stated, “my whole body, not just in my head.”

Participants related that this initial exercise was an awakening to sensing their physical experiences. This is expressed by the following:

P1: M-huh, it was. It definitely was. Where is your senses? Where is, you know, I guess even anytime, where is that feeling in your body. All of that is, uh, for me that sensory piece, that, that, that extra-sensory piece, really uh, really moves something, like it’s not just in my head, it really brings my whole body. I know that I have a difficult time, uh, sometimes, uh, staying out of my head and being in my whole body, and that process really, really does that for me. And, uh, I feel it in my whole body. Not just in my head.

P2: You know, back in those days, when I was doing EMDR, I had never, I had no body connection with myself at all (laughing)! I mean, you know, when people would say, ‘What does your body say?’ I would think, and ‘What are they talking about?’

Relinquishing stage: Cognitive field (mind). In the cognitive field of relinquishing stage, the goal is to be able to change the past cognitive perspective of a disturbing thought or memory to a present cognitive perspective. This is accomplished by the ability of the person to remain focused on the disturbing thought or memory while staying in the present. However, the ability to sustain this focus and remain in the present is difficult for most people. Often the person is triggered by emotion and drawn into the thought or memory and loses touch with being present. The capacity to maintain a good sense of oneself in spite of distressing challenges is referred to as resilience. McFarlane and Yehuda (1996) state, “vulnerability and resilience factors may operate at any part of the process of the stress response” (p. 158). Therefore, the concept for the cognitive field of
the relinquishing stage is *strengthening resilience* and the properties are *trusting the therapist* and *changing feeling states*.

In the relinquishing stage, the first property of the concept *strengthening resilience* is *trusting the therapist*. *Trusting the therapist* refers to the therapeutic alliance that is reinforced so that it becomes a resource for security and trust throughout the process. Trusting the therapist was clearly important to many participants.

P1: Well I think it’s, it was really important for me to feel that I had a good connection with you. That made it I think easier.

P 2: I went and met with her and felt very comfortable with her and so went forward. I didn’t really know a whole lot about it at the time.

P 3: (a) be sure you get with a therapist that you, that you feel comfortable with; even go see the therapist before they do the EMDR first, talk to them a little bit. And then secondly, to really allow yourself to trust the experience, that even though it’s not something that has a common reference point for you, to really trust the experience and follow the therapist’s directions and you know, they, they will definitely have an experience.

This concept, as a property of strengthening resilience, refers to trusting the therapist as a guide or coach in the process. The importance of this point is that it deviates from what is traditionally known as a psychotherapeutic relationship. In a psychotherapeutic relationship, issues of transference, projection, boundaries and roles are stated and met for analytic reasons. In EMDR, the therapist role differs since the approach is essentially client-centered facilitating the client’s self-directed healing process.

In the relinquishing stage, the second property of the concept *strengthening resiliency* is *changing feeling states*. *Changing feeling states* refers to the realization and acquisition of the specific skills/techniques, often called resources, to change the feeling
state in the moment (present). Examples of these resources are imagining having the
characteristics of a positive role model; imagining being in a place that evokes peace and
calm, or posturing stances of strength. Other more common relaxation skills are
imagining a container to put all the negative feelings, thoughts, and sensations, or just
imagining a safe place. The outcome creates a different emotional and physical
experience in the body; however, it is the mind that sets this transformation in motion.
Therefore, this is the beginning of the patient realizing that they can change their
emotional and physical state by disciplining their mind. The ability to learn the resources
and sustain focus on them was an essential part of the relinquishing stage. Many
participants expressed the usefulness of these resources and found that they continued to
use them in their everyday lives.

Teaching the use of resources is often referred to as affect regulation. Affect
regulation is the next step in persons realizing that they can choose their experience in the
present. When this choice is achieved and maintained, then the person is more resilient,
less vulnerable and prepared to move forward in processing.

Hence, in the relinquishing stage of the cognitive field (mind), the temporal
perspective is in the past (past-in-past) with the beginning recognition of a present
perspective. Similar to the experience in the physical field (body) of relinquishing, the
patients not only experience a sense of achievement and empowerment but also a sense
that they can protect themselves:

P1: She was doing some resourcing, so there was, you know, for example, um, I had gone from at the beginning a kind of cowering with my fists up position as my body position. She asked if I could, you know, was there a body position, or was there a stance, or anything that starts with my feelings, represented how I was feeling. And I started with that. By the
time we were done I had my hands out and open up to God, and um, with one palm, and in the other a walking staff of strength (laughter).

P2: When I would go into situations that scared me or were stressful, she would have me sort of wash my hands up and down myself to put up a shield, or protection. And that’s been very helpful for me at times. That’s something that I still use now. It helps me not regress and get all scared and wigged out about things. It can roll off me easier.

P3: There was one in particular, and I can’t remember all of it specifically, but I know it was in my upper chest, and it was, um, it was a way of when uh, I was very agitated to soothe myself, and it had to do…it was a blue color…And it was, I don’t remember if it was, um, it was a blue like a cloud or a softness or, not a cloak …but a blue space that I could recall and pull up to my upper chest to calm me…

P4: Yeah (laughing) putting it in a box, putting it in a box and hiding it and leaving it there... was a very sweet technique and it’s handy

Relinquishing stage: transformative field (inner-self). In the transformative field of relinquishing stage, the goal is to awaken patients to the understanding that their experience of trauma and all their unsuccessful efforts at changing their experience is beginning to transform. This is accomplished by focusing them on the previous fields of relinquishing in which they began to loosen the hold on and attachment to past experiences of a disturbing thought or memory in the body and the mind. In the transformative field of this stage, patients are guided to focus on their newly acquired knowledge and abilities. These include their success in tolerating being vulnerable, trusting the therapist, becoming aware of and present for their senses, and changing their feeling state by using specific affect regulation techniques.

Consequently, the patient begins to become aware of the how the past experience of a memory can block their experience of being present for themselves. It is in the relinquishing stage of the inner-self that the temporal perspective begins to move from the past perspective into the present perspective: past-in-past to past-in-present.
As a result, the concept for the transformative field in the stage of relinquishing is *becoming separate from the experience*. The properties of *becoming separate from the experience* are *recognizing the self* and *noticing*.

In the relinquishing stage, the first property of the concept, *becoming separate from the experience* is *recognizing the self*. *Recognizing the self* refers to not only to the participants’ ability to distance themselves from the emotionality of the experience but also to be aware of the presence of the self. Hence, recognizing the self with newly acquired knowledge and abilities is the beginning of knowing how to make decisions and choices about and in the present moment. Participants expressed the recognition of the self as follows:

P1: Um, it's just again for me, it's just really a feeling like I can do this, I've been doing it. It's in me, it's part of me, uh, it's sort of a feeling of power, and then a feeling of, ahhh, you know, okay.

P2: If they [thoughts] came into my conscious mind in the daytime, or whatever, I would try to reframe them, you know, push the thought out, like it's a thought that it's dark and I'm alone and I'm scared and I'm fearful, I would try to reframe that into okay, you are, but you are not alone, and I can handle this.

P3: And my impression is that I was… whatever decisions I made were from an inner guide.

In the relinquishing stage, the second property of the concept, *becoming separate from the experience* is *noticing*. *Noticing* refers to the change in the response as the participant focuses on a disturbing thought or memory. As a result of facing vulnerability, sensing feelings, changing feeling states and recognizing the self, less disturbance is being triggered. This allows the participant to notice the memory or thought of the experience without feeling like they are in it. Participants expressed this as follows:

P1: Because I can get distance on it, and it doesn’t feel like I’m in it any
more, you know.

P2: If I didn’t have that separation, I would have been caught in it and I would not have been able to move forward into my day. That is a very important piece of helping people to re-enter reality, …separating.

In the following section, the second stage of processing trauma, namely, *presencing*, will be discussed in relationship to the processing fields and the temporal perspectives (see Table 4).

**Presencing**

The presencing stage is reflected in the processing fields of the physical field (body), the cognitive field (mind), and transformative field (inner self). In the previous stage, the patients practiced separating from a minimally charged thought or memory to learn what their body and mind had done and can do with the memory. As a result, the patients experienced the beginning of the concept of being present for the past memory as a result of relinquishing the hold on or attachment to it. From the practice of relinquishing the attachment to the past memory, the patients acquired the ability to sense how the memory affected the body, the skill to name and describe the feeling being triggered, the capacity to transform an uncomfortable emotional state into a state of comfort, safety, and protection and the beginning of becoming separate from the experience. Consequently, the relinquishing stage acts as the preparation for the presencing stage.

In the presencing stage, the goal is to achieve and maintain the temporal perspective of the present while sensing the experience of a highly charged traumatic memory (target). This is accomplished by the shift of the temporal perspective from the past-in-present to present-in-past. Since past-in-present is interpreted as focusing the continued dominant experience of the past with the beginning of the present perspective,
it may seem that the goal of presencing could be completed in this temporal perspective order. However, in the presencing stage, completion occurs only when the dominant focus switches from the past experience to the present perspective of the past experience. Hence, the order of present-in-past denotes the momentum of transformation is being lead by the present perspective. The concept of the present leading the past is important to understand since the very introduction of the present perspective is what changes the perception of the past and in some ways can be seen as the present freeing the past from the entangled prison of misperception.

Since the process in this stage is freeing the perception of the target from the entangled prison of the past, the temporal perspective is primarily focused on achieving and maintaining a present perspective. Subsequently, when patients experience perception as freed from the past simply by being in the present perspective, it becomes plausible that they will be motivated and influenced to stay in the present perspective of any temporal experience (past, present, or future). This progression leads to the next stage of emerging.

Since the process of freeing the perception begins with the mind, the sequencing of the processing fields will be the cognitive field (mind), the physical field (body), and the transformative field (inner self). The following section reviews presencing in each processing field as past-in-past moves into present-in-past.
Table 4

**Presencing Stage**

<table>
<thead>
<tr>
<th>Processing field</th>
<th>Concept</th>
<th>Property</th>
<th>Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive field</td>
<td>Focusing as witness</td>
<td>Identifying the target</td>
<td>Sometimes I have to kinda be stopped and kept on track, and let’s just stick with what we’re doing now, and I guess I’m saying, it’s not that that’s not helpful, but that’s a more difficult thing, where I, I’m like “no, but in this moment I’ve changed, I changed, I changed my mind.” This is the thing that I feel like maybe I should be working through right now. Cause this is kinda big.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Directing self-beliefs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>So for me there was a definite taking the positive pieces we came to and setting those in place for me. And the words ‘permanent strengths’ were coming out of my mouth.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Shifting focus</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>I don’t know that I understood that enough. Nor do I know that if it were explained to me in great detail whether I would have heard it or understood… You know, back in those days, when I was doing EMDR, I had never, I had no body connection with myself at all (laughing)! I mean, you know, when people would say, ‘What does your body say?’ I would think, and ‘What are they talking about?’</td>
</tr>
<tr>
<td>Physical field</td>
<td>Focusing with the body</td>
<td>Activating focus</td>
<td>Very early childhood memories, uh, that I hadn’t thought about in a long time and some that I had thought about quite often, but didn’t seem nearly as disturbing as when they were really brought into focus…you got there in a much different, the route that you took to get to this point of this real sort of processing was much different in EMDR because things seem to pop out of nowhere. You know, I’d be thinking about an ice cream cone [chuckle] and the therapist would say, OK, stay with the ice cream cone, and then, you know, you’d go to the next sweep and then suddenly, wow, this whole thing about dad popped up out of nowhere</td>
</tr>
</tbody>
</table>

