Exploring EMDR with Trauma-Impacted Clients Using Video Therapy

by

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A Thesis Submitted to the Faculty of Graduate Studies of

The University of Manitoba

in partial fulfillment of the requirements of the degree of

MASTER OF SOCIAL WORK

Department of Social Work

University of Manitoba

Winnipeg

Contents

Abstract

Eye Movement Desensitization & Reprocessing (EMDR) is an 8-phase psychotherapy approach that has been proven effective with various populations and presenting client issues, including and beyond the treatment of Post-Traumatic Stress Disorder (Ehring et al, 2014, Valiente-Gomez et al, 2017, Edmond, Rubin & Wambach, 1999, Yunitri et al, 2020, Gerge, 2020, Schwarz et al, 2019, Cuijpers et al, 2020). However, existing research focuses on validating the claims of EMDR, rather than examining its power of engagement and the motivations behind its growing use with practitioners. In addition, with the onset and continuation of the COVID-19 pandemic, therapy modalities such as EMDR have been presented with the challenge of adapting treatment to video-based services. This project explored the specific strategies and experiences of therapists using EMDR and how they construct an understanding of its value in the field of trauma treatment. Within this project, five Winnipeg-based EMDR clinicians participated in interviews, analyzed using Riessman's "Analysis of Personal Narratives" (2000), and findings were organized into themes of qualities of a strong therapist, determining appropriate EMDR services, video-specific considerations, working with differences and oppression, and supports for therapist efficacy. This research examines the processes and strategies that create meaning for EMDR practitioners and contributes to a larger discussion about the challenges and strengths of trauma treatment in the current social climate.

Acknowledgements

This project was made possible with the support of advisor Dr. Judith Hughes and committee members Dr. David Delay and Dr. Hai Luo, as well as the assistance of numerous faculty and personal supports.

This project received endowment funding from the University of Manitoba for the purchasing of recording materials, transcription services, and research participant honorariums.

Introduction

Eye Movement Desensitization & Reprocessing (EMDR) has been shown to be effective in reducing post-trauma impact for a variety of clients (Ehring et al, 2014; Valiente-Gomez et al, 2017; Edmond, Rubin & Wambach, 1999; Yunitri et al, 2020; Gerge, 2020; Schwarz et al, 2019; Cuijpers et al, 2020). Missing from the literature is description of the strategies used by therapists practicing EMDR with clients. Further, with the start and continuation of the global COVID-19 pandemic, therapies, such as EMDR, that have been delivered in-person have had to be adapted to distance-based means, such as video-delivery therapy. Consequently, little is known about how EMDR is specifically used with clients or how these practices have been translated into an online delivery method. This project explored how a group of EMDR practitioners constructed narratives of how they understand EMDR to be meaningful and their construction of themselves as therapists. Using Riessman's (2000) approach to narrative analysis, the thesis examines the strategies used by five Winnipeg-based therapists practicing EMDR with clients who have experienced trauma. Additional themes explore risks related to distance-based therapy, trauma-informed distance-based therapy, and video-based EMDR.

Statement of the Research Questions

1. How do therapists using EMDR construct an understanding of the methods of EMDR and its value in addressing client trauma?
2. How do therapists view and use distance-based video EMDR treatment?

Literature Review

Background

EMDR was developed in 1987 by psychologist Shapiro and was first tested on people with histories of sexual trauma in 1989 (Edmond, Sloan & McCarty, 2004). This intriguing and highly debated method attracted interest and research in connection to both its unique use of eye movements (and other sensory movements) and its clinical effectiveness within short client interventions (Edmond, Sloan & McCarty, 2004). Lewis et al. (2020) divides therapeutic treatment for PTSD based on their underlying theoretical approaches. These writers note a distinction between trauma treatment methods that directly explore the traumatic events and those that centre on alleviating related symptoms without addressing specific trauma memories. Lewis et al. conclude that EMDR bridges both approaches with a dual focus on systematic exploration of trauma memory symptom reduction.

EMDR is a methodical, eight-phase treatment plan that, in part, accesses "unmetabolized components of memory" (Shapiro & Laliotis, 2011, p. 193) to 'unfreeze' traumatic memories and shift associations that have contributed to distressing post-trauma symptoms in the lives of clients. In the phase of recalling a specific traumatic memory, participants of EMDR are not simply describing memories but are asked to experience the emotions associated with the memories in the present. In connection with the clinician, the client then focuses on making rapid eye movements by visually following the clinician's fingers, as they move back and forth (or, alternatively, tapping or audio tones), while they recall a trauma memory, to dampen the continued impact of that memory. The clinician then guides the participant to recall more positive thoughts to reprocess these past traumatic events as appropriately organized memories, rather than as ongoing traumas. Shapiro and Laliotis (2011) summarize the specific phases of treatment to illustrate the activities of EMDR therapy sessions. The first client history phase is used to collect client information and for assessing the fit for EMDR and name 'targets' of negative and positive associations for the client. Shapiro and Laliotis (2011) state that these 'targets' capture a sense of the types of traumatic memories the client is interested in changing their relationship with through the EMDR treatment. The second, preparation phase includes the resourcing and stabilizing of clients so that they can more easily access positive affects, which may involve supporting the client in identifying personal strengths and positive memories. The third phase, assessment, begins the recalling of the memory image, and the fourth, desensitization is the processing of the past through the unique movement procedures. The fifth phase is installation, which occurs when the emerging or transforming positive beliefs are identified and strengthened. Body scan is the sixth phase through which the client and clinician create awareness of the remaining physical sensations. The final seventh and eighth phases of closure and re-evaluation are used to create safety and stability for the client between sessions and assess the work (previous sessions and present) within the larger client situation. While there is much more to the process of EMDR practice, these unique features of EMDR are referred to as 'rapid learning', which is at the core of the treatment approach (Shapiro & Laliotis, 2011).

The literature affirms a similar basic understanding of EMDR that aligns with Shapiro's initial development of the treatment and is congruent with the continued tenants of EMDR practice. For example, Colosetti and Thyer (2000) adhere to Shapiro's 1995 guidelines for safe

practice in their research using EMDR with battered women prisoners, some of which include the requirements of clients to be truthful to the clinician, agree to utilize self-control and relaxation in between sessions, and the requirement for clients to not have a medical history that includes respiratory, brain, heart, or certain eye conditions (Colosetti & Thyer, 2000). Many articles reiterate Shapiro's eight phases of treatment as unquestioned and central to proper EMDR delivery (Leer, Engelhard & van den Hout, 2013, Marich, 2012, Chen, Gillespie, Zhao, Xi, Ren & McLean, 2018). These phases of client history, preparation, assessment, desensitization, installation, body scan, closure, and re-evaluation (Shapiro & Laliotis, 2011) contribute to the unique systematic approach of the EMDR treatment.

While most literature focuses on the uniqueness of EMDR practice, Shapiro & Laliotis (2010) have suggested that EMDR treatment is compatible with a wide range of clinical approaches. They assert that the method focuses on information processing, rather than explicitly relational approaches to post-trauma treatment (such as those rooted in attachment theory). In contrast and through focusing on the shared emphasis of dysregulation and disorganization as the impact of trauma, Ringel (2012) presents an integration of EMDR treatment with other conceptual frameworks, such as attachment theory and a relational psychodynamic approach. Using a case study, Ringel places EMDR practice within a longer span of relational, trauma-informed therapy that tend to the "intersubjective implications of the traumatic experience" (Ringel, 2012, p. 141). With this, Ringel emphasises the need for clinicians to focus on the unique client interpretation of traumatic events as sites for therapeutic work, which adheres to the client-centred practice concept of the client as the expert in their own situation. Through this description, Ringel (2012) notes that the addition of EMDR sessions into these relational approaches allows access to different aspects of memory and states of self that may not yet be part of the client's consciousness, which could then be further processed in more flexible, relational, and spontaneous ways later during therapy treatment. In a different approach, Cowan and Ashai (2020) focus on and outline general trauma-informed treatment practices at the centre of psychodynamic, trauma-focused cognitive behavioural therapy (TF-CBT), and EMDR therapies. Cowan and Ashai (2020) focus on client psychological safety, which includes validating the client's emotional experience, creating a space free of judgement, and offering compassion to clients and emphasize that EMDR practice is not complete without these elements of client safety.

EMDR Practices and Effectiveness

Through a systematic review of seventeen global randomized control trials, Valiente-Gomez et al. (2017) examined the existing research on EMDR with clients with a variety of diagnoses, such as bipolar disorder, depression, anxiety disorders, panic disorder, obsessive-compulsive disorder, substance use, and chronic pain. Valiente-Gomez et al. (2017) determined that EMDR is effective with very specific phobias, however conflicting levels of symptom reduction were reported with generalized panic disorder. While the research is limited in that often only a singular RCT represented each diagnosis, the authors point to the potential usefulness of EMDR for a variety of client difficulties. Another meta-analysis of 76 trials that examined the effectiveness of therapeutic treatments for mental health and anxiety observed that EMDR was more effective than other therapies (Cuijpers et al., 2020). Reports of EMDR treatment outcome effectiveness across a further 17 trials with 647 participants, included significant reductions in anxiety, panic, phobia, and somatic symptoms (Cuijpers et al, 2020). A final meta-analysis of sixteen studies compared treatment outcomes for EMDR and Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) with adult clients with childhood sexual abuse-related PTSD (Ehring et al, 2014). This review obtained mixed results, but did validate the practices of EMDR in particular, by stating that "importantly, most theories suggest that characteristics of the trauma memory and/or excessively negative trauma-related appraisals lie at the core of the disorder" (Ehring et al, 2014, p. 653). This distinguishes the characteristics of EMDR from trauma-focused therapy in general by emphasizing the role of traumatic memory in current mental health outcomes. In a different evaluation of EMDR treatment with 25 women survivors of sexual and domestic abuse, Schwarz et al. (2019), report that the average depression score dropped by 44% at post-test when measured by the Beck Depression Inventory-II. In terms of broader well-being, the study showed that "55.6% of those with anxiety, 52.9% with depression…and 56.3% with PTSD prior to treatment scored below the criteria for diagnosis or referral after completing EMDR" (Schwarz et al, 2019, p.7). Finally, two recent meta-analyses of EMDR effectiveness for mental health and anxiety, examine a larger picture of EMDR effectiveness. Cuijpers et al. (2020) observed that across 76 trials EMDR was more effective than other therapies. They note, however, several possible risks to internal validity in these studies, including heterogeneity of diagnosis and lack of follow-up information. The authors caution that the results might not be as accurate to the true EMDR intervention impact, because

of these bias risks (Cuijpers et al, 2020). In their review of 17 EMDR trials, Yunitri et al (2020) outline similar risks, including in the "randomization process, deviation from intended intervention, missing outcome data, measurement of the outcome, and selection of the reported results", and conclude that despite reports of efficacy in existing studies, further research is needed (Yunitri et al, 2020, p.103). Sikes and Sikes also explore the history of EMDR's mixed research outcomes and the extreme nature of some research client impacts and the reliance on self-report data (Sikes and Sikes, 2003). Greenwald (1996) identified that at the time, it was becoming clear that high intervention fidelity is required to practice EMDR effectively and that Shapiro's training may not be sufficient for practitioners to implement the protocol needed (Greenwald, 1996).

Other criticisms and controversies of EMDR exist and focus on the aspect of the therapeutic approach that makes it unique among other approaches, which is the impact of the eye movement component (Jeffries and Davis, 2013). Jeffries and Davis reviewed the theories present in the literature of EMDR, which include the orienting response, based on the human evolutionary use of rapid eye movements in detecting threats and opportunities, the interhemispheric interaction, focused on increased activity between the left brain and right brain, and working memory, concerned with the storage of information in what is called the visuospatial sketchpad and how this relates to memory vividness. Sikes and Sikes (2003) directly question whether it is the rapid eye movement aspect that makes the treatment effective. They assert that EMDR has some overlap with other trauma treatment models and emphasize that changes from eye movement to bilateral tapping and audio tones over the last few decades have also proved sufficient in delivering this specific treatment phase.

Lebow and Jenkins (2018) emphasize the division the EMDR controversies have created and offer recommendations for a more productive relationship between researchers and therapists. Respecting the importance of clinical competency and accountability (in practicing according to researched evidence), Lebow and Jenkins state "researchers need to better understand what make certain approaches engaging for both clinicians and clients" (Lebow & Jenkins, 2018, p.132). In this way, they argue that noting what makes EMDR tolerable and attractive in the larger picture of trauma treatment models is critical to understanding the needs of clients and practitioners and cannot be ignored.

Despite the lack of consensus regarding the strategies used by therapists practicing EMDR, therapists must adopt some working beliefs beyond the important client feedback and experience to support their use of this treatment. Exploring therapist impressions of EMDR speaks to the challenges outlined above when researchers fail to incorporate additional information about how and why EMDR remains useful to clinicians and clients aside from empirical measures of effectiveness.