*(table continues)*
<table>
<thead>
<tr>
<th>Processing field (Body)</th>
<th>Concept</th>
<th>Property</th>
<th>Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical field</strong></td>
<td>Focusing with the body</td>
<td>Accelerating Processing</td>
<td>The actual EMDR part, I don’t know how long it took, but I mean it was such a short time that I went from one thing to the other I thought this is… but it happens that fast. So, yes it’s great… Because I can get distance on it, and it doesn’t feel like I’m in it any more, you know…it kept me a safe distance from what I was exploring. I felt like I was in the present, and, uh, I don’t even know if that makes sense.</td>
</tr>
<tr>
<td><strong>Anchoring in the present</strong></td>
<td></td>
<td></td>
<td>Because I can get distance on it, and it doesn’t feel like I’m in it any more, you know…it kept me a safe distance from what I was exploring. I felt like I was in the present, and, uh, I don’t even know if that makes sense.</td>
</tr>
<tr>
<td><strong>Desensitizing the target</strong></td>
<td></td>
<td></td>
<td>Drawing on a picture and doing the eye movements…that it did desensitize me. It made me realize, um, things about myself… It depersonalized it, uh, it took the edge off enough for me to get to reality, to get beyond that scene. But it was much more about the eye, the actual eye piece. And, I liked that, I remember, I remember the very first time doing it that I immediately felt a shift, that very first session that it worked well enough that I definitely felt a shift. And I felt like it was very effective for me.</td>
</tr>
<tr>
<td><strong>Listening to the body</strong></td>
<td></td>
<td></td>
<td>After these two particular sessions where I felt very discombobulated afterwards, and you know like I really needed to kind of go, I really felt like I needed to take a nap. Just kind of lay down, kind of decompress, for awhile. And I would say that that particular sensation can be a bit scary.</td>
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<tr>
<td><strong>Transformative field (Inner-Self)</strong></td>
<td>Changing perceptions</td>
<td>Experiencing the witness</td>
<td>In other words, what I perceived as the problem was making life difficult more than reality… Um, made it more clear, or more, uh, I came closest to the truth of what was really going on.</td>
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</tbody>
</table>
*Presencing stage: Cognitive field (mind).* In the cognitive field of the presencing stage, the goal is to shift the temporal perspective from the past to present perspective using the cognitive field (mind): Past Experience-in-Present Perspective → Present Perspective-in-Past Experience. Consequently, the patients will be in the process of refocusing and moving into the new temporal perspective of the present which requires the cognitive field of processing. This is accomplished by assuming the temporal perspective of the present (witness) while focusing on the target. Normally the position of present perspective might be considered only within the transformative field. However, it is the cognitive field that will lead the experience of presencing. Consequently, the concept for the cognitive field of the presencing stage is *focusing as witness*. The concept of *focusing as witness* includes the properties of *identifying the target, directing self-beliefs* and *shifting focus*.

In the presencing stage, the first property of the concept of *focusing as witness* is *identifying the target*. *Identifying the target* refers to choosing an image (target) that best represents the most distressing aspect of the trauma. Throughout this stage, the person is supported to stay in the temporal perspective of the present (witness). This is accomplished by maintaining the structure of the phases of EMDR and the focus on identifying the target which proved to not be an easy task. In this study, participants thought they knew the target; however, some cases reported that they had too many attachments to the target. This researcher found several references to participants’ degree of attachment to the target had a correlation to the level of commitment needed in taking the witness stance. For many participants, the urge to find cause and effect or talk about their reasoning was compelling. This urge is the impulse to stay in the past perspective of
the trauma rather than move to the new temporal perspective of the present. When identifying a target, some participants expressed how the structure and focus kept them in the present.

P1: And that you cut me off when I would start wandering down the road, which I wander down every single moment if possible…Uh, you weren’t interested at all in that. And, although at first I found it, uh, I was taken aback…I found that very, very, very, very helpful because it required that I become more…present. OK, without my mind, which is usually chattering away…I had to sit up, I had to pay more attention…I found that very significant and helpful. Because most people I don’t have to do that with…

P2: Uh, and it was structured. So that made it easier. Uh, the structure of the session. We do this and then we do that.

In the presencing stage, the second property of the concept, focusing as witness is directing self-beliefs. Directing self-beliefs refers to the next step in setting up the target for processing. At this time, the person chooses the negative self-beliefs that are triggered by the image of the target. This is followed by developing the alternate positive self-beliefs that the person would rather have and by rating how true the positive self-beliefs seem at that time. Usually the person reports that the positive self-beliefs are either not true at all or mostly untrue within the context of the target. It is at this time that the patients face the realization that they have self-discrepant beliefs about themselves.

According to Higgins (1987), a person has three self guides: actual self (who they are), ideal self (who they want to be), and ought-to self (who they believe they should be). When there is a discrepancy between the actual self and either the ideal self or ought-to self, the person will experience negative emotions. During this stage, patients realize there is a discrepancy between the self-guide (actual) related to the target and the self-
guide (ideal) they want to be. What emerged from the interviews was that the participants expressed being motivated by the realization of this discrepancy.

Consequently, the task of imagining the negative self-beliefs as positive self-beliefs within the context of the target requires the person step back or separate from the past perspective. This stepping back was first practiced in the relinquishing stage. Therefore, even though it stands to reason that attachment to the past perspective leads to the inability to change the negative self-beliefs, the ability to change focus in the previous stage of relinquishing compounded with the realization of self-discrepancy prepared patients for this level of processing. Therefore, directing self-beliefs facilitated the additional realization of choice for participants, thereby influencing and motivating the momentum to remain in the present. The following are some examples:

P1: So for me there was a definite taking the positive pieces we came to and setting those in place for me. And the words ‘permanent strengths’ were coming out of my mouth.

P2: As an integrating process, as a way of taking conflicting beliefs, uh, or confusing elements and having a chance to integrate them.

P3: and OK, now that we’ve done that, let’s do some eye movements. So for me there was a definite taking the positive pieces we came to and setting those in place for me. And the words ‘permanent strengths’ were coming out of my mouth.

P4: Uh, I think one side are negative self beliefs and the other side was sort of an affirmation statement that was more positive. Like if I would say I'm unlovable, the reframing or rephrasing of it would be: I am lovable. And, and I remember listing the negatives and the positives. Um, I remember intellectually being interested in how you could flip the negatives to positives.

In the presencing stage, the third property of the concept, focusing as witness is shifting focus. Shifting focus refers to the ability of patient to change the focus of their
sensing (feelings) from what they remember in the past to what comes up now as they focus on the target from the present temporal perspective.

Similar to the relinquishing stage of the cognitive field, changing feeling states much like shifting focus has an outcome related to the physical field. Yet, although shifting focus creates a different emotional and physical experience in the body, however, it is the mind that sets this transformation in motion. The capacity to shift focus on the past and sense what is happening in the body in the present prepares the patient to remain in the present temporal perspective for every stage of processing, especially for the next phase of bilateral stimulation.

As mentioned previously, most of the participants had long histories with “traditional [talk] therapy.” However, in the relinquishing stage, many participants expressed confusion and a lack of awareness regarding sensing feelings. At this stage, most participants thought they knew what they were feeling, but for many the same confusion arose when the target was a highly charged memory. Therefore, when asked, “Where do you feel the anger in your body?” or “The anger in my stomach feels like…?”, patients were lost until reminded of their experience with the minimally charged target in the relinquishing stage. Participants either remembered this difficulty or had difficulty remembering it at all:

P1: I don’t remember the feeling part…because I had a lot of trouble back then with feelings… And, I was just kind of just following along, and had, you know, in so much pain that I couldn’t even identify the pain, you know, I could be in pain and not even know it…

P2: I don’t know that I understood that enough. Nor do I know that if it were explained to me in great detail whether I would have heard it or understood…It is possible some beginning exercises could be done to allow someone to differentiate between a thinking answer and a feeling answer.
On the other hand, participants found that knowing the full dimension of their feelings led them to greater gains later. For example:

P1: Inside myself on a physical level, like where locations are of, um, experience, becomes, it creates an opening. It’s like an aperture. Can you believe I’m thinking about this as a camera. That’s so interesting.

*Presencing stage: physical field (body).* In the physical field of the presencing stage, the goal is focusing on the target by using the body. The primary mechanism to create and maintain the *temporal perspective* of the *present* in the *physical field* of the trauma is bilateral stimulation. However, within the bilateral stimulation several concepts emerged as important factors of using the body to focus on the target.

Bilateral stimulation may provide the movement that creates the evolving nature of the processing of the target. Evolution requires the movement of time and space and in this study, time is the temporal perspective and space is the processing field. In *focusing with the body*, the patient simultaneously witnesses the target, maintains awareness of the negative self-beliefs and the physical sensations being triggered, while attending to bilateral stimulation.

In the presencing stage of the body, the temporal perspective is in the present where past-in-present switches to present-in-past. Instead of viewing the resolutions and new perceptions of the past as creating a movement from past to present to future, the goal is that the past becomes one within the present and, therefore, within the future.
Consequently, it is the physical field that will lead the experience through the following properties of the concept of focusing with the body: activating focus, accelerating processing, anchoring in the present, desensitizing the target and listening to the body.

In the presencing stage, the first property of the concept, focusing with the body is activating focus. Activating focus refers to the process of intense focusing which results from simultaneously remaining in the present perspective (witness) and attending to bilateral stimulation while maintaining focus on the target, the negative self-beliefs and the physical sensations. Many participants reported a more intense degree of focusing due to the bilateral stimulation. As reviewed in chapter II, there are several theories that try to explain this activation of focus.

First, according to Rauch et al. (1996), as the patient relives the trauma the area of the brain that is activated is the right hemisphere, specifically the limbic system (emotion). At the same time the left hemisphere, specifically the left frontal cortex (cognition), is essentially turned off. However, Rasolkhani-Kalhorn and Harper (2006) research explains that bilateral stimulation induces low frequency stimulation found to depotentiate circuits in the limbic system. In addition, Levin et al. (1999) found that bilateral stimulation activates the left frontal cortex (cognition). Therefore, as the limbic system’s hyperarousal is diminished, the left frontal cortex is stimulated which activates the focusing.

Most of the participants expressed feeling an intensified focus that moved forward through processing, while some others expressed they did not. First, for some statements from participants who experienced processing with greater focus:
P1: Well, just, uh, the first thing that comes to mind is, is very early childhood memories, uh, that I hadn’t thought about in a long time and some that I had thought about quite often, but didn’t seem nearly as disturbing as when they were really brought into focus…you got there in a much different, the route that you took to get to this point of this real sort of processing was much different in EMDR because things seem to pop out of nowhere. You know, I’d be thinking about an ice cream cone [chuckle] and the therapist would say, OK, stay with the ice cream cone, and then, you know, you’d go to the next sweep and then suddenly, wow, this whole thing about dad popped up out of nowhere, where did that come from?

P2: It’s a way to focus and, um, sometimes I feel that things come up more readily while I’m focusing on it. And other times I feel like, um, or I would say almost at the same time I feel like things dissipate as I’m focusing.

P3: I know it fills, it fills your mind…I think you’re concentrating on movement of the eyes and the pictures…I think it stops all that pattern stuff, all the negative and focuses on this…And enable, enables your mind to work on this…It puts it in overtime…made it more clear, or more, uh, I came closest to the truth of what was really going on. I think what happens is, it’s almost as if…uh, that it’s like a flickering…although it’s not that…um, of your fingers, creates a physical and…[sigh]…it’s not like wa…wan…waving a magic wand…boy you’re going to have fun transcribing this thing, or someone is…[laughter]…waving a magic wand, but it’s almost as if it’s this fast shutter…

As the experience of activating focus occurred, some participants experienced the focus as overwhelming and difficult to deal with. This researcher accounts for this experience by proposing that the preceding stages were not adequately completed. The influence of completing the stages of relinquishing and presencing in all the processing fields is important to the preparedness of the patient. These participants made comments such as:

P1: Um, um, and, actually I got worse, by the way. Though it’s hard to know if that was the EMDR, or, or if that was this, this relapse, this PTSD relapse that I was going through… it’s hard to know which is which. I was more symptomatic when I was done with the process than at the beginning. But again, like I said, I was increasingly symptomatic at any case. So it’s hard to know which was which. I can tell you this for
example, that there were sessions I ‘d walk out of shaking and deeply frightened and much more agoraphobic than when I went in that morning.

In the presencing stage, the second property of the concept, focusing with the body is accelerating processing. Accelerating processing refers to the participants’ experience that the processing of the target is accomplished faster as a result of simultaneously remaining in the present temporal perspective and attending to bilateral stimulation while maintaining focus on the target, the negative self-beliefs and the physical sensations. Evidence for this experience was reviewed in chapter II. In summary, four studies produced significant improvement in different treatment conditions; however, EMDR was more efficient with less overall treatment, either because of less session time (Ironson et al., 2002; Rothbaum et al., 2005), less homework (Ironson et al., 2002; Lee et al., 2002) and/or no homework (Power et al., 2002; Rothbaum et al., 2005).

As mentioned throughout presencing stage of focusing with the body, the ability of the patient to remain present while witnessing the target image with bilateral stimulation allows this acceleration to be a positive experience. For example:

P1: The results were so profound and so quick… seemed to be much more integrated, much sooner than any kind of traditional therapy could have ever done…

P2: The actual EMDR part, I don’t know how long it took, but I mean it was such a short time that I went from one thing to the other I thought this is… but it happens that fast. So, yes it’s great…and it’s such a strange thing, that, um, it helps me to realize how much I had transferred onto my sweetheart, um, probably my anger and rage at my abusive husband. So separating the two, and getting which one is dead and which one is alive (laughing), um, I seem so clear after, you know, a little bit of time doing this

P3: Well, I don’t have to yell and scream and fall on the floor. Cause even talk therapy, if I talk for 50 minutes, I can just be emotionally traumatized.
And in the EMDR, you know, Robin sees a little piece of what’s going on and does EMDR with it, and it seems to resolve…And faster.

In the presencing stage, the third property of the concept focusing with the body is anchoring in the present. Anchoring in the present refers to the ability of the patient to simultaneously remain in the present perspective (witness) and attend to bilateral stimulation while maintaining focus on the target, the negative self-beliefs and the physical sensations. Within this concept of anchoring in the present (perspective), participants felt the experience of being in two separate places (temporal perspectives), in the picture experiencing the trauma but also outside the picture watching it. Participants expressed sensing feeling safe as a result of this separation and described the experience:

P1: felt safe, and all the, you know, the ugly stuff, ugly as it was, I wasn’t in it. It kept me in the moment and in the present. And I think that’s what made it so effective for me. It was being able to work through it and not be in the past… expect that while working through difficult subject matter with your therapist, you’ll be in the moment. It won’t be like you are reliving it, you don’t have to be afraid. It won’t feel the same.

P2: It was like I could see myself, I could hear the words that were being spoken, I could, but I wasn’t in that space of huge emotional trigger, and damage, all that stuff I felt when I first went into it.

P3: Because I can get distance on it, and it doesn’t feel like I’m in it any more, you know…it kept me a safe distance from what I was exploring. I felt like I was in the present, and, uh, I don’t even know if that makes sense.

In the presencing stage, the fourth property of the concept, focusing with the body is desensitizing the target. Desensitizing the target refers to the resolution of the target which results from simultaneously remaining in the present perspective (witness) and attending to bilateral stimulation while maintaining focus on the target, the negative self-beliefs and the physical sensations. Participants used words like, “disappeared,” “lifted,” “gone,” and “integrated” to describe the experience of resolution.
P1: And, so, coming to EMDR for, you know, post traumatic stress regarding 9/11, having certain things disappear as a part of my every day life is the end of the experience… Um, shocking…to my surprise, to my amazement, and in which case I would be...I am...a huge advocate of EMDR, um, working with you, that lifted in a very distinct and particular way. It was as if one day it was there and then it...because you and I worked on that...Uh, and specifically, this thing about the plane, the sound of airplanes, or overhead noises, you know helicopters, whatever, I live in a city where that’s, you know, generally I hear them a lot, and that immediately…that, that my reaction completely changed from my...experience......with EMDR. And that was very, very specific, and I’m surprised. because I really didn’t think it would happen. I didn’t think it would lift. And it lifted...things like, leave, go away...it has nothing to do with it...so things go away. That’s what was so remarkable about the planes… It, uh, it, it significantly changed, I mean I can’t emphasize enough how remarkable it was to no longer have a fear of, of something happening, and I just cannot tell you...

In addition, desensitizing the target increases healing without reliving the trauma. Greenwald (1994) notes, “The protocol [in EMDR] is essentially client-centered, facilitating the client’s self-directed healing process in a spontaneous, unpredictable manner” (p. 30). Accordingly, the participants’ experienced this self-directed healing, but without reliving the trauma during the treatment. As mentioned in the process of activating the focus, the de-arousal of the limbic system (emotion) coupled with the activation of the left frontal cortex (cognition) contributes to the experience of not reliving the trauma. In addition, Levin et al. (1999) reported activation of the anterior cingulate with bilateral stimulation which functions in distinguishing between real and perceived threat. Participants in this study described the experience this way:

P1: … drawing on a picture and doing the eye movements…that it did desensitize me. It made me realize, um, things about myself… It depersonalized it, uh, it took the edge off enough for me to get to reality, to get beyond that scene.

P2: the nervous system, the brain chemistry, whatever’s up there, and in our body, because it affects neurons all the way down to our toes
(laughing). Uh, it’s just incredible how it works. So there’s pathways that I don’t know what’s going on, but I like it.

P3: I saw it more from a standpoint that, like, almost like being able to use an eraser, having a painted memory, might be up there, and being able to erase the emotional component of that incident. Not the memory, but the emotional component.

In the presencing stage, the fifth property of the concept, focusing with the body is *listening to the body*. *Listening to the body* refers to timing the processing in a way that allows consideration for the response of the patient’s body. For the patient, listening to the body can be part of remaining present as the witness and participating in the flow of the process. Several participants spoke of issues related to listening to the body. Some said they experienced physical reactions to the processing which included being very tired or exhausted. Some described different physical symptoms and as a result requested supportive sessions between EMDR sessions. This study suggests that the ability to express these physical feelings and request pauses increased as the patient mastered presencing. Participants described these physical reactions and feelings as follows:

P1: There were certainly a couple sessions that were, uh, that I would describe as the most difficult… where I felt fairly exhausted, um, you know, emotionally and mentally afterwards, and my perception of those was that definitely something was different, something was, was changing. Just because of the, you know, because of the impact emotionally and physically as well.

P2: After these two particular sessions where I felt very discombobulated afterwards, and you know like I really needed to kind of go, I really felt like I needed to take a nap. Just kind of lay down, kind of decompress, for awhile. And I would say that that particular sensation can be a bit scary. Because usually when one feels that, uh, drained it’s after something that’s been more strenuous, whether it be physical or emotional, you know or both. And I think that there’s something in this process that has the same, for me anyway, that has the same effect without really, maybe, anticipating it. If that makes sense.
P3: You know, it does drain me, I feel very tired afterward and, um, it’s nice if I can come home… …and be quiet... maybe take a nap. Although sometimes, some things would come up that would be uncomfortable. I often had physical sensations, I remember that. I would often sweat or get red in the face or just feel very distressed.

Presencing stage: transformative field (inner-self). In the transformative field of the presencing stage, the goal is witnessing the emergence of changing perceptions of the trauma. Throughout the presencing stage, the focus with the body has evolved into witnessing the target free from the past perspective. In order to maintain presencing in the transformative field (inner self), the present temporal perspective (witness) is maintained and the concept of changing perception evolves. Changing perception represents not only the changing perceptions of the target and the transformation of the trauma but also of the self. Consequently, changing perception denotes the realization that the person is in the present perspective as being outside the experience looking on, witnessing. This realization is the beginning of transforming suffering and changes in perception. Some participants described the changing perception as:

P1: Authenticity, that was a part, authenticity, um, it’s difficult to be authentic when there are so many parts all acting out at once, all acting, or all speaking, all calling for attention. Well, I’m definitely in charge of my life now, and I’m a lot happier. Um, part of the end result, during being a sit-down comedian, and I really don’t care any more whether my eccentric ideas are not received well by some people because they are always received well by somebody, (laugh)

In the presencing stage, the property of the concept, changing perception is experiencing the witness. Experiencing the witness represents the participant’s experience of not only the separateness or distance from the target but also the presence of the witness. This property of changing perception accounts for the most dramatic part of the theory, as the participant reports moving from experiencing the trauma to noticing or
witnessing the trauma. The outcome of presencing in the transformative field is decreased arousal, increased safety, and increased strength as well as a connection to a higher self:

P1: through something, whatever it was specific to…with confidence, knowing that I can get myself from A to B to C to D, without…that I can get myself there, get through there…

P2: In other words, what I perceived as the problem was making life difficult more than reality… Um, made it more clear, or more, uh, I came closest to the truth of what was really going on.

In the following section, the third stage of processing trauma; namely, emerging, will be discussed in relationship to the processing fields and the temporal perspectives (see Table 5).

**Emerging**

The emerging stage is also reflected in the physical field (body), cognitive field (mind) and transformative field (inner-self). As seen in the stage of presencing, the participants reported many indicators of practicing, constructing and maintaining the temporal perspective of the present through presencing with the body, mind and inner-self. In this stage, the goal is to support the patient to embrace what is emerging from the place of the inner-self. The changes may present as new perceptions, clarity of vision, sense of freedom, and release from pain or conflict which had been experienced for a long time. Also, the sense of e(energy)-merging creates a feeling of openness and sometimes timelessness, freeing the person to harness the power of the senses and use them to be in and maintain a higher state of consciousness in the temporal present perspective.
The temporal perspective of this stage is the expansion and e-merging of present perspective-in-past experience with present perspective-in-present experience with present perspective-in-future experience.

Table 5

<table>
<thead>
<tr>
<th>Processing field</th>
<th>Concept</th>
<th>Property</th>
<th>Quote</th>
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<tbody>
<tr>
<td>Physical field (Body)</td>
<td>Freedom from suffering</td>
<td>Peace in body</td>
<td>It does last, and gives me a feeling, a relief. I, I don’t know if I can quantify and say for how long, because it all seems to be a cumulative effect as long as I’m having consistent sessions … Well, I think I mentioned that, um, my mood improves, I’m less depressed, um, I seem to, uh, you know have a, an easier, lighter sense of being… Um, less stress, less anxiety, happier.</td>
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<tr>
<td>Cognitive field (Mind)</td>
<td>Acknowledging the knower</td>
<td>Experience the knower</td>
<td>But bottom line was there was a sense of greater self knowledge, much greater self knowledge. And that’s very difficult to put into words. That’s not just some kind of cognitive thing, it’s that too, it’s more of uh, uh, not in words inner experience. Not in words friendly inner experience basically.</td>
</tr>
<tr>
<td>Transformative field (Inner-Self)</td>
<td>Merging energies</td>
<td>Higher consciousness</td>
<td>There was a higher goal, a higher consciousness that would be uh, the goal was not just to take whatever’s there and, uh, resolve the conflict, but to uh, move toward more self-esteem and more self-uh-evolution, more evolution of my own consciousness, and that’s what I tell people, if you’re having…if you don’t know what to do, then do EMDR and you will discover within in you the right path for yourself. A better life basically.</td>
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**Emerging stage: Physical field (body).** In the physical field of the emerging stage, the goal is to emerge from the suffering and embrace the transformation of peace in the body. Suffering prior to the transformation was expressed as emotional and physical pain,
stress, depression or anxiety. The resultant freedom from suffering becomes the concept for the emerging stage with peace in the body as the property. Participants expressed this experience:

P 1: But up to this day I still haven’t, I mean, I can still see the whole, I can bring up the whole thing in my mind, but it’s not painful. I felt as though it was very, you know, I was just, I just felt thank God I don’t have to feel this anymore.

P2: Well, most helpful, after just a few sessions, it seems like I really came to terms with this. I mean it still hurts that I lost that piece of my life that I loved, but I went on, and I found other things I love to replace it, and I don’t cry about it any more when I talk about it. It’s more like a beautiful memory now.