EMDR and Trauma-Informed Practice

The theme of clinician-client relationship within the EMDR context overlaps in several of the academic texts, especially those texts that emphasize knowledge of identity-based trauma as critical to successful post-trauma treatment. In this way, some texts assert that client-centered treatment is required for desired clinical outcomes when using EMDR, and that client-centered practice requires ongoing awareness of the social and contextual issues that shape a client's experience both day-to-day and in connection with a therapist. Marich (2012) examines the importance of the therapeutic alliance and client safety in her work researching women in addiction continuing care programs using EMDR. She questions the rigidity sometimes associated with such a methodical treatment by stating that "it is insufficient to rely on EMDR method and protocol for the sake of relying on it; rather, EMDR clinicians must be flexible in their application of method so that the client remains engaged" (Marich, 2012, p.405). This emphasizes the social and human aspect of clinical treatment that asks the clinician to center around the participant's knowledge and worldview (as it is shaped by many dynamic forces) even as it differs from their own.

Other literature points to the need for trauma-informed practices that focus on clinician awareness of the ongoing oppression confronting clients on systemic and socio-political levels. For example, within the realm of clinical treatment with clients who are survivors of sexual abuse, both Gilligan and Akhtar (2006) and Sanchez, Benbow, Hernandez-Martinez and Serrata (2019) create important considerations to working with racially oppressed clients and examine the barriers to seeking support post-trauma. These writers assert that trauma-informed clinicians must be aware of intersecting and compounding traumas that shape the life and clinical experiences of a variety of clients. As it stands, the phases of EMDR practice do not specifically or sufficiently speak to addressing systemic traumas such as racism, which limits EMDR's ability to be fully trauma-informed without additional theoretical and practical clinical input.

The literature more generally varies in concepts of trauma-informed practice, which is critical to the focus of post-trauma treatment in EMDR. Szczygiel (2018) articulates that trauma-informed clinicians must understand the biological implications of traumatic events and environments that become internalized because "biology affects one's psychosocial experience of the world" (Szczygiel, 2018, p.116), which connects to the information-processing focus of EMDR. Knight (2015) defines trauma-informed social work practice, as including a sensitivity to the possibilities of existing trauma and that "the client's current problems can be understood in the context of past victimization" (Knight, 2015, p.26). This aligns with EMDR's concept of unprocessed memories, which disrupt meaning and organization throughout a client's development. Elliot, Bjelajac, Fallor, Markoff and Reed (2005) offer ten principles for trauma-informed practice that shift the focus from treatment to empowerment through shared knowledge between the clinician and client, a focus on client choice and control, and a highlighting of client strengths (such as resilience) rather that pathologizing symptoms (Elliot, Bjelajac, Fallor, Markoff & Reed, 2005). This interpretation of trauma-informed practice is seemingly less congruent with the methodical and knowledge-based nature of EMDR treatment and has roots in feminist and anti-oppressive social work practice, which seek to address the power dynamics present in traditional therapist-client relationships. As much of the research literature has focussed on treatment outcomes and efficacy of EMDR practices, little is known – directly from EMDR clinicians about how they view their own role in the therapeutic process of EMDR and how they adapt the treatment for specific clients.

Distance/Video Therapy Delivery

In using distance delivery methods that include phone, video, text, email, and other forms of communication, Reamer (2018) highlights "novel and unprecedented ethical and risk-management challenges" (p. 257). These challenges remain new and are lacking widespread empirical research that may come with long-term legitimization within social work and clinical practice. While much of the existing academic work focuses on practice issues for telephone service delivery, video delivery remains somewhat absent from the literature (Irvine et al, 2020). Reamer (2018) urges for the updating of policy and professional standards, as a critical response to the need for distance-delivered services during the pandemic, including increased training to ensure competency, but does not detail the knowledge and skills uniquely required for effective distance-delivered practice. The literature exploring therapy using telephone technology overlaps

significantly. For example, Brown and Sorter (2008) connect client-therapist regulation through audio and vocal signals to attachment theory in their argument for the clinical effectiveness of telephone-based services and urge practitioners to examine and probe their own resistance to these alternatives as a way to cultivate increased awareness about their own professional roles (Brown & Sorter, 2008). Elsewhere, Rosenfield also argues for the legitimization of phone-based therapy by drawing on social work's history of telephone-based crisis services as a point of contrast from which to build telephone therapy's distinct identity. The author is careful to distinguish crisis services as counselling most often conducted by trained volunteers, rather than therapy by accredited professionals, but still highlights the significant role telephone crisis services play in the mental health support landscape (Rosenfield, 2002). Irvine et al.'s (2020) systematic review of studies comparing in-person and telephone-based therapies demonstrate a lack of evidence that telephone therapy is detrimental to client outcomes, but that barriers to successful delivery are present, such as inadequate system support and therapist ambivalence.

While EMDR treatment has been studied with a range of clients using in-person methods, there is limited understanding of how EMDR is being delivered through video technology. Practitioners and 'Virtual EMDR' websites have a range of online accounts of the success of this joining of EMDR and virtual therapy, but this is not reviewed in the majority of academic literature (emdrfocus.com, 2020). The research interviews will examine therapist impressions of specific potential challenges, such as those involving confidentiality, technology access and comfort levels, safety, and impacts of video (delay, audio issues, interruptions).

Justification

EMDR is important clinically due to its ability to create client improvements with as few as one session, which implies that significant clinical treatment and client benefits can be achieved in shorter times than other traditional therapies (Shapiro & Laliotis, 2011). Yet, little is known about how EMDR therapists construct an understanding of the treatment and its value in addressing client trauma. The project of exploring the effectiveness of EMDR in virtual therapy is a critical academic response to the changing global landscape, which requires increased flexibility. The COVID-19 pandemic has required clinical social workers to deliver distance therapy services, as people worldwide have been isolated physically to control the COVID-19 virus and are largely unable to access in-person services. Therapists have been tasked with

treating clients who have the potential anxiety and stress of coping with a global pandemic compounding on their pre-existing issues, many of which involve experiences of trauma.

The purpose of this research is to explore: 1) EMDR therapists' constructions of the methods of EMDR and the value of the modality to EMDR clinicians themselves based on how they frame EMDR in their narratives and 2) how therapists view and use distance-based video EMDR treatment.

Methodology

This qualitative research uses a narrative inquiry design (Riessman, 2000), which establishes meaning through the views and stories of participants. The philosophical stance that this project will adopt is the social constructivist worldview, which involves the concept that, as Creswell and Creswell (2018) state: "meanings are varied and multiple, leading the researcher to look for the complexity of views, rather than narrowing meanings into a few categories or ideas" (p. 8). This shifts the research goals away from empirical measurement and determinism and towards understanding complex meanings as they exist, as constructed by and for the participants involved. Social constructivism has been shaped in the modern context by Crotty in the 1990s, and emphasizes the interpretive, social "generation of meaning" (Creswell & Creswell, 2018, p. 8). Creswell and Creswell (2018) state that, as shaped by authors such as Berger and Luckman, "individuals develop subjective meanings of their experiences; meanings directed toward certain objects or things. These meanings are varied and multiple, leading the researcher to look for the complexity of views" (p. 8). Upheld by this philosophical stance, the narrative process involved interviews with five Winnipeg-based therapists who are choosing to utilize EMDR treatment with clients who have experienced trauma and have adapted their treatment modalities to video.

In discussing narrative research, Riessman highlights how personal stories are shaped by historical and social contexts and "illuminate individual and collective action and meanings" (Riessman, 2000, p. 5). Riessman distinguishes between three traditions of narrative study- life story, discreet story, and extended account- and identifies some of her work as discreet story, which best fits this project's content (Riessman, 2000, p. 7). Riessman describes how narrative research resists offering a singular set of steps for analysis. To demonstrate her approach to narrative inquiry, Riessman describes her research examining infertility in India. She identifies the construction of boundaries to mark distinct narrative segments as a way in which the researcher approaches the story, and that offering detailed sections of speech helps the reader

note the story as separate from the analysis. From here, the wide variety of ways in which a researcher's interest may shape the analysis are listed: "personal narratives serve many purposes--to remember, argue, convince, engage, or entertain their audience. Consequently, investigators have many points of entry" (Riessman, 2000, p. 12). In connecting to her emphasis on storytelling as performance, as described above, the author asks, "in what kind of a story does a narrator place herself? How does she position herself to the audience, and vice versa? How does she position characters in relation to one another, and in relation to herself? How does she position herself to herself, that is, make identity claims?" (Riessman, 2000, p. 12). These serve as a point of entry for performance-based analysis, and the researcher is mindful of how the narrator creates 'scenes' of content. Riessman articulates that:

> "To make the process visible, we analyze scenes in relation to one another, how narrators position characters, self, and audience, and we can "unpack" the grammatical resources they select to make their moral points clear to the listener. Interpretation requires close analysis of how narrators position audiences" (Riessman, 2000, pp. 18-19).

This makes clear the focuses of her analytic process.

Riessman rightfully offers the consideration that "to emphasize the performative element is not to suggest that identities are inauthentic, only that they are situated and accomplished in social interaction" (Riessman, 2000, p. 12), which is important to recognize as validity and trustworthiness are also crucial elements to qualitative research. Emphasizing that this performing is a *social* phenomenon, existing for an audience, strengthens the idea of subjective knowledge in narrative research, as the participants also negotiate meaning as they consider their audience of interviewer, researcher, and reader.

Recruitment and Data Collection

EMDR therapists were recruited through the EMDR Canada Manitoba listings and through snowball sampling. The project sought to interview 3 to 6 individuals and 5 interviews were completed overall. The researcher worked at an agency where various staff met the inclusion criteria and could have been possible participants, and this conflict of interest was disclosed to and approved by the University of Manitoba Ethics Board as low risk. The researcher distributed the research poster and information sheet (Appendices A-B) through email, and the consent forms (Appendix D) were signed and received through email correspondence due to the COVID-19 distancing measures. The researcher also provided

participants with a Doxy information sheet upon request if participants had questions regarding the video platform used in interviews. The interviews were around 1 to 1.5 hours in length and were recorded on a manual audio recorder (rather than recording computer software), and the researcher took handwritten notes during the interviews. The interview recordings were transcribed by an outside individual, who signed an oath of confidentiality (Appendix I, p. 128), and then stored on the researcher's password-protected computer in password-protected files. The researcher provided participants with gift card honorariums and had a debriefing statement available on request if participants experienced distress or had concerns after their interviews.

Participants

All five therapist participants were women who identified as White in terms of race and culture (including Western, European, colonizer, Portuguese, Caucasian, British, Scottish, and Mennonite as self-descriptions) and ranged in ages from 39-62 years old (4 out of 5 disclosed their ages). All five participants live in the Winnipeg, Canada area and practice therapy with clients in Manitoba, Saskatchewan, and Ontario. They work in both private and public therapy settings and ranged from 5-12 years of EMDR practice. Their educational backgrounds include Social Work, Psychology, Theology, Marriage and Family Therapy, Clinical Psychology, and Educational Psychology, at Masters' and PhD levels. Through the interviews, therapists first told the story of how they decided to become an EMDR therapist, their experiences with EMDR, and how they adapted it to video-based services. Next, they were asked a selection of 14 possible prompting questions by the principal researcher to gather further information.

Analysis

This project used Riessman's (2000) approach to the analysis of personal narratives to guide data analysis. In this case, while the interviews do not gather lifespan data, they situate around an event experienced by the narrator. One temporal event or perhaps a different temporal framing is the moment of adoption of EMDR practice methods and what this offered each participant as a clinician. The second temporal event, the start of COVID-19 health restrictions is the temporal event used here to understand how EMDR practitioners adapted their practices to video or distance methods. Riessman describes storytelling as the performance of identities. The participants in this research specifically perform their *identity* as EMDR therapists through the descriptions offered in the interviews. Interestingly, Riessman's contesting of the notion of an essential self that must be 'revealed' from behind a façade of performance offers insight into the

insufficient binary paradigms of *inner versus outer self* or *personal versus professional self* that do not adequately capture the experiences of EMDR trauma therapists. In the case of EMDR in general, these contrasting narratives do not assert that one sense of EMDR's value is more authentic or revealing of EMDR's true nature than another, because "truths" rather than "the truth" of personal narrative is the meaningful semantic distinction" (Riessman, 2000, p. 19). In analyzing, I first examined the initial stories of the participants. This process of reviewing, summarizing, and quoting the separate stories is critical to Riessman's vision of narrative analysis and the assertion that narratives exist within a specific context that must be recognized. For example, the ways in which each narrative connects the various events, descriptions, and characters are part of the meaning to be analysed. I used direct quotes to provide the reader with sufficient information to experience the narratives before my specific analysis, and to add to the trustworthiness of this qualitative data within this project.

Next, I used Riessman's concepts of narrative as performance to ask how different narratives highlighted different aspects of their practices and experiences with this therapy to shape a performance of EMDR. Specifically, I asked how each narrative, based on the descriptions and events shared, assigned value to EMDR through the various qualities of the modality they find meaningful. This is demonstrated in the section 'Encountering EMDR', and the framing and contextualizing of EMDR was extracted when the narratives mentioned both the participants' experiences of becoming familiar with EMDR and the positive qualities they saw in it, according to their subjective positions. This revealed the multiplicity of 'truths' possible when considering how EMDR is practiced and how these narratives provide a vehicle for the interviewed therapists to communicate what is meaningful and valuable in EMDR practice for them as clinicians. This concept of multiple 'truths' highlights the focus on subjectivity and positionality, rather than objectivity, integral to narrative analysis.