P3: It does last, and gives me a feeling, a relief. I, I don’t know if I can quantify and say for how long, because it all seems to be a cumulative effect as long as I’m having consistent sessions … Well, I think I mentioned that, um, my mood improves, I’m less depressed, um, I seem to, uh, you know have a, an easier, lighter sense of being… Um, less stress, less anxiety, happier.

Emerging stage: Cognitive field (mind). In the cognitive field of the emerging stage, the goal is to emerge from the entanglement of the mind and embrace the transformation to knowing. Consequently, the concept for the cognitive field of the emerging stage is acknowledging the knower. The property of acknowledging the knower is experiencing the knower. Participants expressed this in the following:

P1: I would want to say that the goal of making clear decisions is not so much what I achieved as knowing that I have the power to make decisions, or the power to execute them.

P2: But bottom line was there was a sense of greater self knowledge, much greater self knowledge. And that’s very difficult to put into words. That’s not just some kind of cognitive thing, it’s that too, it’s more of uh, uh, not in words inner experience. Not in words friendly inner experience basically.
Emerging stage: transformative field (inner-self). In the transformative field of the emerging stage, the goal is to emerge into the state of higher consciousness and freedom from the past. It is within this stage that the temporal perspective of past, present and future and processing fields of body, mind and inner-self merge. With the culmination of these energies merging, participants have reported a sense of an inner experience, coming from within. Consequently, the concept for the transformative field of emerging is emerging energies. The property of emerging energies is higher consciousness. Therefore, the participants experienced the freedom from the past perspective as a state of higher consciousness.

P1: There was a higher goal, a higher consciousness that would be uh, the goal was not just to take whatever’s there and, uh, resolve the conflict, but to uh, move toward more self-esteem and more self-uh-evolution, more evolution of my own consciousness, and that’s what I tell people, if you’re having…if you don’t know what to do, then do EMDR and you will discover within in you the right path for yourself. A better life basically.

Summary

In summary, this chapter focused on what 15 interviewees had to say about what it was like to experience eye movement desensitization and reprocessing as a psychotherapeutic method. This researcher did not align the stages of the substantive theory with those of the EMDR approach; however, it is important to note that all the stages the participants refer to are contained within the eight stages of the EMDR approach.

Each of the participants had traumatic histories and they were seeking to resolve their traumatic experience and/or the associated symptoms/behaviors. All the participants, except one experienced resolution of the traumatic experience. This
participant expressed having worsening symptoms and served as a reminder of what can happen when the stages leading up to bilateral stimulation are not completed.

From the beginning of transforming suffering: changes in perception using EMDR, participants moved through the three stages of processing: relinquishing, presencing, and emerging. Each stage contained processes with a conceptual framework to guide practice. The properties of each concept enrich the substantive theory with specific ways of achieving the transformation of suffering and changes in perception. This realization only further intensified with the words of the participants who were there and who were healed.
CHAPTER V

DISCUSSION

The substantive theory generated from this study is titled: *transforming suffering: changes in perception using EMDR*. The discussion of how this theory was discovered from the data will reflect the progression from codes to categories with the resultant one core category/basic social psychological process.

**Transforming Suffering: Changes in Perception Using EMDR**

Several attempts were made toward coding before this researcher could avoid the attraction to fit any pre-conceived knowledge of EMDR. Three precipitating factors served as obstacles to this goal. First, this researcher has provided EMDR to hundreds of patients in private practice for almost two decades; second, this researcher has participated in EMDR trainings and consultations for several years; and, third, this researcher has avidly read most of the literature in EMDR since it was introduced.

The beginning efforts at coding resulted in labeling codes with the phase of EMDR that this researcher thought correlated with what the participant was expressing. Another attempt resulted in delineating responses into codes such as pro-EMDR and con-EMDR or helpful and non-helpful. It became evident that this researcher had to relinquish the attachment to past knowledge of EMDR and be open to what the participants experienced. Hence, coding for the patterns of their experience commenced and resultant codes and memos such as “can get distance on it,” “creates an opening through the physical level” or “attachment to the past” emerged.

As categories emerged, patterns were compared until one category subsumed the other relevant categories. Such categories were “separating from the experience,”
“evoking temporal duality,” and “tri-zonal processing.” Although these categories spoke to one or two aspects of what was being experienced, none told the whole story that the participants were revealing. After continued constant comparison, three patterns kept re-occurring: time, when participants expressed being “in the present while going to the past”; location, where participants expressed different sensations within their body related to processing; and stages, where participants described temporal changes which ranged from not knowing what to expect to not knowing what they were feeling to sudden switches in their perception and their sense of present and past.

Heath and Cowley (2004) indicate that as these patterns and categories are revealed, they are deducted and verified through comparison to the data and other categories that are already saturated. Then the remaining categories are refitted according to existing literature, and concepts are derived. Therefore, the concept of temporal perspectives will be discussed and compared to existing literature in the following section.

**Temporal Perspectives**

According to Slife (1995), “the lived dimensions of space are an important aspect of world, but the lived dimensions of time are also vital to this network of meaning relations” (p. 543). Slife reviews the preponderance of the familiar notion that the three dimensions of time (past, present, and future) occur in a sequence of one continuous flow. In this linear view, the past, present and future are sequential with the present separating the past and the future. Therefore, the present cannot exist in the past and the past cannot exist in the present. The implications of this linear view of time presented
problems with what the participants had expressed about being “in the present while going to the past.”

Heidegger (1962) presents another view of time. Time does not have separate dimensions, is not linearly sequential but is both sequential and simultaneous. The implications of simultaneity of time fit the data from the participants as well as agreed with the understanding known to traumatologists. That understanding being that past trauma is considered to live on in various emotional and physical permutations within the person’s present perception of oneself and the world. Therefore, in order to change the present, the perception of the past must be changed. However, in this study, participants kept referring to being in both the present and the past at the same time. It is this very point of temporal simultaneity that led to the naming of this dimension of processing: *temporal perspectives*. It also raises the question, is it the processing in two *temporal perspectives* that enables the acceleration of processing?

**The Nature of Change in Processing**

Hayes et al. (2007) state, “A common assumption in psychotherapy research is that change is gradual and linear” (p. 715). Within this study the process of change showed no pattern of being gradual or linear. Often participants reported such rapid changes that they needed to pause, rest, or take a nap. Important indicators of change pointed to the acquisition of both temporal and field sequentiality and synchronicity. However, the sequential and synchronic nature of psychological change is in its infancy, and at the very least, is multivariate. In this study, changes in the temporal perspectives during the processing of trauma indicated not only the synchronic dual states of time as determinants of greatest movement toward resolution, but suggest that being grounded in
the moment (presencing) leads to clarity, peace, and knowledge. Similar indicators of change resulted in processing fields. Progression toward resolution was not suggested as continuous or linear. Participants reported moving from their heads to their bodies for the first time. Several shared greater, more rapid progression toward resolution in the physical field as opposed to the cognitive field. Therefore, determinants of psychological change may be correlated to the location of processing (field/s). This study suggests that the processing field that yields the greatest degree of being unaffected by internal and external stressors is the transformative field (inner-self). Bishop et al. (2004) discuss a similar field of processing when the authors describe mindfulness, “mindfulness meditation involves observation of constantly changing internal and external stimuli as they arise” (p. 238). The authors explain a two-component model that includes self-regulation of attention and orientation to experience. Both components have a striking resemblance to relinquishing and presencing since self-regulation is the ability to maintain a state of sustained attention and orientation to experience is noticing and, therefore, accepting.

**Lack of Linearity and Discontinuity of Change**

The lack of linearity and discontinuity of change is reviewed in other therapies. Hayes et al. (2007) discuss their research on symptom change and positive growth with EBCT (exposure-based cognitive therapy) in the treatment of depression. Much like the staging of EMDR, there are three phases in EBCT. A stress management phase precedes the exposure-activation phase followed by the consolidation and positive growth phase. Hayes et al. also report an early decrease in depression during the stress management phase, followed by a period of increased disturbance during the exposure-activation
phase (depression spikes) with a subsequent decrease in the consolidation and positive growth phase. Depression spikes were determined by the assessment of depression and by coded narratives written each week by patients about their depression. Hayes et al. state that “the exposure-activation phase of EBCT was disturbing in that 62% of the sample experienced at least one period of transient symptom exacerbation (depression spike) and some as many as 3 spikes” (p. 418).

Similar results were expressed by participants during the presencing stage where participants began to process trauma. However, the difference lies in the symptoms. Participants in this study reported increased physical symptoms as opposed to exacerbation of depression, anxiety, etc. Another difference was that participants equated these symptoms to the depth of emotional and physical work and progression. In addition, participants in this study reported successful use of the resources to stabilize any disturbances. This researcher postulates that this lack of gradual linear change leads to the need for other measures of change during processing. This study implicates the development of measures of temporal perspectives and processing fields pre-during-and-post processing. Further discussion of the processing fields and how they relate to change during processing follow in the next section.

**Processing Fields**

Another re-occurring pattern that emerged from the participants was the felt location within their body during processing the trauma with EMDR. Two dimensions of space (locations of processing) were labeled directly from the data: *physical field (body)* and *cognitive field (mind)*. However, although participants had used words like “inner-self” or “inner journey” or “higher consciousness,” there was no mention of the location.
In reviewing the literature, especially physics and Eastern philosophy, there is no set place for the inner-self experience. While it is true that several references were of the solar plexus, the spot between the eyebrows or the heart, there was no agreed upon place where the inner experience occurred. Govinda (1976) explains that when one attains the state of higher consciousness, there is an awareness of all the elements of time and space simultaneously. In essence, there is no one time or space and, therefore, this researcher labeled the inner-self experience as being in the transformative field.

Govinda (1976) also discusses time and space and connects time-feeling with the movement of the mind and space-feeling with the movement of the body. This implication fits two patterns occurring in the data: first, delineating the sense of feeling space and time (body and mind) was an important dimension of processing and equally important to the stages of the core category, and second, movement was essential to feeling change or evoking change. The movement in this study was bilateral stimulation.

**Stages of Transformation**

**Relinquishing**

The stages of transformation were derived from the data as patterns of change during the EMDR processing. Participants reported being distant or separate from the trauma. This was followed with the expression of safety and not reliving the experience. This led the researcher to “separation from the experience” as a core category; however this category did not account for other indicators of change taking place during processing. Then it became obvious that “separation from the experience” was actually the first stage of transformation within the core category. The term *relinquishing* was chosen due to meanings such as “letting go,” “releasing the hold on” or “attachment to.”
This term had better fit and relevance, especially since separation from the experience can be misinterpreted as avoidance, denial, or inability to cope.

*Presencing*

The next stage, *presencing*, developed from combining the two words “present” and “sensing.” The pattern of being present re-occurred repeatedly, and participants described that being present allowed increased focus and sensitivity to the images of the target. This writer researched the term, *presencing*, and found that it is widely used. There are websites, books and retreats on *presencing*.

Of special interest to this researcher was Theory U developed by Otto Scharmer (2007). The theory U is used to enhance leadership and decision-making. Within the theory there are several concepts of: seeing, sensing, presencing, crystallizing, prototyping and performing. They contain the properties: suspending, deep dive, letting go, letting come, enacting, and embodying. Presencing points out the blind spot in leadership and social experience and becomes a center point of the theory.

In this study, the concept of *presencing* was not an easy task for participants. Another term used in the literature similar to presencing is grounding. When a person is grounded in the self or from within, it implies that he or she can remain witness to what is going on around them. As seen in the stage of *presencing* in the physical field, there are many properties that the participants point out as assisting them to maintain being present and sensing. Some of these are shifting focus, activation of focus, acceleration of focus, anchoring in the present, desensitizing the target, and listening to the body.
Emerging

In this stage, as reviewed earlier, participants reported “inner self,” “inner journey,” and “higher consciousness.” In addition, participants reported the experience of changing perceptions, freedom from pain, release and relief from suffering and sudden shift of clarity or peace. This researcher labeled this stage e-merging to capture the essence of e(energy)-merging and to capture the emergence of not only the changes in perception within each dimension of processing but also the changes in perception of self.

Implications for Nursing Practice

According to McCabe (2004), there are few nursing publications that describe or support EMDR. McCabe cautions nursing to “approach EMDR with a degree of caution until more rigorous conclusive models of action are developed and more stringent empirical establishment of efficacy occurs” (p. 111). As reviewed in chapter II, stringent empirical efficacy has been established. McCabe also states that the decision of nursing is “to use or reject EMDR as a clinically meaningful treatment modality . . . based within the science of our profession” (p. 111). This grounded theory study serves as a response for McCabe’s request for more rigorous models of action and more stringent establishment of efficacy based within the science of the nursing profession.

The substantive theory of transforming suffering: changes in perception using EMDR has several implications for nursing. The three subcategories are the stages of transforming suffering, namely, relinquishing, presencing and emerging. The three stages of transformation from suffering contain the two dimensions of sequencing of time (temporal perspective) and space (processing fields) that can be utilized in the assessment of any patient’s readiness to move forward in processing trauma. These dimensions of
processing also provide concepts and properties to assess progress toward not the change in perception of the trauma but the change in perception of self. These dimensions of processing will be discussed in the following section.

Temporal Perspectives

Temporal perspective is more than whether the patient is in the past, present, or future. As a result of this study, it became clear that efficiency in processing trauma relates to whether the patient can engage in presencing. In order for the patient to be prepared for presencing, the stage of relinquishing must be complete. Their hold on and attachment to the trauma should be minimized prior to presencing. Consequently, the patient is able to take the temporal perspective of the present as they proceed in processing the trauma. This ability to take the witness stance as desensitization (bilateral stimulation) proceeds while the patient watches the target reduces the risk of the patient feeling revictimized or reliving the trauma. The shift that many of the participants expressed may happen at the point where the past trauma dissolves into the present temporal perspective. This is the point where participants expressed clarity, changing perceptions, and peace. It is at this point in temporal perspective that the patient experiencing e(energy)-merging where the past, present, and future are merged and the inner-self is invoked accompanied by the emergence of knowledge.

Hence, knowledge related to assessing the patient’s temporal perspective, enhancing presencing through the properties found in this study and using bilateral stimulation to process trauma efficiently and effectively are just some of the implications for nursing in treating PTSD/DESNOS.
**Processing Fields**

*Processing fields* are the *physical field (body), cognitive field (mind)* and *transformative field (inner-self)*. Much of nursing literature and theory contains the body and the mind in the process of healing and assessment of recovery. However, in comparison, there are considerably fewer references to using the *inner-self* in the process of healing or the assessment of recovery. A quick key words search of “nursing literature” with “body” equaled 230,000 returns, with “mind” equaled 208,000 returns and with “inner-self” equaled 2,720 returns. Perhaps this result reflects the difficulty with a subject that is intangible and therefore difficult to document; or perhaps the number of people who know and maintain inner-self practices are as low as was found in the comparison. Out of curiosity, this researcher put in a search for “nursing literature” with “spiritual” equaling 132,000 returns. After completing a random check on many of the results, “spiritual” was more often than not associated with religion, moral standards, and ethical concerns. Therefore, another implication for nursing is that healing from suffering will include the measurement of the person’s field of *inner-self* in the *temporal perspective* of the *present*.

As noted previously, there is value in the patient gaining the skills in *temporal perspective* and *field positioning*. Usually when clinicians teach patients skills such as relaxation, power stances, and positive introjects, it is to help a patient reduce anxiety and learn affect regulation. This study suggests that these skills can accomplish more than that; these skills can prepare the patients to learn the ability to change their *temporal perspective* by positioning in the *present* as they go to the *past* as *witnessing*. This also pertains to the patient learning to include their *body, mind, and inner-self* into their
awareness so that too much emphasis on one field does not blind them to moving forward. In other words, presencing and witnessing both add another dimension to how patients experience being in the world. After EMDR, it is not only the doer who is present; now there is the witness of the doer. Many participants alluded to this kind of experience with words such as “higher consciousness,” “friendly inner experience,” and “self-evolution.”

With the exception of focusing with the body, each concept can be used individually or sequentially to promote temporal perspective and field changes. It is within the concept of focusing with the body that bilateral stimulation is introduced. This is the desensitization phase of EMDR approach and cannot begin until the patient has completed the phases that precede it.

In the study, there was saturation of participants’ responses such as “miraculous,” “amazing,” “very effective,” and “unbelievable” about the experience during and after this phase. Those responses suggest that bilateral stimulation/focusing with the body may carry the deepest implications for practice since this stage is where many patients felt the switch of the past dissolving into the present perspective and emersion into the inner-self.

In the study, one participant experienced worsening of symptoms. When asked what would have helped, he responded that it would have helped if his therapist could have done something to get him back into the present and out of the trauma experience. This response further corroborates the need to follow the EMDR phases of treatment. The skills preceding desensitization would have benefited the patient at the end of the session because he would have already learned about affect regulation, presencing, and witnessing the trauma. In desiring help to get out of the traumatic experience and back to
the present, the patient insinuates that he did not experience any level of being present as witness. The key implication for the practice of EMDR approach, then, is to use the eight phases of EMDR in a way that achieves these goals. The results of this grounded theory have several implications for practice, but the core category of changes in perception provides significance and meaning to the concepts that are subsumed in the substantive theory.

**Limitations of the Study**

The following are the limitations of this study:

1. Inclusion criteria did not account for how long ago the participant had ceased treatment with EMDR approach. Therefore, some of the participants had difficulty remembering more than others.

2. Taped interviews were transcribed by this researcher and checked several times; however, no one else verified the accuracy.

3. This researcher had many years of using EMDR in private practice as well as a consultant and trainer in EMDR. How this might bias any interpretation of the data may be suspect. On the other hand, understanding the material without need for translation of terms may outweigh any bias or lack of objectivity.

4. The failure of the researcher to change the interview questions based on emerging categories may have hampered the ability to fully understand the category and reach saturation.

5. Further questions related to the stages and processes could be refined for a more complete view of the processing of trauma.
6. Most of the participants had past history of other therapies. The addition of questions related to processing in EMDR compared to the participant’s experience with other therapies could have enriched the data.

7. This researcher was not measuring processing as it occurred but actual transcripts of the researcher’s retrospective interviews of participants.

**Recommendations for Future Research**

Transforming suffering: changes in perception using EMDR represent an expanding conceptualization for future research. As discussed in chapter I, the availability of quality treatment of traumatic experiences is a vital need around the world. Increasing the efficiency and effectiveness of treatment is a universal goal for health care. Since the basic social psychological process of transforming suffering: changes in perception using EMDR refers to the quality of treatment, this researcher offers the following recommendations for future study:

1. Develop theoretical sampling questions to analyze the stages of transformation, such as open-ended questions as to whether the participant experienced being in the present while processing a past or future trauma, and, if so, when and what impact did this temporal duality have on progression?

2. Further study on how much effect the two dimensions of processing had on changing perceptions. This may include comparing which combinations of *temporal perspective* (past, present, and future) and processing fields (body, mind, and inner-self) during each stage of processing (*relinquishing*, *presencing*, and *emerging*) are more efficient and effective in transforming suffering.
3. In order to compare different temporal perspectives and processing fields, an instrument to measure both these dimensions of processing would need to be developed.

4. Examine if combining different temporal perspectives and processing fields accelerates resolution with or without bilateral stimulation through randomized trials.

5. Engage in a follow-up study to examine whether patients have maintained the skills learned during EMDR related to temporal perspective choice, field choice and the stages.

6. Further research to give the therapists’ perspective and answers to important questions about processing.

7. Determine whether any of these process recommendations and experience with EMDR varies with individuals from other countries and cultures.

**Summary**

In this chapter, the results of the grounded theory study and what is it like to experience EMDR as a psychotherapeutic approach are discussed. The BSPP/core category, transforming suffering: changes in perception using EMDR, and the three subcategories of *relinquishing*, *presencing* and *emerging* are reviewed with the inclusion of concepts and properties.

The dimensional quality of processing in EMDR approach, the sequential and simultaneous significance of time (*temporal perspective*) and space (*processing fields*) as well as constructing and maintaining presencing (grounding) while processing trauma are also discussed. The researcher recommends that nursing science and practice embrace these concepts as well as engage the EMDR approach as a resource for treating patients suffering trauma.
The chapter discusses implications for nursing practice related to the value of using the concepts derived from transforming suffering: changes in perception using EMDR to improve the assessment, treatment, and continued stability of those suffering from trauma. Finally, recommendations for future research are offered to increase the understanding of how the concepts may improve and enhance the assessment, treatment, and continued stability for those suffering from trauma.
REFERENCES


APPENDIX A

INFORMED CONSENT

Project Title: What is it Like to Experience Eye Movement Desensitization and Reprocessing (EMDR) as a Therapeutic Process?

The purpose of this study is to understand the individual’s experience while participating in EMDR. I would like you to tell me your experience of the EMDR process in therapy. I am asking you to participate in an interview that will last approximately 60 minutes and I would like to audiotape our interview. The interview will take place at the office of Celia Naccarato, CS, ARNP or on the telephone at a time convenient to both of us. I may also contact you as a follow-up to ask you a few more questions about your experiences. This second interview will last 10-15 minutes and I would also like to audiotape this interview.

You will be asked questions about your feelings and behaviors related to your experience of the EMDR process. Some of the questions may discuss issues that might make you feel uncomfortable or cause you stress. Your participation in this study is voluntary. You are free to withdraw from the study at any time without any negative consequences, and you may skip any questions you do not want to answer. If you become distressed during the study, a referral will be provided to you.

The recorded interview will be transcribed. The investigators and their assistants will consider your records confidential to the extent permitted by law. All interviews will be coded and no names will be used. Once the study is completed, the tapes will be destroyed. Your records may also be reviewed for audit purposes by authorized University of Miami employees, The Department of Health and Human Services (DHHS), or other agents who must follow the same rules of confidentiality. You will receive a copy of this consent form.

You may ask and will receive answers to any questions during the course of the study. If you have any questions about this study, please contact Dr. Lee Schmidt at (305) 284-1525 or Celia Naccarato at (631) 907-8681. If you have questions about your rights as a research participant you may contact Maria Arnold, Director of the Human Subjects Research Office, at (305) 243-3195.

Participant’s Signature ______________________ Date ____________

Person Obtaining Consent ______________________ Date ____________

Print Name: Person Obtaining Consent ______________________ Date ____________

I.R.B.
APPROVAL DATE: 11/18/04
EXP. DATE: 10/12/05
INITIALS: KEC
APPENDIX B

SEMI-STRUCTURED INTERVIEW GUIDE

Semi-Structured Interview Guide

Introduction: My name is Celia Naccarato and I am a PhD student at the University of Miami. As you know, since you have experienced EMDR (Eye Movement Desensitization and Reprocessing) as a therapeutic process I would like to ask you some questions related to your experience. Are you ready to begin?

Questions:

1. What brought you to EMDR therapy?
2. What was it like to experience EMDR for the first time?
3. Having experienced EMDR, what did you find most helpful?
4. What did you find least helpful?
5. What were your impressions after you completed EMDR therapy?
6. What things would you tell others about the EMDR approach?
7. Is there anything you would like to add that I didn’t ask?
APPENDIX C

INTERVIEW #1

EMDR Study

R: So the first question I have is what brought you to EMDR?

P: I, over the years, I’ve been in therapy for many years, actually. Oh, good lord, I started, in um. (faded out) And um what I had over the years at times were symptoms of depression, uh, feelings of unreality, and then eventually very, very very severe panic attacks. Uh, and I worked through a number of different clinicians, uh, um, and, uh, got myself to the point of doing, pretty much Ok with it, uh, uh the panic attacks are the thing I kind of ended up with. The, the, that became in time the dominant evidence of that. And it related to agoraphobia. And I used um, desensitization for years, and, uh, made major progress…went to XXX got my MSW, uh, uh, driving all over the place on the highway. After a while I began to relapse. And I wasn’t quite sure what to do. And, I had come into contact with EMDR as a result of getting my MSW, and working um, um in family services.