Next, I reviewed, summarized, and extracted quotations from the second sections of the interview transcripts, in which participants responded to various probing questions. These responses were compiled and organized into the following five categories of analysis: qualities of a strong therapist, determining appropriate EMDR services, video-specific considerations, working with differences and oppression, and supports needed for therapists to be effective. The responses are represented with direct quotes and summaries within each category to further compare and contrast the multiple 'truths' existing for the participants interviewed.

Findings- Initial Storytelling

This section will examine each of the five participant's initial stories of their experiences with EMDR and practicing with trauma-impacted clients through video. Following Riessman's (2000) approach to the analysis of personal narratives that "privileges positionality and subjectivity" (p. 3), this section will resist separating themes from their narrative as a whole and instead outline the stories as they were told relationally. Each of the five interviews will be explored separately before further analysis and the incorporation of themes from the probing-question sections.

Participant 1

Participant 1 began her story with her interest in trauma work through the approach of education in theology and spirituality. She described beginning a volunteer placement with a chaplain at a hospital, who introduced her to the concept of EMDR in approximately 2005 when she was working towards her career as a spiritual health provider in healthcare settings. While she had worked in crisis phone line services, she was seeing acute trauma in healthcare but was officially working in a spiritual care capacity.

This participant described her more specific interest later in EMDR as an 'inkling' (54), and that at the time, she was able to complete basic training in EMDR with special permission, as her professional regulation was with the Canadian Association of Spiritual Care (rather than with a social work or counselling/therapy association). In mentioning training, she specifically focused on the aspect of receiving EMDR therapy as one trains, and that this revealed to her a vision of professional goals, including opening a healing centre to incorporate trauma healing through EMDR into healthcare. She described the multiple events that shaped how she moved forward at this time, including becoming pregnant around the time after her vision, recognizing she valued the stability of her healthcare employment and pausing on her dream of working in private practice, and completing her Master's of Marriage and Family Therapy (MMFT) over seven years. She described how during this time, technically trained in EMDR, working in healthcare and working on her education, she used some of her knowledge of EMDR to support her healthcare patients without using full protocol. This involved psychoeducation about trauma, resourcing (as its understood in EMDR), and incorporating in EMDR mental health tools for trauma and anxiety, such as the 'container' used in EMDR. She highlighted informed consent

and relationship-building (with both healthcare teams and patients) as supporting her success in incorporating EMDR tools in hospitals.

She described her gradual transition to private practice therapy work after graduating with her MMFT and how, in the middle of the COVID-19 pandemic, she finally left her position in healthcare (remaining as a casual employee) to work with private practice EMDR clients full-time. She mentioned how only in one client situation have she and her clients not moved beyond phase 2 in EMDR protocol, and that pacing and safety are critical to trauma-informed practice.

At the onset of the COVID-19 pandemic, participant 1's caseload decreased by half, and she reflected on the thought at the time that it would be only several weeks before the pandemic was over and she could resume regularly. However, it became clear to her that openness to video was the determinate of which of her clients continued therapy. In fact, she described some interesting findings from her initial switch to video therapy:

> "There was a couple of clients who really struggle with emotional vulnerability. For the first few sessions when we switched to online, it actually gave them permission to be more emotionally vulnerable. And I'm not sure if that's just because they felt like they could hide a little bit, they didn't feel as vulnerable as like being in front of you, and so there was a really nice shift for a couple of clients when we shifted into online." (366)

At the same time, as she described the change from working through video (in this case, the Zoom platform) to in person and back to video again, she focused on the limitations of the screen and simply working with clients' faces visually:

> "People who are really dysregulated that I've only met via Zoom, I struggle sometimes, I sort of wish, 'cause I use my body and my energy to regulate a lot, and I think some of those clients just don't pick up on that through Zoom. So it's a real balancing act, I look forward to a day when I can see people in person without a mask on again. But for those people who are out of town and who otherwise wouldn't get therapy, its great. And I have someone who's in town but she's got some agoraphobia issues, only due to a trauma." (474).

Towards the end of this line from her story, the therapist mentioned some of the ways in which video enhances trauma-informed practice, such as allowing clients to have more control over how they transition to the therapy session (in this case, by allowing the client to remain in her own home).

As this participant completed her initial story-telling portion of the interview, she offered near the end her experience of working in the healthcare setting throughout the onset of the COVID-19 pandemic (first permanently, and then remaining as a casual employee). She highlights what she understood as conceptual and structural barriers to adaptation of healthcare (including trauma support and EMDR within this) in this passage:

> "I know in the hospital…how much more telehealth, telemedicine we're doing. And it was totally possible two years ago, but it was like, we just didn't, we couldn't conceive of it, you know? It just was like technologically, I don't know, like we couldn't wrap our brain around figuring how to do it. And now its like, by necessity, we've had to. And in the hospital too right away like, we were like, we need to get some iPads in the offices, and it was interesting because it was, it was the docs who were just like, this needs to happen now and doctors actually bought the iPads before the hospital did. Because it was like, the bureaucracy of waiting to get the iPad would have taken months and it was just the docs were like, "we're buying 10 iPads" and now there's 40 iPads right, 'cause the hospitals caught up to it and like we need to do this, we need to Zoom with everyone because we can't have anyone at the bedside, so we need to be able to do this. So I think there will be benefits to that, the technology" (484).

In her healthcare position, she reflected on the challenges to meeting patients' needs (including post-trauma) in the changed circumstances of distancing measures to minimize the spread of COVID-19, and how a need was met for patients to receive care (through the doctors purchasing iPads) before the various policies of the hospital allowed this to happen on a more official level and "caught up". While this is not regarding her private practice therapy work, this participant shares here how her work supporting those impacted by trauma in the hospital setting faced barriers to adapting quickly to the changing environmental threats. She also shares her belief that the tools purchased and learned during this time will have positive impact after COVID-19 restrictions are no longer needed. This is where her story ended before clarifying and probing questions began.

Participant 2

Participant 2's story opened with her identifying that she learned about EMDR before becoming a therapist, perhaps 15-20 years ago, when she was a clinical case manager working with individuals impacted by dual diagnosis and complex mental health needs. She identified

some of these as Borderline diagnoses (which often coincide with trauma impact), cognitive disabilities, self-harm, and dissociation. She described her first impressions of EMDR as a concept as "cutting-edge" and "very, very successful" (39). After training in family therapy, this participant worked with families doing crisis work and therapy limited to 6-8 sessions with parents and youth.

She described several things happening around the same time with some uncertainty about the specific dates, including securing employment as a school psychologist in a setting for youth experiencing mental health issues and trauma, completing EMDR basic training, and opening a part-time private therapy practice. She sensed that her best estimate was that this happened 6 or 7 years ago. This private practice she felt was "very very trauma-based" (73) and titled it to reflect the combining of art and trauma therapy that she was using, with the addition of EMDR and somatic experiencing therapy. She shared about her experience of EMDR in connection to somatic experiencing and mindfulness by stating:

> "That's where I really had clients to come to me and I was, I really found that EMDR gave me this, these were clients that came to me and I could really, I would talk about somatic experiencing and EMDR, I think that I really always prioritized a very body aware version of EMDR where I do this whole preparation phase that's very much about grounding and becoming aware of being in the, in the moment with the therapist, and, you know, establishing safety within that. 'Cause that's my idea of where you can really do trauma work is in the moment- dual experiencing, right? …So my EMDR and somatic experiencing really always kind of combined…you can sort of really slow down EMDR, especially the preparation phase, to always be kind of that, to "what are you noticing now?". It's not just between sets of eye movements, but just always coming back to, "let's just stop and come into the moment". And so, in my private practice I had quite a few clients that I worked with that I did all, the full protocol with" (68).

In this part of her story, she chooses to emphasize the pacing, mindfulness and relationship-building used to practice EMDR safely with trauma-impacted clients. Similarly, she asserts that in her experience, EMDR is always combined with other established trauma therapy modalities in her preparation phase and full protocol. She stated that this private practice went like this for 1.5 years before events changed her narrative.

Next, she closed her private practice because she was hired as a trauma therapist for a local non-profit trauma therapy agency, and ended her experience as a school psychologist working with youth. She found that at this agency, the therapy she was doing was always an opportunity to use EMDR, as the clients were given access to up to two years of therapy through the agency's programming. She described it in this way:

> "Because its long-term, two years, I could do a lengthy assessment and treatment plan and phase, and that's what they came for. They're ideal clients for EMDR, because they came very ready, they've waited on a waitlist for a long time.. they wanted to address childhood trauma, unlike many of the clients prior to my private practice you know I had. It was ideal, because they really came to really do the work. They were really ready, they really understood wanting to do the stability and safety and stability phase, phase 1 and then establishing the foundation for EMDR which is container calm place or any other missing skills or resources they might need to be able to shift states. You can't do EMDR or stage 2 work unless the client's able to shift states to a calm state." (91).

In describing her experience using EMDR with trauma-impacted clients, this participant then shared about how only the minority of clients did full protocol work, but many did the foundational work of the earlier stages of protocol. She connected this to the mandate of the agency (working with adults impacted by childhood sexual abuse), and how some clients do not feel comfortable revisiting childhood in the therapy space. Therefore, working with smaller targets in EMDR (for example, not with childhood abuse memories in particular, but with other distressing life memories clients identify as more minor) may be beneficial enough for clients experiencing day-to-day post-trauma symptoms. She shared a variety of tools she used in-person with clients open to EMDR. For example, she described creating the calm place/container with clients, and using that as not only the preparation phase but as an entry point to give hesitant clients a sense of EMDR before deciding whether or not they are interested in the modality in general (to process targeted distressing memories). The calm place "assists in preparing a client to process traumatic events, to close incomplete sessions, and to help equalize or stabilize a client's distress in session if the information that emerges is too emotionally disruptive" (Hensley, 2015, p. 94). It is often a combination of developing a visualization, at the client's choosing, and then enhancing the sense of calm it brings with bi-lateral stimulation, such as tapping, eye movements, or audio tones. Additionally, she mentioned her preference for using

hand tappers, hand-held pulsing devices that offer a tactile version of the bilateral stimulation, as she found that with clients, that these offered a slowed-down pace clients responded well to. These, however, were only available for in-person sessions.

In addressing the changes brought on by the COVID-19 pandemic, this therapist immediately mentioned education support as critical, such as a six-hour virtual EMDR training and something involving Roy Kiessling. The next training, she felt added to her story took place a few months later, and she shared:

> "Another thing that really elevated my ability to do virtual as well is, was, Peter [Phil] Manfield's Flash protocol. I did that in August, last August, and it was a six hour training and a Flash technique I love… I know virtually I literally offered that to everybody, because I love Flash, because its taking a positive focus, and that's just a beautiful way of sort of integrating- "am I working on resourcing?" or I'm working on addressing because you're sort of shifting. You are linking, I mean neurologically, linking a new pathway of positive engaging focus, so that when you go and you are tapping on your legs, so these things became very easy, I found if anything virtual, what I offered virtually, whether its tapping on the legs, or tapping on the shoulders, I found it less of a difficult choice than when I was in the therapy room" (179).

Flash technique was originally developed as a part of preparation phase in EMDR, but now exists as a more flexible tool available to a variety of trained mental health practitioners to decrease the impact of disturbing memories. According to the Flash technique website:

> "A Flash Technique-trained therapist will begin by asking the client to identify a trauma memory. A principle underlying the Flash Technique is that unresolved traumatic memories are responsible for most non-organic symptoms. If the client presents with a symptom not associated with a specific memory, the therapist will help the client to find the memory that seems to be generating the symptom. After this "target" memory has been identified, the therapist will ask the client to turn his or her attention to a positive a positive and engaging memory, image, activity, piece of music or visualization. While continuing to focus on this positive distraction, the client periodically is asked to momentarily interrupt that focus. Processing of the target memory is accomplished without the client consciously attending to the original disturbing memory" (flashtechnique.com/wp, 2021).

After describing the benefits of the Flash technique, her story moved to how COVID-19 distance therapy has limited ability to do full protocol trauma work, and she identifies 'survival mode' to describe the necessary shift back to preparation, listing: "strengthening, stabilizing, resourcing, foundational- and its way more than just that, because with Flash, people have been finding the research on Flash supports that its really, it has enduring effects, it has long-term affects" (232). In this, she shares about preparation work *being* trauma work, despite the pervasive view that full-protocol processing is needed and trauma memories need to be revisited to do impactful work. In mentioning 'survival mode', she emphasizes the extreme change and uncertainty faced on a global level at the onset of the pandemic, impacting the mental health of a wide range of clients.