R: Can I just interrupt one second?

P: Yes.

R: For those who may not know, what do you mean by you used desensitization with success?

P: Well, what that means is, you grit your teeth and you just get out there, and bit by bit by bit in a partialized way you proceed to go to places and do things you normally would not do…and, uh,

R: That is like exposure…

P: It is exposure therapy, yes…

R: OK.

P: The problem with it is, is that you can relapse profoundly and very rapidly. One time I was walking in Mashomack forest, which is a 2,000-and some odd acre nature preserve on Shelter Island, and uh, I was, it was a three-mile walk, and I was as far as I could get on a three mile walk, and bang, I had a major panic attack. I was out of it. um, um, And I had techniques I used, for years, and I did obviously. Uh, uh, but what that meant was you get this truncated reality. Next time I went back to walk in Mashomack, I couldn’t walk as far. And the next time I couldn’t walk as far, still further. And next time I couldn’t go at all. It’s classic stuff, it’s it’s… so all the gains I’d made in the initial
process of ever walking in the Mashomack to begin with, was you start a little bit and you
do a little more, you do a little more, uh, uh, one panic attack wiped that out. So that I
thought …I figured, this, this….I don’t like these losses. And I don’t like giving up what
I, what I, such work and re-obtaining. So I thought maybe EMDR will help me with that.

R: What was it like to experience EMDR?

P: I don’t know. I mean, it, I wasn’t, I mean, I knew…I knew about the technique. I’d
been through level one EMDR training, basically. And, um, also I heard, we’d been
through some supervision related to that training, that family services organized. Plus,
being in the business you hear anecdotes and stuff, about, about people’s successes and
failures and stuff with various clients. Uh, so it wasn’t like totally unfamiliar to me. The
initial sessions with, with, it was Dr. XXX by the way, the initial sessions were trying to
lay out what my symptoms were, and uh, uh, how they related to history of PTSD,
basically. Um, um and then how possibly to use EMDR in a way that might be effective
to moderate or make those symptoms (faded out). I mean that’s really where my focus
was. Um, later, um, as I went through the EMDR process, I discovered a number of
things. I mean, that I didn’t know at the time. It took awhile for the smoke to clear. Also
you shouldn’t... I did probably delve, maybe 15 sessions, basically, not all of them were
actual EMDR, some were talking sessions. The bulk of them involved, or at least half the
sessions doing EMDR, and those sessions were an hour and a half in length.

R: OK…good….

P: Um, um, and, actually I got worse, by the way. Though it’s hard to know if that was
the EMDR, or, or if that was this, this relapse, this PTSD relapse that I was going
through... it’s hard to know which is which

R: Right. Uh, when you say you got worse, did you get worse after actually doing the
stages of EMDR, or later when you did the actual eye movements.

P: Later, actual eye movements.

R: When you say you got worse, what do you mean?

P: I was more symptomatic when I was done with the process than at the beginning. But
again, like I said, I was increasingly symptomatic at any case. So it’s hard to know which
was which. I can tell you this for example, that there were sessions I ‘d walk out of
shaking and deeply frightened and much more agoraphobic than when I went in that
morning.

R: OK, Ok, that’s good to know. Do you have any ideas or, did you at that time,
what would you say about that experience?
P: Reaction you mean? What I, what I, to fill you in a little bit …One of the things that I think from childhood, neglectful mother, antisocial older sibling, only older sibling, uh, uh, very violent toward me, in my extreme youth as an infant and a little older, and amazingly I still have memories of. And, un, um, what we decided to do with the EMDR is to focus in on those memories and then do the process and see if they would ameliorate them, or if it would change them in some way. And, uh, uh and I, I, ahhh, sigh. I’m not sure where I should go from here.

R: Whatever you want to say…

P: OK. Um, only once during the actual EMDR process, for the older memories, as opposed to new ones… uh, uh, was I aware of like, the recovery of affect. One things that was true about these memories was that they were visual, totally visual, and there was no affect with them at all, basically. They were sheered of their affect. And, uh, during one of the EMDR sessions, a piece of affect returned. And, uh, Ben kind of, it’s hard to put words into what happened…(laughing)

R: And what happened when the affect returned? What did he do, what did you do?

P: He said… he identified it. I was aware that something was going on. He said oh, look at that, it looks like affect is returning. And I said, yeah, I think so. Cause this thing sort of came to me, almost a visual thing or appearance that came at me, and uh, uh, this is very hard to put into words…

R: Did anything help you at that moment, with the affect?

P: Well, it wasn’t threatening.

R: It wasn’t?

P: No, no not at all. It was just simply, like a stone regaining its affect, basically. That part wasn’t frightening. What I had trouble with, as I’d leave the session and drive from Riverhead to here which is (location omitted), I would at times, often times be shaky, truly frightened. I even started trying to find less threatening roads, that process, it was a classic agoraphobic aversion, basically.

R: Sure. So the next question we run into is having experienced the EMDR method, what did you find helpful?

P: Certainly being able to talk openly about my symptoms…in the strict, in the really pure and in the strict context, that being symptoms of PTSD, though I had done that before in therapy, it was still useful, very useful. Um, when it was all over, when I ended, when we decided to end it, and again, I was increasingly symptomatic, and I still felt that the effort had been worth it, in that, in that um, things had moved around, in other words, I was different. A little bit freer, maybe all in all, a little bit less frightened. That sense that I think people with, with, with panic disorder have, and PTSD, that part of their
experience is uninhabitable, it’s truly toxic. I, I do not feel that anymore. I still had panic attacks. And they suck. But bottom line was there was a sense of greater self knowledge, much greater self knowledge. And that’s very difficult to put into words. That’s not just some kind of cognitive thing, it’s that too, it’s more of uh, uh, not in words inner experience. Not word friendly inner experience basically. Um, so I don’t regret doing it. It was good for me.

R: OK. Is there any component that you found more helpful?

P: Well, for one thing, I mean, I think it was able to reach part of me that no talk therapy had ever been able to get to.

R: And what do you mean by “it”?

P: In EMDR. The actual process of doing EMDR.

R: There are actually 8 stages, which one are you talking about, of EMDR?

P: The actual process of the eye movements.

R: Good. That’s what I needed to know. OK, so you’re saying that actual eye movements processed issues or went somewhere.

P: Oh yeah, very much so.

R: Can you say something more about

P: Well, it was several years ago…

R: One of the things I want you to remember is,… your own words

P: No, no. This is my own words. This is me as patient basically…

R: Good.

P: Did you ask what was most useful?

R: What we got to specifically was the eye movements aided you…

P: Yes, aided me (both talking over each other here)

R: …and I’m asking you what was that experience like?

P: Well, it wasn’t just a one-shot deal. It’s still with me. Uh, uh, I, me now, is different from me prior to ever doing EMDR. Now, it’s, it’s subtle. Uh, uh, did I have panic attacks before and after? Yeah. But was I somehow freer, maybe a little, a little… less
avoiding of my own internal experiences. OK? That’s what how I would say that would be…if I were going to say it that way, that would be the way I would do it. Less avoidance of that. Still having panic attacks, you know, out of nowhere, etcetera.

R: And you’re saying somehow being in an experience with the eye movements helped you?

P: Oh, yeah.

R: What was it like during the eye movements?

P: Tiring…I’d say, I’d say tiring. I wasn’t, I often wasn’t really sure what was happening…I was aware that something was, but I wasn’t sure what. Uh, the anxiety reactions I was starting to have would occur as I was leaving basically. That’s pretty much it.

R: OK. What did you find least helpful?

P: It would have been nice, if, … I mean, I can close my eyes right now…and still call up a visual imagery of, of Fred and his devious behaviors. It would have been nice, and, and, though it’s different, again, than prior to doing EMDR. I would have liked to have gotten rid of it.

R: And when you say gotten rid of it, do you mean gotten rid of the actual visual picture, or the actual…?

P: Well, both, all of it. I mean, the whole package. There’s uh, the visual picture, uh, um…I mean, I’ve since moved on. The EMDR was 6 or 7 years ago. I have since gone on to other things. I, I, uh have a lot more anger now, for example. Uh, uh, and, I don’t think that relates to the EMDR, that wasn’t something I accessed at that point. Uh, uh, and, the med therapy actually, the panic attacks are gone, I mean, um, um, there, there, uh, so, uh, uh, so there’s a sense, I don’t know, the thing I worked for for so many years has finally happened. But, I mean, um, I hope that’s helping…

R: Everything you say…there are many helpful points you’ve brought up. Because what this is a contribution of your experience, that’s what makes you the expert. You’ve given the experience so from where you’re sitting, you can give so much and then therapists can use it in their practice, hear what might be able to be added, subtracted, changed, so everything you say is worth it. And, we were on what did you find least helpful?

P: Well, like I said, I wished, I guess I could get more out of it. Um, um, and certainly like I said, I would leave those sessions being as frightened as I was. That certainly wasn’t good.

R: So, it would have been more helpful if you weren’t worse leaving than when you walked in.
P: Yeah, basically, yeah.

R: OK. So, now I am going to refer to feeling worse. Can you think of anything that would have helped?

P: Probably not, because I think what you had was you had me going nearer to what had been overwhelming experiences as an infant and young child, which were, I firmly believe are at the root of the panic disorder. Uh, uh, yet being, whether my defenses or the age, because I was 30, I was 40-some odd years old, 43 or so years old when I attempted this, uh, uh, the stuff I am talking about happened 40 years earlier. So, the, the EMDR was not able to ameliorate the traumatic memories basically. Um, um, and…

R: So, let me ask you another way…

P: Yeah.

R: Let me ask you another way, you’ve had, before EMDR, you said in practices, like desensitization. So I guess what I’m asking is any tools to use when you’ve been triggered into severe or moderate anxiety.

P: I see what you mean. By me, or for that matter by the therapist. I suppose maybe more time..

R: At the end?

P: At the end, yeah. Or some way to ground me, some way to bring me back to the here and now…

R: I get you, yeah.

P: …more out of memory and into the present, uh, and that would be anything from standard subsets reinforcing present state that I’ve learned in other settings, that actually probably would work, in other words literally using sensation to bring the person out of, out of really the recall.

R: Yes, yes. OK, I hear you. That’s good. With that realization, anything else that was least helpful?

P: No. Uh, one thing that I think that was excellent, was when it became apparent that it wasn’t working, that the panic attacks were continuing, the therapist suggested we stop for awhile, and I admire him for that, I think. That was the right call, that was the ethical and clinically appropriate call. Other than that, not much.

R: OK. Good. Um, what were your impressions after you’d completed.
P: You mean, as what, my version of what had transpired, what had gone down basically. Um, I was different. Not radically different, but different. I was not better. Um, as to my stated goals of getting rid of it. Guess that’s about it. I’m glad I did it, very glad I did it, actually.

R: And this may sound similar (sneezes) excuse me. What things would you tell other people about EMDR.

P: Speaking of my own circumstances, I don’t think it really works for all trauma. I did have one event, where I had, in one of those trips back to my place of work from my therapist’s office, I had a traumatic event, real difficult time, and I was able to do recent EMDR, recent memory EMDR, and I was floored by what happened. It’s effectiveness in dealing with that.

R: Want to say more about that? Now you’re talking about a recent single trauma…

P: A recent single trauma. And I, we decided to try that. I talked about it in session and we decided to try using EMDR with it. And, I used the same technique of, of calling up in my mind’s eye the recent memory, the visual memory of the recent single trauma and I proceeded to do the eye movements and the thing went away. Absolutely amazing. I don’t even remember now what the trauma was, where I can tell you to the moment when I was three years old of my brother choking me in the garage, I can tell you all about it. But the recent trauma I’d just been through, I can’t even remember. So that’s what I mean by having it go away, that would mean that memories go where they’re supposed to go, until you call them, you know …

R: So that’s what you were saying is that I wish that what happened with my single recent trauma would have happened with my old one?