This therapist shared that her current impressions of her EMDR work are very much shaped by the concept of the 'healing vortex' and the resourcing so that clients can shift states and feel a sense of presence rather than fear of trauma triggers. While the 'healing vortex' was not described as a formal concept, the therapist described it as the culmination of positive resources that shape a client's energy and allow them to engage with trauma content with more choice and awareness. This is possible when they know that they have the security of positive resources, both physically and with mental resources developed through positive engaging focus in the therapy space. She described clients gaining this sense of control and having not only their comfort objects and physical grounding tools, but, in connection with Attachment Theory, developing supportive figures that clients can visualize in order to resource. She emphasized the positive, 'beautiful' resourcing parts of protocol and how important they are to how she practices now through video. She also identified the work of Katie O'Shea and Sandra Paulsen on preverbal trauma as compelling to her at this point. At the end of her story, she mentioned how, while it "took a lot" (298) to integrate different trainings focusing on belief systems, emotion, and shame into her original EMDR training, she senses now that she has sufficiently combined the practice approaches that make sense for her. These comments ended her story.

Participant 3

Participant 3 opened her story with her initial interest in trauma and addiction work. She worked in group homes during her undergraduate degree and felt she saw intergenerational trauma and substance use everywhere throughout the work. Part of her graduate education involved her working in the field of addictions services, and here she was reminded again of the

'marriage' of trauma and substance use. She described the range of similar and conflicting theories she noticed in trauma treatment modalities, such as the idea of encouraging clients to 'open up' about detailed traumatic memory, which she sensed almost to be exposure therapy, but also leaders in the field who teach that talking about trauma memories is retraumatizing. She described the sense that trauma was treated as a 'scary' area of therapy to work in, but that paradoxically, it was unclear as to which modalities were safest and most effective. In addition to this, she mentioned needing simultaneously to follow clients' preferences in order to be client-centred, leaving her with a variety of options but not a specific path of treatment.

When she found EMDR, she remembers being drawn to the specific protocols. At the same time, she felt EMDR was able to fit for both clients interested in telling their trauma story as well as those who cannot tolerate discussing memories, making it more effective for more people than previous tools she was using. She mentioned adaptive information processing, and the ability to access emotions and neuropathways associated with trauma, without needing clients to verbalize trauma memories. In her view, emotions 'stuck' because of trauma could be processed through the bilateral stimulation component either way.

At this time in her personal history, she was working at a community-based agency and proposed to her employer that she complete the EMDR basic training. This non-profit worked in the inner city with community members experiencing complex trauma, intergenerational trauma, sexual exploitation, and substance abuse, and the participant proposed that if they funded her training, she would use it at the agency. She was successful in this initiative, but she offered her view on her foundational training in this passage:

> "That's the other thing about therapy that I think is really frustrating… the training teaches you some stuff, but, and maybe this is like every other profession as a psychologist, you're probably going to laugh at me, but its like- why? Why can't we learn EMDR in our training program? Why do I have to do this outside of my training program? And these kind of modalities end up being the interventions that I'm using with people!" (109)

She ended up completing the training and felt she used it successfully at her agency, identifying that it became her dominant tool or outlook regardless of the client. She then brought it to her present work in private practice and emphasized this impact by stating that, in her own experiences, she guesses that for 98% who access her services for EMDR, they have fully

processed the target issue they identified within 12-14 sessions. They end the therapy relationship as they feel they have had their therapy goals met within that time period. She mentioned here a client who ranges in his comfort level with the bilateral stimulation piece of EMDR, but that she notices significant processing happens at a quicker pace when they are in a period of using EMDR in sessions. In keeping with the efficiency, she has noticed, she described feeling like EMDR "cuts through all the rationalizing and intellectualizing and narrative that we create around things" (151) to let the client lead their own healing with bilateral stimulation to support. She described this as immensely satisfying to clients as well as to herself as the therapist.

Participant 4

Participant 4 opened with her experience of working in private practice, specializing in work with children and adolescents, and that one experience of a young child's mother dying from cancer urged her to work more in trauma to support families. In surveying trauma therapy training modalities, this participant noticed that many seemed, to her, to work with clients outside of their windows of tolerance, which did not seem appropriate to her. She trained at the basic training level of EMDR and found this to be a better fit for her work, but that some of the approaches from her first trainer left her wanting more information. She trained to become certified with a well-established educator and completed the required 20 hours of consultation to achieve this level of training. This trainer resonated with the participant based on their mutual value of structure, and the participant found that in her practice, this additional training resulted in her being more aware of dissociation and pacing of EMDR protocol. This participant shared additional information about her training and work that has been omitted due to the presence of potentially identifying information.

She then highlighted some of what attracts her to EMDR, such as its ability for flexibility and expansiveness to include additional tools and techniques. The participant credited the Adaptive Information Processing model as a lens through which she can see a variety of possibilities for client, including the incorporating of Cognitive Behavioural Therapy, Dialectical Behavioral Therapy, and Acceptance and Commitment Therapy. In this passage, she tells about the mindfulness and body-centred aspects of how she practices EMDR:

> "It just kind of really fits with how I love to do therapy. And I can bring anything in that I want to. So I use a lot of somatic therapies as well, or pieces with somatic therapies,

> ‘cause we’re processing from the bottom up right? Bottom up is body. So if you’re in EMDR therapy and you’re not aware of the body, you know that’s a little dicey, you need to be aware of the body right? I’m always watching my clients body language for clues of what their experience is. They don’t always notice their body and how their body is holding the trauma, so sometimes we have to bring attention to that so that they can release and honour how their body is holding the trauma. So my experience has been amazing.” (123).

Next, she mentioned the efficiency and minimizing of harm possible with EMDR and how, by removing the need for memory details encouraged by other approaches, EMDR is not only efficient in focusing on the body and brain *impact* of trauma for clients, but it decreases the exposure of trauma content on the therapist. This minimizes the vicarious trauma that is a reality for practicing trauma clinicians.

In describing the skills needed for effective practice, this participant used the metaphor of a musical record being played to symbolize trauma events (which she credits to Kathleen Martin). In this metaphor, if the record represents the course of time, then, if the record can only play certain sections for a client, the memory is not processed. Because the therapist must not skip ahead beyond a client’s pacing, this metaphor highlights patience and client-centred practices as critical to effective trauma work in EMDR.

When the participant’s story moved towards adapting practice to video, she identified the Flash technique as an important tool in making EMDR versatile and safe to use with clients online. She explains:

> “The Flash technique has become a main staple in my telehealth toolbox, it’s an implicit processing protocol, so you don’t have to explicitly visit the past memory. And because you’re processing implicitly, you can bring that, the subjective units of the stress down pretty quickly, and when you can bring that down then you can use the standard protocol to target it. So sometimes we want to bring that distress down a little bit, especially if you haven’t seen the client in person before or you haven’t processed with them before ‘cause you don’t know how they’ll react to the processing. Then we can do the implicit processing through the Flash technique first.” (219).

This passage demonstrates the ability for clinicians to utilize EMDR tools, such as the Flash technique, to explore a client’s ability to work with the processing in EMDR without needing to

verbalize the trauma memories. This can be important in gauging a client's needs within the first stages of relationship-building with clients, even through video services, while still being supportive to the client's presenting issues and distress. The participant went on to describe other considerations for her when working through video. These included setting up the cameras to view more of the client's physical presentation (based on the therapist's need to gather more visual information to learn about the client's state, as the therapist connected to Polyvagal Theory), developing with the client body self-awareness and observational skills, and checking in with clients about their physical locations in case of an emergency.

The participant emphasized the importance of *planning* in ensuring safe trauma EMDR work, such as planning for the client's privacy throughout the session in their personal space, planning self-care with them for after session, and setting up the bilateral stimulation plan (such as reviewing the use of the eye movement app or demonstrating the Butterfly Hug tapping). With this planning and additional considerations, the participant shared about EMDR's continued ability to be an important trauma treatment model through video.

Participant 4's story ended with her impression of the EMDR community at the onset of COVID-19 as an experience of *coming-together*. She gave an example of the power of EMDR in navigating the global pandemic:

> "Ignacio Jarero, who invented, we'll say, the Butterfly Hug, has been around during the pandemic right from the very beginning and talking about how the Butterfly Hug could be used for medical professionals. Especially those in Italy at that time, that were experiencing a lot of distress, they were working really really long hours, and so he talked about how to help them. Even just for five to 10 minutes at the end of their shift, using the Butterfly Hug. [He] has rewritten his Butterfly Hug protocols and…has talked about how he is using the PRECI protocol, which is a recent events protocol for COVID long haulers and people who have experienced trauma during the pandemic- whether they've been separated from a loved one, a loved one's passed away, they've had their own traumatic experiences with having COVID or watching somebody else have COVID, or even disruptions to their life because of the pandemic" (344).

She shares about EMDR leaders responding effectively to emerging global tragedy (and both individual and collective trauma), but also mentions Global Alliance of EMDR Practitioners and EMDR Canada supporting their members through webinars and volunteer consultation groups.

These remarks about the EMDR community's strength during a time of transition (for practitioners and clients alike) end her story.

Participant 5

Participant 5 began her narrative with working with youth at a community health centre, where she was for five years, and that this is when she first became aware of EMDR. Her youth clients were experiencing disordered eating, self-harm, and various issues with self-regulation and coping, and she was working with traditional 'top-down' therapies, such as CBT, DBT, and some mindfulness-based approaches. While she often felt she received the feedback that having a safe place was most beneficial to the clients, she noticed sometimes youth getting 'stuck' and not achieving their therapy goals with participant's existing tools and techniques. She was aware that some similar local agencies had staff working with EMDR, but it wasn't a part of her organization or something they were entirely familiar with. She created a proposal for her health centre and received funding through a city-based foundation to complete the training and then use it at her place of employment, and she guessed this was in 2015. She shares about her first impressions in the training by stating, "I was, really shocked I think by the effectiveness and what it was like to step aside, I guess, and let peoples' brains do the healing. So to be directive, but also kind of shifting from leading to holding and following, I guess I would say" (48). She described the outcomes of this treatment but also how it differed from her 'top-down' therapy training. She identified some of the presenting issues she addresses with EMDR work, including, "needle phobias, fright anxiety, like a history of childhood neglect, abuse, medical trauma, just a huge range of, of things that would just be overwhelming for someone's brain, and just disrupt their functioning, and get stuck" (76). She highlights how a variety of life events can be considered trauma, and that in her EMDR viewpoint, trauma overwhelms mental processes, interrupts functioning, and creates the 'stuck'-ness clients often feel. This may expand 'trauma' to include a wider range of things that may impact client well-being. She described being largely successful with her implementation of EMDR work, but directly after, emphasized the longer process of informed consent necessary to be trauma-informed. For her, this may include more detailed explanations, providing a demonstration, watching educational videos, and practicing the sensory components in advance. In addition to this extended informed consent, this participant identified her own belief and passion for EMDR as important to authentically showcase its potential to curious clients:

> "People kind of, they shift, and so it's been hugely successful in helping people um get better in a way that I found traditional talk therapy isn't… Overall, I think the therapist is really the, the tool and its whatever, like you know me being able to kind of sell it, and my belief in it, I think really helps people adapt to that and be successful with it" (92).

This concept of the therapist as the tool asserts the importance of the human component beyond the adherence to protocol.

When this participant moved her story towards her experience of using video, she shared that she's been using video EMDR therapy with a rural client before the onset of the COVID-19 pandemic, so it was something she had familiarity with. She shared first trying a free online program that provided the bilateral stimulation on-screen for the client, rather than the therapist or client creating it, but that this was 'clunky' (118) and insufficient. She then found she used mainly the Butterfly Hug form of bilateral stimulation and identified some barriers she has noticed in practicing through video. These three included being less able to recognize micro-expressions through the video screen, finding clients are already less regulated by the uncertainty of the pandemic, and noticing frequent interruptions during video sessions, such as seeing clients' family members walk by in their homes, or realizing clients are on video from their cars. She named using shorter sections of processing, if she was in a stage of processing trauma memories with a client, as well as facilitating more check-ins throughout sessions as important steps. She mentioned how, despite these limitations, good therapy was happening and that clients appreciated therapy remaining accessible and constant during a time of change. She shared that shifting from more imagery-based regulating to body-based regulating has been helpful in making EMDR feel more tangible in video sessions. These last comments ended her story as she experienced it.

Narrative Methodology and Analysis

Before the participants were asked a selection of probing questions, detailed and thematically organized, their interviews were shaped only by the introduction interview question, asking them to share their story of discovering EMDR for trauma-impacted clients, practicing generally, and then adapting to COVID-19 pandemic conditions. These five narrative accounts were first attended to distinctly, as individual narratives, and will now be analyzed in connection to Riessman's "Analysis of Person Narratives" (2000).

Encountering EMDR- The Use of Narratives to Perform and Convince

Riessman lists, among the uses of the narrative, the ability to perform preferred identities, but also to "remember, argue, convince, engage, or entertain their audience" (Riessman, 2000, p. 12). While she analyzes her featured narrative interview through the lens of story as performance, I argue that here, the stories told can combine performance and convincing in their purposes. Through their descriptions of using this modality for therapy and trauma treatment, the five EMDR practitioners performed their understanding of the meaning and value of EMDR in order to *convince* the audience of the value of EMDR. Riessman argues that narrative research analysis can draw on many different framings and resists a singular objective truth, and this particular data cannot be separated into entirely pure categorizations. Themes weave throughout different stories and echo previous and upcoming ideas, challenging my ability to organize meaningfully across different participant interviews. Notably, while the stories are marked here with one set of categories, concepts return again and again throughout their accounts. Through the lens of storytelling as convincing, I will analyze the temporal moment of therapists first encountering EMDR in their interviews and explore how they construct EMDR to *convince* the audience of its value through their accounts of practice strategies. This construction will consider the entire span of the participants' interviews and offer one interpretation of analyzing the data thematically.

First Encounters with EMDR

Participant 1's narrative connected her initial encounter of EMDR to her journey to develop greater knowledge of trauma treatment through the lens of spiritual care, and remarked of the first person to introduce it to her: "he was a trauma chaplain in the hospital…and so he told me about EMDR, and it was one of those things that I kind of stuck in the back of my mind, and I didn't worry about it at the time, I was really intrigued by it…I, I learned a very little bit about it, um but it kind of, I put it in the back" (line 44). She later mentions that after working in the field, she experienced an 'inkling', that it "popped in my head" (59) to pursue the EMDR training. Her word choices situate her pursuit of EMDR as an intuitive choice, rather than a requirement or a pressuring from outside forces, which lend a deeply personal tone to her introduction to this modality. In stating "it was one of those things", she suggests a shared understanding with the interview audience of a common experience of being spontaneously impacted by something, and the language choice of 'inkling' suggests the inner, rather than outer, motives for seeking this modality. Here, her narrative performs a framing of EMDR as an

intriguing, personal option from her therapist perspective, which serves to convince the audience of EMDR's personal value (of therapist interest, rather than external expectation based on outcomes).

This performance of EMDR as personal in her narrative appears as she chooses to share about her experience of training, including the receiving EMDR required within the training. She chooses to include her own experience of EMDR, which convinces the audience of her personal belief in the results of the process. In this account, focused on receiving the treatment, she mentions the emotional and cognitive benefits of treatment in her experience, articulating that "I released a lot of emotion and trauma and all the wonderful things that I got to work on, and I felt like my, my brain was alive, like it was, I guess I could feel like, it was like, it was like feeling like my neurons were realigning" (92). She frames this experience as an asset of the training model, rather than a hinderance, when she uses the phrasing "got to work on", implying that working on herself through EMDR training was a positive opportunity. This performs her vision of this modality as improving her life, convincing the reader of its value to her even outside of her professional role and her overall belief in the modality.

She further cements this positive framing, stating, "it broke me open in the best kind of way. And so when I got home, I was like, I was going to quit my job, and I was going to go into private practice and just do this phenomenal thing I just learned" (105). Here, she uses temporal cues to demonstrate to the audience the urgency of her experience, positioning her desire to make shifts in her career directly after returning from training, and uses the strength of the word 'phenomenal' to enhance her convincing further.

Her interview carries the audience through her experiences of working as a spiritual health provider at a major hospital and noticing unfamiliarity amongst the psychiatrists of how this modality works. She states, of the unfamiliarity, that "I worked in the hospital, the idea that I would come and do trauma work for people was like so bizarre, like it was just like out of scope, and I don't know how much of that was my belief about my scope of practice" (173). Despite this uncertainty, she framed EMDR here as having immense potential in the healthcare system, but that the barriers in public health were doing a disservice to patients that EMDR could remedy. She framed her frustrations by stating:

> "I'm in a system that wants nothing to do with integration. And so I'm like, we can be saving millions, we can be intervening in the ER, we can, we can have staff right after

> dealing with that traumatic incident, we can have them being processing onsite or within weeks so that they don't come back with PTSD. They aren't going on Worker's Comp, these, these people that we shove out the door, they aren't coming back in six months with PTSD, going from our ER to our psychiatry room" (181).

Here, she uses her story to imagine possibilities in which EMDR is used as a tool within emergency medicine, and imagines the burden lifted from individuals and systems if patients can process trauma promptly. She advocates that trauma treatment then lessens the involvement of psychiatry and public financial support, and her present- and future-tense account serves to convince the audience of EMDR's possibilities beyond the scope of clinical, long-term treatment. This grammatical strategy places EMDR firmly in the present and future and conveys her belief in the expansion of this treatment's value.

Participant 2's story begins with her experience of learning about EMDR before being a therapist, at the time when she was working in trauma-impacted mental health through her case management work. This was perhaps 15-20 years ago, when she was a clinical case manager working with individuals impacted by dual diagnosis and complex mental health needs. She identified some of these as Borderline diagnoses (which often coincide with trauma impact), cognitive disabilities, self-harm, and dissociation. She described her first impressions of EMDR as a concept as "cutting-edge" and "very, very successful" (39). After training in family therapy, this participant worked with families doing crisis work and therapy limited to 6-8 sessions with parents and youth.

Participant 2 frames her introduction to EMDR (and the introduction to her story) as one rooted in trauma work, rather than in therapy specifically, which is an interesting distinction. In doing so, she positions her noting of EMDR as a response to client need (in this case, clients accessing mental health care) rather than as a therapist-initiated development. She mentions the complexities of her clients' experiences as a driving force to exploring the modality of EMDR based on its potential success for clients even before she completed therapy training. By introducing EMDR within her lived experience story in this way, she performs EMDR as a modality that acts in the service of clients beyond what other modalities or mental health care approaches can offer. This serves to convince the audience of EMDR's ability to meet a range of complex and diverse client needs connected to trauma. In part, separating her work from her initial impressions of EMDR (by beginning the story earlier than her training and practice as a

therapist) convinces the audience that her attention to EMDR at first was in service of her clients, rather than as something she could immediately pursue in her professional area at the time. This showed Participant 2's impressions of EMDR as separate from her practice at the time, which emphasizes its value for clients within the areas of mental health and trauma, rather than its value for professional development.

Participant 3 begins her narrative with her initial interest in trauma work and the connections between intergenerational trauma and substance use. She situates her story first with her background working in group homes and then that part of her graduate education involved her working in the field of addictions services, and here she was reminded again of the 'marriage' of trauma and substance use. She described the range of similar and conflicting theories she noticed in trauma treatment modalities, such as the idea of encouraging clients to 'open up' about detailed traumatic memory, which she sensed almost to be exposure therapy, but also leaders in the field who teach that talking about trauma memories is retraumatizing.

She described her sense that trauma was treated as a 'scary' area of therapy to work in, but that paradoxically, it was unclear as to which modalities were safest and most effective. In addition to this, she mentioned needing simultaneously to follow clients' preferences in order to be client-centred, leaving her with a variety of options but not a specific path of treatment. In this opening account, she situates her story as a practitioner with experience interacting and working with the types of communities and populations she saw as impacted by trauma, but then when developing her skills as a therapist, seeing discord amongst trauma treatment approaches. She describes a moment of feeling unequipped by the mixed information available to her and that impacting her emotions in the sessions here:

> "It kind of left me feeling frustrated because, yeah- just so many experiences with trauma of people feeling like they needed to retell the story, and then as a therapist feeling a lack of confidence and feeling scared, even though if your client-centred and the person wants to tell their story, they should be able to tell their story (chuckle) right… So just with all that conflicting information and nothing feeling clear, when I heard about EMDR it was just like, oh wow this seems like a very clear-cut manualized kind of treatment approach" (64).

This summarized Participant 3's introduction to the modality, before her narrative contrasting of EMDR with other therapy modalities.

Participant 4 opened with her experience of working in private practice, specializing in work with children and adolescents, and that one experience of a young child's mother dying from cancer urged her to work more in the area of trauma to more strongly support families. In surveying trauma therapy training modalities, this participant noticed that many seemed, to her, to work with clients outside of their windows of tolerance, which did not seem appropriate to her. She trained at the basic training level of EMDR and found this to be a better fit for her work, but that some of the approaches from her first trainer left her wanting more information. She trained to become certified with a well-established educator and completed the required 20 hours of consultation to achieve this level of training. This trainer resonated with the participant based on their mutual value of structure, and the participant found that in her practice, this additional training resulted in her being more aware of dissociation and pacing of EMDR protocol. This participant shared additional information about her training and work that has been omitted due to the presence of potentially identifying information. This beginning of her story marries EMDR with effective strategy, in the participant's experience, such as screening for dissociation and strong intervention fidelity. Already, Participant 4's story focuses on therapist needs (strategy, training) to practice EMDR in the way that feels best to her. This frames EMDR as a worthy model to therapists, but that effective strategy is paramount, reinforcing the work of this project and exploring therapist experiences of EMDR.

Participant 5 first positions EMDR in her account in contrast to her first counselling experiences, which serve to offer descriptors of 'talk therapy' that she had been using. This analysis of 'talk therapy' will be explored in the next thematic section. She names Cognitive-Behavioural Therapy and Dialectical Behavioral Therapy as two of the models she was working with, and describes talk therapy as 'traditional' and, like other participants mention, 'top-down', meaning engaging with verbal levels of the brain, rather than somatic interventions. She describes what she understood to be helpful for clients with these interventions, listing having a psychologically safe space, positive therapeutic rapport, and advocacy as some of the aspects that clients liked. She noted here that seeing some participants get 'stuck' and experience limited outcomes with these counselling tools lead her to consider EMDR. This narrative positioning first offers the context of her professional life as a therapist before EMDR training, which lends the audience context to her first impressions of EMDR.

Together, these narratives offer context and background to the significance EMDR has earned in their narratives of therapist practice.

Deeper Impressions and the 'Talk Therapy' Distinction

Throughout each of the interviews, participants interacted with 'talk therapy' as a contrasting practice realm to EMDR to varying degrees. This section reflects on 4 out of 5 of the participant's framings of this concept. Some name this distinction with this phrase outright, and others use a more general concept to organize their impressions of therapy modality usefulness. For example, while some therapists articulate an inability to meet client needs through 'talk therapy' modalities, others describe an integration of 'talk therapy' strategies with EMDR to advance their skills.

Participant 2 tells a story of her first use of EMDR in her private practice, years after her introduction to the model, after completing training. This private practice she felt was "very very trauma-based" (73) and titled it to reflect the combining of art and trauma therapy that she was using, with the addition of EMDR and somatic experiencing therapy. She shared about her experience of EMDR in connection to somatic experiencing and mindfulness by stating:

> "That's where I really had clients to come me and I was, I really found that EMDR gave me this, these were clients that came to me and I could really, I would talk about somatic experiencing and EMDR, I think that I really always prioritized a very body aware version of EMDR where I do this whole preparation phase that's very much about grounding and becoming aware of being in the, in the moment with the therapist, and, you know, establishing safety within that. 'Cause that's my idea of where you can really do trauma work is in the moment- dual experiencing, right? …So my EMDR and somatic experiencing really always kind of combined…you can sort of really slow down EMDR, especially the preparation phase, to always be kind of that, to "what are you noticing now?". It's not just between sets of eye movements, but just always coming back to, "let's just stop and come into the moment". And so in my private practice I had quite a few clients that I worked with that I did all the full protocol with" (68).

She not only walks the audience through some of her practices, but she makes the distinction of EMDR as a somatic practice, separating it from other modalities (which other participants refer to as 'talk therapy'). She describes in this lived experience story her use of tools to keep the client in the present moment (establishing safety and minimizing dissociation). She identifies

that for her, the strength of the trauma processing happens when clients are present to their body experience, and this highlights the previous participant's separation of EMDR from 'talk therapy', in which the language of the 'story' of clients shapes the therapy experience, rather than connecting the verbal component to the use of body awareness (and bilateral stimulation) with a skilled therapist. In this passage, the participant not only describes the importance of client awareness of safety in the moment (and how she, as a clinician, facilitates this), but frames EMDR as offering valuable methods to achieve this. She convinces the audience of EMDR's value for trauma treatment and positions it as original within the context of therapy modalities.

Participant 3 brought her story to her present work in private practice and emphasized this impact by stating that, in her own experiences, she guesses that for 98% who access her services for EMDR, they have fully processed the target issue they identified within 12-14 sessions. They end the therapy relationship as they feel they have had their therapy goals met within that time period. She mentioned here a client who ranges in his comfort level with the bilateral stimulation piece of EMDR, but that she notices significant processing happens at a quicker pace when they are in a period of using EMDR in sessions. In keeping with the efficiency, she has noticed, she described feeling like EMDR "cuts through all the rationalizing and intellectualizing and narrative that we create around things" (151) to let the client lead their own healing with bilateral stimulation to support. She described this as immensely satisfying to clients as well as to herself as the therapist. This narrative employs a choice of framing used by other participants, such as participants 1 and 2, framing EMDR in contrast to 'talk therapy' in order to convince the audience of its distinct value. By describing the process of other clinical modalities as rationalizing, intellectualizing, and narrating, she echoes the idea that talk therapy creates an obstacle to client healing (that EMDR does not) through talk therapy's focus on language rather than felt physiological experience and mindfulness (as Participant 2 described). Here, she highlights this from an efficiency perspective, and how healing from the body and nervous system first is more efficient than from a language- or story-based modality, as trauma is a body experience. She uses her experience here of client outcomes to illustrate this point, successfully performing EMDR as an 'efficient' modality through her narrative framing.