P: Yeah, exactly, exactly.

R: Um, is there anything that you’d like to add that I didn’t ask?

P: Um, no. I think, I think it’s….look, with that recent single trauma thing, that was extraordinary. Uh, uh because if I hadn’t done EMDR with that recent single trauma, I probably could tell you exactly what happened, even now, six years later, see what I mean? So that, the thing, it’s an extraordinarily powerful technique. It would be neat if they could find a way to work with old stuff. In a way that were even remotely similar. It would be amazing.

R: Well, thank you.

P: Are we done?

R: Yes, that was good.
APPENDIX D

INTERVIEW #2

EMDR Study

J. C.

R: So the first of the one, two, three, four, five, six, seven questions…

P: Wow. that’s all… good.

R: Chuckle…is what brought you to EMDR therapy?

P: Um, I had read an article about it, and I’d heard about it over time, um, as a new and effective modality which…uh, I’d been in the traditional uh one on one therapeutic process for, uh, with different therapists for about 23 years, and um, was experiencing, I was experiencing some stress, some distress in my life, and I didn’t want to have to follow the same route. From what I had read, the little I had read about EMDR, it seemed to get really good results and it wasn’t as much, a, I guess psychological or psychoanalytic model…I didn’t want to sit around and talking about my family for the umpteenth time…in order to find some uh, solution … or way of utilizing what was happening, you know, I needed a way to operate in my life on a like practical day to day level. And I didn’t want to go back into…. I didn’t feel my childhood had really much to do with it. Or, if it did, I didn’t want to spend all this time, you know, I didn’t want to spend two or three years developing a relationship with a therapist once or twice or three times a week…in order for them to… um, help me.

R: M-huh.

P: I guess that’s a way of putting it. And I was really interested in what, I uh, I was fascinated with the idea that this had to do, with, uh, I don’t know the word. Correct me if I’m wrong.

R: M-huh.

P: The, the brain, the brain itself, brain waves… neurology at some level. Because something about EMDR, that rapid eye movement, has nothing to do with my psychological makeup.

R: OK.

P: …if I understand that, basically…

R: No, you said it well

P: So, I’m very, very, very fascinated with that…So that’s why I came to EMDR…
R: OK.

P: Um, and, uh, you came highly recommended actually…by the way…

R: [chuckle]

P: So, and that’s no small part of this…I’ve been to many, many therapists over the years, and uh, you came very highly recommended, so…

R: OK. Uh…So then I would ask you next what is it like, and what was it like, to experience EMDR for the first time?

P: [long pause. Deep sigh.] Hmm. Well…how would I describe it? Hmm…I’d say, different, surprising, that really doesn’t give you an idea, it doesn’t describe it. Coming from my point of view, which is everything is psychological in origin and therefore has a psychological solution, which I didn’t know up until that point, I was surprised to find that…you were not interested in how I felt about things.

R: [chuckle]

P: Or, in you know let’s delve into the…how does that feel? You know, that’s a very typical therapist response to things, how does that make you feel…and uh, this is not a therapy…that is interested in you and I developing an intimate relationship in order to investigate or have access to uh, what lies in the hollows of my senses. And that’s very different…

R: M-huh.

P: Uh, almost, probably extraordinarily so…in any kind of a therapy model that has to do with two people sitting in chairs having some uh, amount of conversation.

R: M-huh.

P: And…so, you know I’m also someone who wants to cash in prizes right away, and, uh, I was really interested in…OK, how did it feel?

R: Um, actually you want me to repeat the question?

P: Yeah, what was my first experience with it?

R: What was it like to experience EMDR for the first time?

P: OK, so now I’m, I’m really, I’m doing…what you used to say…

R: Oh, no…
P: I am [slight chuckle]

R: No, no, you can speak about the feeling, that’s part of the experience…

P: What’s it like to experience it…well, it, my answer so far is really, my mind wants to take over and talk about the idea…instead of having the experience…

R: Hmm…

P: …which is what I just did…right?

R: OK.

P: And, uh, I find myself…the experience…well it became physical, it started to, you sort of dislocated me, you dislocated my mind, which my mind doesn’t like. I, I once had a recognition, basically, I want my mind to, you know, I want it to follow my rules and my ideas, and I found that it dislocated that. Not in a really, um, …because I haven’t, because I trust you and therefore I trust…I guess, I believe the process. Uh, so it wasn’t a dislocation that was, you know, traumatic in any way.

R: M-huh.

P: So my experience was, uh, as I recall, a…kind of a…oh, wow, it gave me access…I don’t really know how to say…I don’t know how to describe it…

R: Try. You’re doing good.

P: [sigh]…Oh, my god, I can’t describe it [mumbling to self]…[dog barking]… I’m sorry…

R: That’s OK.

P: Hello…pardon me (silence).

P: (after silence) Sorry about that.

R: No problem.

P: Ah, OK. I have a very visual idea of what the experience was.

R: OK.

P: And, uh, there was something that it’s almost as if with that…with my following your directions…and then tracking your, your fingers?

R: M-huh.
P: …I entered into, or a different place was opened up in me…I wouldn’t say I entered it.

R: M-huh.

P: I think what happens is, it’s almost as if…uh, that it’s like a flickering…although it’s not that…um, of your fingers, creates a physical and …[sigh]…it’s not like wa…wan…waving a magic wand…boy you’re going to have fun transcribing this thing, or someone is…[laughter]…waving a magic wand, but it’s almost as if it’s this fast shutter…

R: Ahhh. OK.

P: That’s what I’m thinking. That’s the image, of this fast shutter, uh, that, so that, so that, the…(mumbling to self: I can’t believe….) …that the data I have access to inside myself on a physical level, like where locations are of, um, experience, becomes, it creates an opening. It’s like an aperture. Can you believe I’m thinking about this as a camera. That’s so interesting.

R: Yeah. OK. That’s great.

P: And so, I was very, very interested, and I found that …OK, so that was my first experience. OK. Go ahead.

R: If you want to add to it, please do.

P: Well, I would start talking about it over time then. The effects of….

R: And you can do that too. Uh, I’ll tell you…

P: Cause I don’t know if those are the questions.

R: All right, let me give you the next one because I believe it may, you can definitely fit that in.

P: OK.

R: Having experienced the EMDR method, what did you find most helpful?

P: Well, specifically I, uh, had , uh, I was , um, [mumbling…I have no idea what…] um, I was down at the World Trade Centers on Sept. 11, and uh, I found that that experience had, without saying the obvious, certainly changed a lot, changed me, and that I was having a lot of continual reaction uh, to things, like, planes overhead…

R: M-huh.
P: …loud noises, uh, constantly feeling an, a sense of agitation uh, that at any moment something is going to happen in the city that I live in. Uh, and having very real reactions to ordinary, every day sounds, that were heightened for me.

R: M-huh.

P: Um, as a direct result of Sept. 11. I believe, anyway. And, and there was this weight of, uh, …a sense of…uh…there was a weight…I don’t know if doom is quite the right word…recollect is a better word…constantly on …I had… something weighing on me all the time, and it had to do with the sense that there was going to be a human catastrophe at any moment… what am I….you know, this um,…I mean…it’s a terrible feeling

R: M-huh.

P: …a terrible, terrible feeling. And I really believed that I was…that was just something I was going to live with, and, specifically, uh, that was one of the reasons that I thought of EMDR a little. I don’t believe it’s the only one.

R: M-huh.

P: Um, shocking…to my surprise, to my amazement, and in which case I would be…I am…a huge advocate of EMDR, um, working with you, that lifted in a very distinct and particular way. It was as if one day it was there and then it….because you and I worked on that…

R: Right…

P: Uh, and specifically, this thing about the plane, the sound of airplanes, or overhead noises, you know helicopters, whatever, I live in a city where that’s, you know, generally I hear them a lot, and that immediately…that, that my reaction completely changed from my…experience…

R: M-huh.

P: …with EMDR. And that was very, very specific, and I’m surprised. Because I really didn’t think it would happen. I didn’t think it would lift. And it lifted…

R: M-huh.

P: I mean, literally. I thought well, maybe we’ll work something through, and I’ll, you know, be able to talk to the 20,000 people that inhabit me and, you know, we’ll all have long conversations, and the next time we hear …and it was not like that at all.

R: M-huh. Right.

P: Brilliant.
R: And so, when you say it lifted, it means, it disappeared?

P: Yep. Yeah (emphatically). So there was this huge space I got from it. Because the, because the oppression of that reaction took up a lot of room that I didn’t know…I didn’t know I was being pressed by it until like the hand lifted, so to speak. It was amazing.

R: M-huh.

P: …Really distinct, distinct. I still…very distinct. Very powerful. And it has maintained.

R: OK. And, would you, or can you speak to any part of the process that you felt was the most helpful? …And, if you can…

P: Well, I liked that you didn’t want to know how I felt.

R: M-huh.

P: And that you cut me off when I would start wandering down the road, which I wander down every single moment if possible…

R: M-huh.

P: Uh, you weren’t interested at all in that. And, although at first I found it, uh, I was taken aback…

R: M-huh.

P: I found that very, very, very, very helpful because it required that I become more…present.

R: Mmm.

P: OK, without my mind, which is usually chattering away…I had to sit up, I had to pay more attention…I found that very significant and helpful. Because most people I don’t have to do that with…

R: M-huh.

P: And the other part was, uh, …I felt it, it was, it started to give me some internalized skills, and what I mean by that maybe it isn’t skills as much as, there were images that came up or pictures that then I could refer to and, and uh, retrieve…when I wasn’t with you…To help, to help, to help me…

R: M-huh.
P: …through something, whatever it was specific to. And, I found that I really liked that, uh, you’re very direct, and uh, you know, everything began and ended on…there’s something about your manner, and I don’t know if it’s uh, there’s a, there’s a quality of interaction that I haven’t experienced before with a therapist, that I found very, very helpful. Because I felt as if I was being treated as an adult…

R: M-huh.

P: I felt that, that I was treating myself as an adult, I suppose, would be a better way of putting it.

R: M-huh. OK.

P: And that’s extremely helpful, I live in, I believe, I feel I live in a culture that is constantly power tripping and fantalizing everybody all the time.

R: Hm.

P: And, uh, so, it was very, it’s very refreshing actually.

R: OK. Can you tell me more about the images, or how, or um, maybe even an example?

P: Uh, hmmm…

R: And if you can’t think of an example, just about…it was interesting what you said that it gave you something to refer to or retrieve and that gave you another set of internalized skills, which you enjoyed.

P: M-huh.

R: And then later, you, you’re bringing up adult, and that kind of sums up the adult experience of, you know, being able to retrieve and comfort yourself.

P: M-huh. Right. And, and with confidence, knowing that I can get myself from A to B to C to D, without…that I can get myself there, get through there…

R: OK.

P: Oh, there was one in particular, and I can’t remember all of it specifically, but I know it was in my upper chest, and it was, um, it was a way of when uh, I was very agitated to soothe myself, and it had to do…it was a blue color…

R: M-huh.
P: And it was, I don’t remember if it was, um, it was a blue like a cloud or a softness or, not a cloak …but a blue space that I could recall and pull up to my upper chest to calm me…

R: M-huh.

P: ..in relationship to when I felt agitated about, uh, about, I had, we were also working with some uh, professional boundary, meaning, I was unable to, uh, in my own work with clients, uh, I was having problems with, uh, when they didn’t come on time, and charging them the amount of money and had a policy … and, uh, that kind of thing. And you and I were working with that…

R: M-huh.

P: And my kid, the part of me that wants to give everything away all the time and gets agitated and all if they don’t love me and all that stuff, um, no matter how, my intellect can’t negotiate any of this…because otherwise… because it just can’t. So what EMDR did and is able to do, I believe, was give me like a reference that was for me very imagistic…

R: M-huh.