Further to this theme, when describing some of the strengths of EMDR later in her story, she returns to this theme of EMDR as distinct from 'talk therapy' modalities in general. She

strengthens this distinction for the audience, highlighting the value of EMDR, by using multiple metaphors. She comments:

> "Getting the brain offline to process the emotional stuff is also another strength. I don't know what the bilateral stimulation does, like I don't think that they have like a very specific thing that they know, "okay, when we do the bilateral stimulation it specifically does this", it doesn't, but whatever the BLS does, clients respond…So that's a strength, whatever it is that it's doing (chuckle) its super effective and powerful, not only in the processing of emotions but even when you slow down the machine and use it in the rhythmic resourcing state, that tactile stimulation or those eye movements are super powerful" (510)

Her illustrations of the brain 'offline' to describe focusing on the felt sense of emotion regulation, rather than the verbal describing of emotion regulation (which could here be described as 'online', accessing the verbal part of the brain), connects to her earlier telling of EMDR 'cutting through' some of the components of talk therapy that EMDR may find unnecessary for healing. Again, she describes the bilateral stimulation through EMDR protocol as slowing down a 'machine', which lends a very distinct understanding of the client compared to other therapies, and these metaphors create a stronger understanding of this distinction for therapists and their valuing of EMDR at a practice level.

Participant 4 focuses on strategy in her narrative, even when commenting on the 'talk therapy' distinction seen by other participants. In this next passage, she not only lists the tools available to her, such as the calm place exercise, breathing, incorporating in CBT and DBT, but paints EMDR as a framework (and names the Adaptive Information Processing lens, discussed in the Literature Review) through which a variety of tools can fit at any given time. She uses the term 'house' to describe this:

> "What I love about EMDR is it doesn't say- "this is the only thing you can do". It says, you do what you need to do for your client, but know which house you're working out of, are you working out of your CBT house? are you working out of your DBT house? are you worked out of your EMDR house? I work out of my EMDR house. So that means that I always am looking at a client through the AIP lens, Adaptive Information Processing lens, and then I bring in what I need to bring in. So in stabilization phase EMDR certainly has, in the studies it tells you, you know you can do contain their calm

> place, maybe some breathing and then get into processing, but that's not typically my mode of operation unless I have a client who's very well stabilized coming in. I'm usually doing a lot more work in phase 2 but I'm bringing in other things, like DBT skills, I do cognitive behaviour therapy…so mindfulness is obviously a main practice, because EMDR is a mindfulness therapy, no if, ands or buts, we're always noticing, observing, in the present moment. We're now and "notice now" becomes part of your vocabulary, we say it like a broken record, right? So mindfulness is very, very key to EMDR. But I have all those tools and I can bring them in whenever I see fit, so whether its during stabilization or processing or, you know, closure phase, which is basically make sure you end your therapy session in a good way, where your client has some closure" (93).

Interestingly, when she describes the tools she uses to support client safety and encourage stabilization, she addresses the 'talk therapy' concept and how EMDR incorporates the advantages of talk therapy into a trauma treatment approach. She notes next that, although clients are not required to 'tell their story' within the EMDR therapy process, disclosing details of traumatic events (this being likely the focus of some 'talk therapy' modalities), often feels important to them *after* they have experienced some sense of safety through the emotional regulating and preparation stages. In her experience, clients are perhaps only able to receive the empowering benefits of 'telling their story', such as determining their own meaning of life events and receiving normalization and validation, once they can share verbally in a way that is no longer re-traumatizing. When clients have resources to stay present, cope with trauma triggers, and regulate their emotions through EMDR, they can make sense of their life experiences without causing themselves further harm.

In describing EMDR this way, Participant 4 demonstrates how 'talk therapy' and EMDR do not need to remain separate, but that EMDR can enhance the work of 'talk therapy' while supporting clients in staying present and mentally resourced. She describes several metaphors for her practice strategies, such as 'peeling back the layers of an onion' and 'playing a record all the way through, no longer 'skipping' on the moments of trauma', and these unique interpretations demonstrate her vast experience using EMDR with clients. This uniting of modalities in Participant 4's account demonstrates how EMDR is valuable even for clients interested in exploring their experience through a language- or narrative- focused lens.

Similar to Participant 3, Participant 5 describes EMDR as effective while (or, because of) bypassing certain aspects of talk therapy. She describes the role of the therapist in EMDR as a stepping aside in order to facilitate clients' brain healing, and uses the language of shifting from leading to holding and following a process in EMDR. When she describes using this modality with clients, she draws upon themes articulated by others:

> "I don't necessarily mean full, full protocol reprocessing. So a lot of the time its, its I think more about coming at it from an EMDR understanding of neuroplasticity and regulation and our nervous systems and so you know even with someone that would come in to see me for, you know, just really straightforward anxiety and no necessary histories of, of trauma (although I would argue that like, growing up with anxiety would be trauma and very overwhelming for people). And I think a pure EMDR therapist would say, no you need to do you know full EMDR on that, but, but I have found its quite successful to, to use this lens to build self-regulation resources, to help, like help explain what might be going on for people in their body to help them tell the story that makes sense for them" (56).

She echoes Participant 2's focus on resourcing as healing and helping participants develop coping tools that they can use in sessions and in their life contexts. Additionally, she mentions the role of helping participants conceptualize their own experience, which aligns EMDR with strengths of talk therapy modalities. Here, a narrative therapy concept works to empower clients to frame their experiences with an understanding that is emotionally meaningful to them. Finally, like the other interviews, her story emphasizes the need for therapists to use protocol flexibly, which emphasizes its value to the audience of adapting to a wide range of situations.

She reiterates her own value when describing what makes a strong EMDR therapist later in the interview, saying "I think that coming to EMDR with a really strong base of trauma therapy and other techniques makes you a better EMDR therapist" (247). This combination of EMDR with other therapy frameworks strengthens her ability to be trauma-informed and client-centred. She returns to her narrative thread of strategy later when she describes:

> "for me, I need to assess- what's someone's level of dissociation? Are they able to regulate between the sessions? Do they have supports, you know, are their basic needs being met as much as possible? 'Cause we can't always control that with folks who are traumatized, just in terms of sleeping, eating, movement. Yeah, so I think anyone can do

> it, it's about, can they manage that intensity and, even if folks can't, we adapt, so we do things like the, like the Flash protocol" (326).

Here, she uses trauma-informed practice and tangible steps to guide her client-centred work, and highlights the Flash protocol, which was discussed by participant 2 in more depth. This ends Participant 5's addressing of the 'talk therapy' contrast.

While these narratives center the distinction between 'talk therapy' and EMDR in their accounts of strategy, experience, and opinion, they similarly highlight the unique strengths that EMDR brings to trauma therapy in general. They perform, through their stories, the value of EMDR in making any integrated trauma work psychologically safer, mindful of the body, and more intentional. These constructions of EMDR are used to convince the audience of EMDR's usefulness as a framework.

Tools and Techniques

Participant 1 describes her use of EMDR in the medical setting of her story by saying, "I would do, you know, resourcing and, and installing resources…or just teach people about containers…that phase 1, phase 2 stuff, but really, like the odd, odd time I'd do a little bit of tapping with people, and help people through some stuff" (196). She names 'containers', one of the tools used in EMDR to support clients in grounding and to increase safety in processing traumatic events, and mentions only the beginning phases of EMDR protocol, framing EMDR as having treatment abilities without the necessity of full protocol (and all phases of the model). This narrative serves to convince the audience of EMDR's flexibility and ability to adapt to the situation and treatment-receiver's needs.

In Participant 2's narrative, she details working at a community agency and mentions again and again the safety and stability components that lay the foundation for other processing and full protocol EMDR. She emphasizes the role here in supporting clients to fill in resources they lack in order to be prepared for other phases of EMDR, and these resources including developing a 'container' with clients (being able to access a 'container' visualization for the EMDR processing work to support client psychological safety in between sessions) or a 'calm place' internally (so that clients can shift states when in distress or when faced with being emotionally overwhelmed). In this way, she echoes Participant 1's first comments of strategy in mentioning containers. She deepens this emphasis on the foundational stages by sharing how she introduces this to clients, which involves psychoeducational material on safe trauma therapy and

how EMDR tools can be beneficial to all clients, whether they complete the full protocol or not. With this, she adds that at the agency where she works (supporting adults impacted by childhood trauma), she has been able to offer EMDR to 98 percent of her client caseload. When she tells this story this way, she frames EMDR as critical to *safety* within trauma treatment, and that body awareness and present mindfulness contribute to this value of EMDR. She convinces the audience of EMDR's value while emphasizing its distinction within trauma treatment.

Participant 2 then shares an account of her practice with clients at her current position and here describes some of her practice. She again distinguishes how she does not often complete the full protocol with clients, but that this is not necessarily the goal of treatment, emphasizing that the client preparation phases create significant stability. She identifies how full protocol maps out targets, or specific memories to process with bilateral stimulation, and that this involves "the first, the worst, current triggers and future" (121) experiences of trauma as experienced by the client. However, she describes how in her practice, focusing on creating client comfort means she begins with smaller targets that clients might feel create less distress. In addition to this, Participant 2 inserted context into this story, reminding the audience that at her place of employment, clients typically have more than one trauma event, and that sorting through which order a client wants to address and process the past is part of the process. In this narrative framing, Participant 2 reconnects EMDR work to trauma-informed work by demonstrating her practices that serve the psychological safety of individual clients.

Participant 4 offers an interesting passage about framing EMDR to clients, and this enhances how she frames EMDR throughout the story. She describes, in getting to know a client for the first time, arriving at a metaphor based on their personal interests, and will use, for example, sports analogies to describe EMDR to a client interested in sports. She begins explaining to them the 'window of tolerance', her preferred description of hyper- and hypoarousal, as well as signals this is occurring, symptoms, and possible triggers. This passage shapes the arch of this story:

> "A pretty basic explanation, after we've explained the window of tolerance and the way that our system works, where we typically go into sympathetic nervous system activation first, and then down into dorsal vagal if our system is perceiving… if it wasn't being able to regulate through that sympathetic nervous system. So we've kind of explained that, the signs that you're either one of those right, developing that awareness of when they're in

> and out of their window, 'cause what we want is one foot in the window at least for processing. We need to be present while you visit the past. If that makes sense. So I do talk about how we need that dual awareness of knowing that you're here in my office with me in 2021 while we visit the memory and the material that's associated with that particular memory…So I like to think of the memories as snapshots…And so we have the snapshot of the memory, of the past event that's occurred, and the snapshot has on it basically the three levels of the brain right. So we have the images and the cognitions associated with it, what we think about ourselves and the world at that time as we think about this particular memory or snapshot, the emotions that go with that, as well as the body sensations and what's happening in our body…So the snapshot has a lot of material on it right, so it has all of our sensory information, what we see, hear, smell, touch, taste and kinesthetics, as well as what we're thinking about ourselves in the world, that image of the trauma and usually that worst image kind of sticks with you…It kind of replays over and over again in your head and then the emotions that are activated that go with that" (691).

Building on that introduction to the window of tolerance, this description incorporates polyvagal theory (involving the nervous system experiences) and the metaphor of memory as a snapshot. She describes dual awareness as having one 'foot' in the present, even as the past is explored, to regulate, and this description demonstrates how she might convey to clients the power of traumatic memory in shaping experience.

She continues in this way with several metaphors that tell the audience how she might explain EMDR to new clients. For example, when she next builds on this concept of memories as snapshots, she describes a filing cabinet metaphor in which, when regular memories are processed, throughout the day or during rapid eye movement (REM) sleep, they are stored where they 'belong', but because the brain views traumatic experiences as 'unfathomable', it is unable to process trauma memories in the same way. This, in turn, 'messes up' the filing cabinet, and EMDR serves an organizational function to accurately associate any particular memory with its time and meaning in history. This then lowers the distress level and emotional charge associated with the memory, and it no longer feels like it is re-occurring in the present. She summarizes, "what we do with EMDR therapy is we start picking up the snapshots one at a time. So we'll work with one snapshot at a time and when we do that, we're going to go through a process that

allows us to allow the information processing system to kickstart again" (786). She describes that, along with diverse metaphors, she will offer clients videos to accompany her verbal explanations and emphasized that psychoeducational work is happening throughout the process. As her story shifts here to walk the audience through the explanations and metaphors she uses with clients, this strengthens her initial story and brings to life the opinions and life experiences of EMDR she first articulated. The range of metaphors illuminates the flexibility and adaptability of this model to different situations, as the language choice contrast offers multiple pathways to framing EMDR for clients. These various passages compliment Participant 4's overall account, using the audience as both listener and stand-in client to demonstrate the value of EMDR in her experience as a practitioner and beyond.

While these tools and techniques run throughout the other thematic categories, here, these interviewees remind the audience of this research's unique position in identifying stories of EMDR effectiveness through lived experience strategies of those who practice this modality. Therefore, these different experiences answer the narrative question of how therapists use stories to describe tools and techniques used in EMDR and their value with clients.

Layering In Therapist Strengths

While some participants used tools and techniques to describe their experiences and others attended to EMDR's distinct qualities in comparison to other modalities, participants 1 and 2 specifically addressed these topics from the lens of *therapist qualities.* This adds another layer to their accounts and attends again to the topic of 'talk therapy'.

Participant 1 shapes a story around practices and qualities that make for strong EMDR practitioners. Her story of how she uses EMDR with clients is constructed around a notion of meeting the needs of clients and being able to intuitively recognize the ability of clients to process emotions. Interesting in her story is that she describes a metaphor of "leaning into" trauma experiences and the processing of these experiences using a "dip in" approach to EMDR practice that is more flexible. She frames a good practitioner as having:

> "some creativity, definitely flexibility, mental flexibility to let go... Like, I thought this is where we were going and the client just went here. Trusting the process is a big big piece, because I think therapists are human, they have their own anxieties, they have their own hopes, and I think when we get in our heads and think this is where it should go, they should feel a certain way, that's where we get in a client's way and sort of like,

> reassuring the client when the client's like, "am I doing this right? am I going the wrong way?" …sort of coming back to trust the process, trust that this is part of what needs to happen" (792).

She continues her story of a strong EMDR therapist by including details about valuing emotions and honouring client capability, and balancing deep knowledge of the model with attunement to the client experience and client-lead processing. Feelings return again and again in the interview, specifically, client feelings and providing the space to know and talk about feelings is necessary for her as a therapist. She also adds to this story later, by emphasizing the role that experience plays in therapist strength, and tells the audience how, "I've worked in, you know, the acute psychiatric care, I've worked with people who have tried to kill themself. I think there's a level of clinical experience that comes with that that reduces that anxiety" (1105). This adds to her story of how experience is important to her practice.

She continues the story of what qualities make a strong therapist by describing her strategies for practice and demonstrating how valuable EMDR is in the context of video therapy. She mentions both the role of supervision as a practice tool and the therapist quality needed to be self-aware about challenging situations by stating, "when I'm in a room with somebody and I realize I'm really struggling, that I go… I'm going to bring this to my supervisor…I'm excited that I have work to do. And I think a lot of therapists struggle like the clients do to be forgiving of themself" (836). She mentions, in her story of good practice, using EMDR phases skillfully in combination with strategies such as screening for dissociation, offering psychoeducation about emotions and mindfulness, introducing parts work to clients, and prioritizing building a trusting relationship. With these tools, she adds to this segment her metaphor of EMDR practice as like an ocean, with a client experiencing different shifts in depth with the support of a skilled EMDR therapist. She walks the audience through some of her process of working with dissociation in EMDR, for example, in this passage:

> "I bring them back to the safety of the room a lot, I teach them about their amygdala, the part of the brain that is like a 24-hour fire alarm…I kind of make a little joke about, like, you know, safety, this is, "are we safe now?", right? And some people say well "no", and I'm- "oh really, like what would happen if we called 911 right now? If we're not safe should we call 911? Well no, that would be silly, right?" …sometimes they just engage their logical brain, 'cause they're going, "but like emotionally I'm not safe 'cause I feel

> vulnerable". But I go "okay, so like, logically, should we call 911?…No, okay so what you're feeling is, you're feeling afraid, so there's nothing dangerous, its just a belief that these feelings are dangerous". So then I, I'm already giving language of separating feelings from beliefs, rather than having a belief in it and leading to an emotion" (997).

This passage ties in working with dissociation to the importance the participant places on emotions and psychoeducation, as well as using humour and tone to engage with the relational process of therapy. In some places, she uses the previously discussed distinction of 'talk therapy' to reference other clinical modalities, and demonstrates where the overlap may be, such as with the therapeutic rapport, psychoeducation, and exploring existing beliefs about emotion. This practice story also includes passages on working with safety and clients experiencing thoughts and plans of suicide, and how she would prioritize these clients for in-person and have a safety contract developed with them and emergency contacts for each client on file.

Participant 2 describes, in contrast, a balancing of roles which make for a strong EMDR therapist, organizing these into directive and collaborative qualities. For example, she shapes an account of therapists needing both strong knowledge of EMDR protocol to direct the client, but also the ability to use relational skills to move through protocol in a collaborative way with the client. Here, she emphasizes what Participant 1 described as 'talk therapy' skills that connect EMDR to other practice modalities, such as developing positive therapeutic rapport, emphasizing client strengths, and listening actively. However, here in Participant 2's story, she frames these as balanced with the features of EMDR that make it outstanding in the trauma treatment field, the direction offered by a strong protocol framework. By doing so, she performs EMDR for the audience as connected to but also working beyond other counselling and therapy models, situating EMDR as distinctly valuable.

Exploring Video Services- What is Trauma Work Now?

The following two categories analyze video service experiences and then narratives of challenge. These themes overlap significantly, and their stories were organized based on the greater emphasis present, but each therapist offered a narrative of therapist challenges that complicated their overall framing of EMDR and added human qualities to the interviews. Some of these narratives were best suited to the thematic category of responding to the shift to video services, and others were more general about difficulty and self-doubt within the experience of

being a human being within a professional role. Regardless, the analysis tracks the impact of these stories and the complexity they bring to therapist participant stories.

Participant 1 describes the shift to online. In this section, she constructs understanding of the differences between online or Zoom connected and in-person counseling or therapy. There is interesting meaning made in her story about in person counseling. She does not construct a monolithic story or narrative about in-person counselling as all good or the best. Rather, she offers a balanced account with the notion that there are good and bad for each. She relates that being online through Zoom can be good for clients, as the client "can be more emotionally vulnerable". The online Zoom method also allowed her to stay in longer contact with some clients who had moved to other provinces and even outside of Canada or provide counselling services to clients living in areas where access to services is limited. Through this story of moving her practice online, she constructs an understanding of counselling that concludes that being online may not matter for clients, but it does for the counsellor. She ended this short story sequence by describing how it is easy for practitioners to become less focused and able to detect body language when providing services online.

Moving forward in her account, the participant's narrative introduction to her experience of private practice EMDR trauma treatment demonstrates the great need she senses for this modality. She explains:

> "I was full pretty quick. And I started realizing this EMDR thing uh was part of the reason and part of it is you know my networking and my you know hospital work, and just people knowing me and sending people to me. But I really feel like most of the EMDR therapists I know are, are full and so there's something, there's something to this and so I guess, yeah, I've been in private practice since then" (284)

In her story, she integrates in her experiences with healthcare providers and therapists alike, and this inclusion broadens her story to include her witnessing of others' value of EMDR. She situates her experiences of great EMDR demand within the larger clinical community, which serves to convince her audience of the larger scope of this phenomenon beyond the individual therapy she provides. She revisits this concept of EMDR demand when she places the temporal event of the onset of COVID-19 into her narrative, stating:

> "there was a period of like March, April, May last year where I just, because we didn't know what was going on, I just did all online. And so I lost a lot of clients, and some

> good clients and I, you know I don't even know, a few off them I emailed at the end of when I went back in person and interestingly, I don't know if any came back, like you know I was full kind of immediately again because then I had all this space to take new clients and because there's no shortage of new clients" (357).

In this passage, she revisits the performance of EMDR as a desired therapy practice again through her language of urgency, using the word "immediately" to follow up her earlier comment of filling up her caseload "pretty quick".

In terms of convincing the audience of EMDR's value through her narrative performance of EMDR, she next employs this framing to conclude some statements about troubleshooting difficulties that she faced at the beginning of switching to remote services (such as using phone at the same time as video, to ensure a continued smooth connection through voice if the video platform freezes). She states, "I've learned lots of troubleshooting, before this I basically just said I don't, I do phone or online and now I think it's opened up a whole new, like, I have a bunch of clients I've never met in person... And so in many, many ways its opened up my practice" (389). Here, she emphasizes the expansion of her EMDR reach as an outcome of successfully navigating the transition to distance services, and how, therefore, EMDR is valuable from a distance and accessibility-focused perspective. She highlights the strength of her perspective through language choices such as "many, many ways", conveying to the audience her conviction in this perspective beyond the specific examples she cites.

Further on, she references again the advantage of distance based EMDR treatment in increasing accessibility, and situates therapy within the broader context of healthcare. She mentions, "it gives you the broader range of, yeah, reaching out to people, and I know in the hospital, just you know, how much more telehealth, telemedicine we're doing" (484), and this narrative moment connects therapy (and the success of EMDR through distance services) to other practice fields (healthcare) that have pivoted their practice during COVID-19. This serves to validate and normalize the experience of therapists by reminding the audience that other, larger fields have reacted similarly to changing circumstances. This identifying EMDR treatment within the broader context of service delivery change serves to convince the audience that issues pertaining to the participant's experience are not unique to EMDR, but a valid experience of working within the limits of COVID-19 restrictions.

Participant 2's story moved to how COVID-19 distance therapy has limited ability to do full protocol trauma work, and she identifies 'survival mode' to describe the necessary shift back to preparation, listing: "strengthening, stabilizing, resourcing, foundational- and its way more than just that, because with Flash, people have been finding the research on Flash supports that its really, it has enduring effects, it has long-term affects" (232). In this, she shares about preparation work *being* trauma work, despite the pervasive view that full-protocol processing is needed and trauma memories need to be revisited to do impactful work. In mentioning 'survival mode', she emphasizes the extreme change and uncertainty faced on a global level at the onset of the pandemic, impacting the mental health of a wide range of clients. This return to the context of the COVID-19 pandemic serves to position EMDR as beneficial in extreme circumstances, and frames EMDR as offering value regardless of engaging in full protocol, shaping it to be a flexible and adaptable modality.

Participant 2's story here moves the audience through some of the trial and error, or benefits and drawbacks of options she has utilized. She described the appeal for her of the hand-tappers (tactile objects used for the bilateral stimulation), stating how in her experience, they help the client slow down and sit further away from her as the therapist, which both can add comfort to the experience for clients. She notes how her colleagues and others often find the eye movements superior, and how video sessions limited her choices, requiring her to then use the eye movements as well. Similarly, when utilizing tools such as the Butterfly Hug (described elsewhere), she describes a simplifying of choice since using video sessions, as she was previously experimenting with clients tapping their shoulders or legs but now uses shoulders so that the clients' tapping experience remains in the video frame.

She continues to position her story here as one of surveying the many options to her afforded by EMDR and frames its value in its ability to offer options, especially during a time of transition. She describes herself "meandering around" (217) the various options, language of a relaxed framing, and mentions how adapting to distance enhanced some of the client-paced, trauma-informed practices of EMDR she was already practicing in her work. For example, here again she highlights how the preparation phases, as well as working with smaller targets to process (rather than first and worst trauma memories) are critical to practicing over video and during times of uncertainty and public risk in the COVID-19 pandemic.

She describes the work she does, in the absence of full protocol, as "strengthening, stabilizing, resourcing, preparation, foundational" (232), and shares more about the frameworks and strategies that inform her practice. She details the difference between a 'healing vortex' and a 'trauma vortex' and adds:

> "if you do enough of the positive engaging focus and you become, your ability to shift states into the positive…and also diminishing the fear of the trauma vortex, so that you recognize- "I'm getting pulled in, don't want to go there now, can do it later. I'm not afraid of it, I just don't want to. I realize I'm being triggered. I'm, I'm not there I'm here, I survived that, I can visit that in my therapy if I want but I'm, I'm here" (241).

She credits this shift as possible through establishing with clients a range of coping tools. She described clients gaining this sense of control and having not only their comfort objects and physical grounding tools (tea, crystals, special books, et cetera), but, in connection with Attachment Theory, developing supportive figures that clients can visualize to resource mentally. She emphasized again here the positive, 'beautiful' resourcing parts of the EMDR protocol and how important they are to how she practices now through video. In this story account, she describes her experiences with clients at the agency where she works and mentions a pattern she notices. With many clients, she shares that the more they strengthen their personal emotional resources through the preparation phases of EMDR, the less they seem to need from full protocol EMDR treatment. She describes this as clients observing that, in doing processing work, they no longer feel the need to revisit all traumatic memories, and clients often feel they have a sense of what is 'enough' to revisit. She described clients reaching the end of their time in therapy and revisiting if there are memories they need to process still, and clients sharing that they have a better ability to organize all trauma memory as in the past, rather than present, making them sense their experience with processing has been enough. Taking significant time with the preparation phases contributes to this, in her experience, and framing this passage this way, with both the participant's strategies and the feedback she receives from clients, illuminates for the reader the power of the preparation phases of EMDR. This story serves to convince the reader of EMDR's value in early protocol phases, which may be underemphasized elsewhere.