P: I don’t even know if there’s such a word…that I then apply to recover the adult who needs to say here’s my 24-hour policy and here’s the standard of practice…

R: Right. Right.

P: Does that make sense?

R: M-huh, it does.

P: OK.

R: Um…

P: Does that give you an image? I like the blue…a lot..

R: Yeah. Yeah. And that makes sense that you could retrieve it…

P: M-huh.

R: And, so, what other times may you, how did you, what times did you retrieve it? In other words, was it planes? Was it clients? Or, you know, when were you retrieving?

P: Um, you know, I still do…isn’t that funny.
R: Hm.

P: No, it isn’t uh, …I’m trying to…it’s not usually when I’m in a situation with other people…It’s much more to do with, I, I uh, it comes to mind, or comes to use, um, when I’m by myself…

R: M-huh.

P: And I spend a lot time alone and I have a lot of,…you know, I’m always thinking about things, and uh, and, I can become very, you know, I think about the meaning of my life on an ongoing basis…

R: M-huh.

P: Really, that’s one of my topics of, of my…of interest…so, um, I can become very agitated and despairing. And, uh, I find that, when I, I have a tremendous, I have a problem with anxiety…

R: M--huh.

P: …and it’s real, it’s also chemical, I have a chemical problem with anxiety, and uh, and or, I’m, I am prescribed an anxiety medication because I have anxiety…

R: Right.

P: So, so, being able to have that kind of retrieval system inside, I find very calming.

R: OK.

P: And helpful.

R: M-huh.

P: Is that…well, I suppose it doesn’t matter to you how I answer this really…

R: No.

P: [laughter] I’m not interested. I can’t wait to send this off to get it transcribed! [laughing].

R: Uh, so any other parts of the method that were helpful?

P: Sigh… Well, let’s see, what I think it does, is that it, um, in whatever way that it is dealing with the real physical/chemical matter

R: M-huh.
P: …it… it dispenses with the need to… what’s it do, things disappear…

R: Hm.

P: …So dispenses with the need to…I’ve got to go talk to my therapist about this-kind-of-thing….but dig deeper into the tunnel of you know, my mother’s neurosis and how it affected me…things like, leave, go away…

R: M-huh.

P: And I don’t think, that’s what I was trying to say from the beginning, or that’s what I suppose I’m answering the first question is that, this is what is so extraordinary about this, because it is never, you know, I haven’t grown up…

R: M-huh.

P: … with any belief like that, let alone any, um, um, no one has influenced me in this way, saying, oh, you should go try, you know, it has nothing to do with me, in a way, it has nothing to do with what I think about… about what I think about…

R: M-huh.

P: …it has nothing to do with it…so things go away. That’s what was so remarkable about the planes…

R: M-huh.

P: They went away. And that’s what I find, I find that hugely significant.

R: M-huh.

P: And I’d be really interested in what you’re actually, what you find, um…

R: And, you will. Like, you will be shown… the study.

P: Yeah.

R: Um, what did you find least helpful?

P: Um, that I couldn’t keep doing it.

R: M-huh.

P: [Laugh]… For, you know, financial reasons…
R: M-huh. Is there anything in the method, or your experience with the method that you would comment on to do more or less of? For you…

P: I think it would have benefited me, to uh, and I don’t know if this is just because of, I don’t know if this is, if this is real, meaning effective, I think it would have benefited me if I had been able to do it more frequently, actually.

Q. Hm. And what would that have been? Because, the, whoever’s listening doesn’t know.

P: Uh, ah, uh, instead of like once a week, twice a week.

R: Ok.

P: That’s what I mean by frequently.

R: OK. OK.

P: And I don’t know if that’s just my, you know, greedy for something to play with in my brain…

R: M-huh.

P: You understand? Is that clear?

R: Yes. Right.

P: Cause I don’t know if in fact EMDR needs a time frame, like needs a lapse so that there’s a process that goes on that has nothing to do with whatever I’m feeling like, you know, in order to, like, reconfigure the wiring so to speak…

R: Right, right.

P: …so I don’t know if that’s…

R: Well, believe it or not everybody has their own timing…

P: OK.

R: …and so if you felt that way, it’s likely that you could have done it more often.

P: M-huh.

R: Good. Anything else you want to say about least helpful, or suggestion?

P: I don’t find anything least helpful. I don’t know how to…
R: Well, there’s an answer… That’s, that’s

P: That’s my answer.

R: Yeah, there you go.

P: ...I don’t find anything least helpful about it. I mean I really, I really trust, you know, your, I mean I really have great respect for your, you, particularly your experience and your, uh, the way you present yourself, you know, how you present, so, no I don’t have anything.

R: OK. Now this question you may feel like you’ve answered already, but I’ll ask it because it’s here. (chuckle) What were your impressions after you completed the EMDR method?

P: [pause] Sigh, well I’m not sure one could ever be completed...

R: [chuckle] I had a feeling you were going to say that…

P: Uh, I think it’s uh, OK, I think it’s, I feel that…now what’s the question again?

R: [laughter] What were your impressions after you completed the EMDR method, and for this, completed means when you finished…

P: Correct…

R: Or, ended.

P: Right, no, I understand. OK. What were my impressions…well, the image I get is like the DNA, you know, the helix, right…where there are discreet packages, which is the experience, specific, but it’s all linked together so that there’s in the discreet experience, something is finished, and yet there is always a possibility that there’ll be a link in the continual spiral…

R: M-huh.

P: Does that answer your question? Was that plain enough for you?

R: Which means, if I get this…Go ahead, which means what…to someone who wouldn’t follow that…[chuckle]

P: Um, I came to EMDR for very specific reasons and I felt it is, uh, what were my impressions?...I felt it was very effective. It, uh, it, it significantly changed, I mean I can’t emphasize enough how remarkable it was to no longer have a fear of, of something happening, and I just cannot tell you…
R: M-huh.

P: It’s really very, very powerful.

R: And so, when you described a DNA helix, where do the planes fit in?

P: Uh, well the plane experience is one of the three packages…

R: OK.

P: And, so, coming to EMDR for, you know, post traumatic stress regarding 9/11, having certain things disappear as a part of my every day life is the end of the experience…

R: Ah.

P: OK?

R: Right.

P: However, there are many other things I could say, oh, well then, but what about this and what about this and what about this?

R: M-huh.

P: And in fact I’ve been reconsidering EMDR…

R: OK.

P: So that’s what I mean in terms of a spiral and a helix…Because, it’s a double stranded technique…there’s a possibility of, that if it works in one place, why wouldn’t it work in another place…

R: Gotcha. Gotcha. OK. Now I got it.

P: OK.

R: Um, so that it all relates, because what you could do with one package, you could do with another package?

P: Right…it …yeah.

R: And that goes back to the only thing that was least helpful was not being able to go more…

P: Right. The only thing that is least helpful is that I don’t have the money.
R: Right. OK. All right.

P: That’s because we live in…I’ll just say this for the transcriber’s sake, we live in a system unfortunately the most powerful in the world, where we do not have health care…so.

R: Yes. [chuckle] That’s the least helpful…

P: So, yeah.

R: Um, what things would you tell others about the EMDR method?

P: I would recommend it to them. I’m not sure I can describe it to them, but I would certainly recommend it as, a, as a way of cutting through a lot of, and cutting out a lot of what I now have come to see as extraneous, not necessary, uh, in the name of processing, um, …um…[mumbling to self] it’s going to cut a lot of time out of the usual therapeutic method…because …it can save you a lot of money…and a lot of time. I find it very effective, in a very practical way. I have a friend actually, um, working with someone, and uh, and I know that I said to her, you can never find an EMDR so you can do it in the city. And there’s also a website.

R: M-huh.

P: But it’s like, you know, I don’t know, me in particular, I’m someone who like, when you go to the movies, I’m not going to tell you what the story of the movie is…I don’t know why you would even see the movie if I already told you what’s going to happen. You know I’m like that about most things…I really feel people need to have their own experience. So I try not to influence them.

R: OK. Good. Is there anything else that you’d like to add that I didn’t ask?

P: pause…Um, I wish it was more in the mainstream…you know, since, it’s not, I mean certainly psychology or psychiatry is not, well, anyway…you know as mainstream as that is, I wish EMDR were available, you know I think people in, in uh, in places other than like, the East Coast, or you know, the cultural elite who do not think much of therapy.

R: M-huh.

P: And, ideally I wish it were, EMDR were, available for them, because I think it doesn’t …it’s a whole other way of um, you know, I feel like it would have meant a lot, and uh, it would be very helpful in a way that… I don’t know how to say it…

R: Well, I think I hear you saying that it would change the way society looks at someone coming for emotional help.
P: Yeah, because it’s not just a, uh, you know people have a lot of prejudices…yes, right, which is why EMDR therapy is [unintelligible] yeah, and I feel it’s not just that, uh, maybe their egos would be smoothed but that it has a real practical application…

R: M-huh.

P: And you don’t need to be sophisticated, well read, you know, upper middle class white, I mean I don’t believe you have to have any of those prerequisites, you probably don’t need, you know, you don’t need a high school diploma… in order to have, to get the benefit. And I’m not sure that that’s true of other kinds of therapy where what you are asked to do is to have some uh, possibility of having an awareness of an interior life, you know. And I’m not sure EMDR needs that, in order to be effective…

R: M-huh.

P: And that’s just [unintelligible] …you know that could really save the world, actually. In a lot of ways…

R: Yes, yes. I hear you…something I didn’t think of…

P: For the woman in Louisiana somewhere …

R: M-huh, yeah.

P: Like the country doctor down the road coming with EMDR,

R: Right.

P: You know…

R: M-huh. Quite a contribution.

P: Yeah. So, I wish it were more in, in the, in the forefront of regular practice…

R: M-huh. So…

P: [singing] The transcriber is going to have to write this down ding ding ding ding

R: [chuckle] So anything else that you’d like to add? About EMDR or your experience?

P: Uh, see this is where I’ll say [unintelligible]…[laughing]….. No, I don’t think so.

R: OK. Good. Well, we have concluded the interview so I’m going to turn the tape off. I want to say thank you.

P: Thank you for asking me.
APPENDIX E
EXAMPLE OF CODING

128  P: Well, specifically I, uh, had, uh, I was, um, [mumbling...I have no idea what...] um, I was down at the World Trade Centers on Sept. 11, and uh, I found that that experience had, without saying the obvious, certainly changed a lot, changed me, and that I was having a lot of continual reaction uh, to things, like, planes overhead...

129  R: M-huh.

130  P: ...loud noises, uh, constantly feeling an, a sense of agitation uh, that at any moment something is going to happen in the city that I live in. Uh, and having very real reactions to ordinary, every day sounds, that were heightened for me.

131  R: M-huh.

132  P: Um, as a direct result of Sept. 11. I believe, anyway. And, and there was this weight of, uh, ...a sense of... uh... there was a weight... I don't know if doom is quite the right word... recollect is a better word... constantly on... I had... something weighing on me all the time, and it had to do with the sense that there was going to be a human catastrophe at any moment... what am I... you know, this um... I mean... it's a terrible feeling...

134  R: M-huh.

135  P: ...a terrible, terrible feeling. And I really believed that I was... that was just something I was going to live with, and, specifically, uh, that was one of the reasons that I thought of EMDR a little. I don't believe it's the only one.

137  R: M-huh.

138  P: Um, shocking... to my surprise, to my amazement, and in which case I would be... I am... a huge advocate of EMDR, um, working with you, that lifted in a very distinct and particular way. It was as if one day it was there and then it... because you and I worked on that...

140  R: Right...

141  P: Uh, and specifically, this thing about the plane, the sound of airplanes, or overhead noises, you know helicopters, whatever, I live in a city where that's, you know, generally I hear them a lot, and that immediately... that, that my reaction completely changed from my... experience...

143  R: M-huh.

145  P: ...with EMDR. And that was very, very specific, and