Participant 2 emphasizes the transformative value of the preparation phases of EMDR through this next account in describing her practice, and demonstrates awareness that the foundation work continues to play a vital role in her practice and her narrative:

> "At the beginning I tell people that I have a worksheet, and every time they start telling me about this or that bad memory I just jot it down for potential targets, and negative cognitions also come up throughout the early work…and its all organized around belief systems. And the original protocol I found was it, it leaned more on…sensations which underly the emotions. So again, it took a lot to integrate Roy Kiessling's stuff with my original EMDR training. And then um I now realize I've integrated them and you know for some people its just very very, its very compelling, they need to work on their negative beliefs, or their shame you know, the shame is very much a belief that I'm no good, I'm unworthy…you just get to know through all of this foundation work as I refer to it constantly, through this foundation work, it's a huge assessment phase. Yeah for me, the history taking, preparation, assessment all blend together and we find out, you know, what they want to do and how, what works for them" (291).

Here, her story states further the value she places on pre-processing work, and she adds in a distinction between her EMDR training and an additional online training she completed with Kiessling, which focused more on negative beliefs as EMDR processing targets as well as traumatic memories and associated emotions. She demonstrates how in her practice strategies, whether incorporating in different views or developing and using her own organizational worksheets, the value of foundational work comes up again and again.

Moving forward in the interview, Participant 2 shapes more to the story of her practice strategies, both before and after the onset of COVID-19. She details her chronological account of changes she has perceived in the community of EMDR practitioners and the broadening of processing to include ongoing triggers as much as traumatic events of the past. She describes, at the time of her original training, a very 'mechanical', linear approach to using protocol and mapping out targets to process, and that this has moved 'sideways' to incorporate in whatever feels most meaningful to clients in their day-to-day lives. She offers an account of how she typically begins introducing EMDR to a new client, starting with explaining the modality, using a calm place visualization and the container imagery (EMDR resources), and potentially adding tapping (bilateral stimulation) with the client if they seem receptive to these steps. From here, she discusses with the client if this might be something they want to incorporate into the therapy work, or if they are looking for something else. She joins this with other pieces of her overall

story, such as the importance of relationship-building, to describe her practice of EMDR with a focus on client direction.

She draws the story of changes in practice to then include the onset of COVID-19 and her experimentation with computer applications that facilitate the eye movements of EMDR, which she ultimately found inferior to using hand movements or set visual points. She situates here online trainings, in the Flash technique (described earlier), for example, as key to removing the mental obstacles to practicing EMDR through video. Included in this account is her personal emotional experience of feeling intimidated by the task of adapting services to video in seemingly unimaginable ways, which once again offers vulnerability and challenge to her account of valuing EMDR from her personal experience. She described needing a 'boost' to feel able to offer her therapy virtually, and that additional trainings increased her sense of competence. This balances and strengthens the trustworthiness of her overarching story, situating it as a narrative that convinces its audience of the value of EMDR in ways that embrace the multifaceted experience of being a human practitioner.

When bringing her story to the experience of video, Participant 4 mentioned the power of the Flash technique in resourcing clients, especially when clients are newer to the therapy relationship or are not comfortable working with explicit memory. She strengthened the strategy thread of her narrative by emphasizing this technique's ability to bring client distress levels down, before full protocol processing, and how critical this is during times of crisis and overwhelming change. She describes setting up video screen viewing with clients to include more than simply a client's face so that she can take in as much information as possible about their emotional or nervous system experience, and adds that preparing with clients by developing their self-observation skills empowers them to notice their own experience even when certain micro-cues are undetectable through the video screen. This preparation demonstrates the importance of client-clinician communication in mitigating the limitations of video therapy. She expanded here her view of client safety to include not only emotional safety, but physical safety, and described gathering information about where her clients are located at the start of session (such as their address) in case of emergency and organizing with clients how they can schedule sessions when they will be least interrupted in their immediate space. Later on in the interview, she revisits her comments on strategy when she asserts that being a 'mindful' therapist is not only about being keenly observant of the present moment, but about acting with intention, or

strategizing. She states, “we don’t do willy nilly processing, we don’t do willy nilly therapy, we have to have a reason for everything that we do” (471). These considerations demonstrate her commitment to the larger picture of ethical video therapy with EMDR and beyond, and reinforce the importance of *therapist strategy* in effective EMDR practice.

Participant 4 adds, to her story of strategy and preparation, the process of connecting clients to in-session tools for mental resourcing, such as ensuring clients have the physical objects that bring them comfort and safety in their vicinity. This offers clients an opportunity to decern their own best physical grounding tools, which helps them to initiate their own resourcing. She describes more technical strategies, such as encouraging clients to use a computer screen rather than a phone to best view her screen during the bilateral stimulation phases, and lists the bilateral stimulation technology application, auditory bilateral stimulation through headphones, and tapping techniques, such as the Butterfly Hug (described elsewhere) as her tools of choice. Like other participants, she refers back to her view of EMDR as a lens through which any client can be seen, but that full protocol is not appropriate or necessary for every client, especially when developing resources that are the most meaningful for clients in difficult situations. She describes knowing that a client is sufficiently prepared for processing when they are not only able to shift emotional affect states but when they are able to be aware in the moment of these shifts. She returns again and again to her story of preparedness:

> “Then after, you know, the client has developed their readiness to do that processing work, they have been introduced to the cognitive, the emotional and the body in terms of literacy and some resources, so psycho-ed is a big piece of that, right. Then we can move into figuring out if this is the right time, right, so if they are in crisis or if there’s a big stressor coming up it might be not the right time to start opening the traumas up to do processing work… we look at setting the stage, so that’s where we’re making sure we have all the elements that we need with them to be able to process. So for someone who’s at home, you know, they’re developing a coping toolbox at home with say, their scents in it or touch items or whatever, Kleenex is handy (chuckle), you know, anything that they might need during a therapy session, that I normally have in my office for them, right…at home we’ve got to create that toolbox a little bit better…we also have imaginal tools that are part of setting the stage, so we’ll bring in our imaginal figures or helpers as well. And we create safety by using those tools… so once we have created that readiness in the

> client and they can shift affect, the timing's good and we've set the stage, we're good to go. Now one of the biggest pieces in phase 1 is- besides finding out about the client past, present and future hopes, and goals, we also need to assess for dissociation" (554).

This longer passage, while occurring later in her interview, connects the variety of elements from throughout her story that shape safe and strategic EMDR practice. She continues on to describe how she works with dissociation, for example, such as finding with a client common language for it, an agreed-upon way to measure it, and then a plan if it shows up in the therapy space. The reoccurring themes add a sense of solidity to the narrative for the audience and continue to frame EMDR as valuable from the perspectives of practicing therapists.

She situates her own adapting to video therapy within the greater context of global EMDR by inserting this next passage:

> "I found that the EMDR world has really come together at this time, and there's been lots of free webinars from people who have developed the protocols that are most helpful at this time and have made those available to EMDR practitioners across the world, so that's been really supportive. EMDR Canada also did some supporting of their membership in, in the spring and summer of last year where they had some trainers to volunteer their time and did consultation groups to support their members which I think was really helpful at the time because we were all feeling so disconnected from each other, and so that was an opportunity to connect" (370).

In this passage, she frames her experience of her own practice and of her connection to national and global EMDR organizations in a manner that demonstrates to the audience the capacity of EMDR to adapt and sustain its practitioners during times of stress and turmoil. She frames her experience as being supported through the connection and education provided by these communities, demonstrating the significant reach of EMDR networks. This strengthens Participant 4's thread of practice strategy throughout her narrative for the audience.

Towards the end of her story, Participant 4 returns to the topic of video-based services and reminds the audience that, while she has a range of tools at her disposal, the shift to video therapy is mentally taxing in her experience. She states, "you've got to work a little harder than in person, for sure" (884), but mentions several positive aspects of video therapy. She lists the confinement of the conversation to the video screen as a containing function, supporting participants in developing self-awareness and emotional literacy, and offering clients more

control of their BLS (bilateral stimulation) experience as some of the strengths, as these were explored earlier in her story. She ends her story with a re-emphasizing of the role of community, training and consultation in therapist support, and then finalizes her framing of the value of EMDR with the statement:

> "It is not just a therapy for PTSD. Everybody has adverse experiences in their life, whether it meets the criteria in PTSD or not. So I think it's important for people to know that you do need to process our adverse or negative life experiences that we hold with us as we grow forward in life. That you don't have to have PTSD to benefit from EMDR therapy… so that's a huge misconception out there" (1010).

She then adds:

> "It can be a very powerful therapy, and even, you know, for intergenerational trauma, it's a very powerful therapy as long as its culturally aware and appropriate for the clients that you're working with, right. So always knowing who your client is, and being curious, and being with them on their journey. So, we are guides, we walk hand and hand in the path, but our client is, is the center of the therapy" (1039).

This comment echoes the theme of client-centered practice and ends her story with a focus on the power of EMDR for clients and the strategy for therapists. Throughout this story, Participant 4 demonstrates the power of strategy in shaping effective and valuable EMDR practice through her metaphors, examples, and life experience.

As Participant 5's narrative moves towards her experience of video EMDR therapy, she states two challenging components mentioned by Participants 1, 2, 3 and 4: disconnect through the flaws of technology, and disconnect through the missed micro-expression process. She describes the EMDR online tools as 'clunky', or misaligned with the fluidity of movements possible when in-person due to programming issues and internet speed. With this, she describes addressing the problem by focusing on resourcing tools and the Butterfly Hug technique (described earlier). When describing the possibility of missing visual cues in both the face and body, she notes a strategy to account for this, that "it's a lot of, of checking in with people, because I can't see their legs, I don't know if there's an urge to flee right, I don't know what their body is necessarily doing. So it's a little clunky in terms of like checking in that way" (140). By noting her ability to cultivate awareness through video and effective communication with clients, she frames these challenges as surmountable, and inserts hope into the narrative of

challenge. This connects to another description of her practice, when she shares, "for regulating we did certainly, like, less guided imagery kind of stuff, like, but we also regulated more body-based stuff…we would be standing up maybe and shifting, rocking back and forth to regulate while we were talking about things and just, I think more body-based grounding" (177). This passage illustrates a shift in strategy and demonstrates a sense of capacity with EMDR, and convinces the audience that EMDR therapists are able to adapt when adapting is required in order to meet client need. She describes a series of actions she considers as part of building safety through video, such as determining with clients how much of their physical body (or her as the therapist) they want visible through the video screen, and plans for in-between sessions if they experience distress.

She articulates in her narrative the increased accessibility being the biggest strength of video EMDR, such as with clients in rural communities, clients with compromised physical health and disabilities, and clients with difficult commute options. This moved into discussing some of her experiences, such as being a health provider with Indigenous communities through distance-based services, and how she uses her trauma-informed social work background working with clients experiencing system oppression. She states:

> "there's a piece about offering teletherapy that is an attempt to reduce systemic barriers and just to be flexible, to meet people where they're at in, in general…overall in my practice, you know, we do a lot of sort of consciousness raising, reflecting on just basically- its social work, right? Like, a person in the environment, right?…So its, its not like, you know- what's wrong with you? Its like well, what have you experienced and why? Why are these systems set up like this and how do you understand that? And what's your experience with, with, you know, racism or ableism or you know, whatever else the person is bringing to therapy" (624).

This joining of increased flexibility, trauma-informed social work practice and anti-oppression work describes the participant's ability to adapt EMDR to a variety of clients and client situations, which she then connects to specific examples. She shares about having an Indigenous client tell her the importance of humour for her and her community as a coping mechanism, and the participant and client were able to incorporate this into their resourcing phases of EMDR. She added to this story the self-awareness needed from the therapist if they are a white settler therapist working with Indigenous clients and clients of colour and offering the space for the

client to express their experience of that. This connects back to the ideas of safety and rapport mentioned earlier in her account.

Towards the end of her story, Participant 5 describes the training online that helped her feel confident and competent in transferring her EMDR practice to video at the onset of the COVID-19 pandemic, and reminds the audience that her confidence was not inherent, but had to be built. This statement keeps her narrative rooted in reality and her multidimensional experience as a human practitioner with strengths and challenges. She lists adapting her consent processes, increasing her client check-ins within session, intentional camera positioning, and EMDR peer support and supervision as critical to her success in using EMDR through video. Her story ends with sharing about the hopes she has that the accessibility strategies learned throughout COVID-19 pandemic periods remain in practice in the future, and the excitement she has that EMDR will continue to be used in flexible ways. She highlights here again the efficacy of this model within her life in her final comments. Her final narrative thread echoes her larger story in being both realistic about the difficulties she faces, her personal motivation to practice EMDR, and the practical components that bridge these two concepts together within her story of practicing EMDR through video during the COVID-19 pandemic. This adds a genuine quality to her account and serves to have the audience both receive this as a lived-experience account and convinces the audience of the continued value of EMDR.

Challenges and Complications of EMDR Narratives

Throughout her interview, while serving to convince the audience of EMDR's value, Participant 1 offers a balanced story that incorporates a sense of nuance and authenticity into her framing of practicing EMDR by including the challenges as well as her positive experiences. This serves to add realism to her position as offering a *lived experience story*, not an account explicit in its purpose to convince the audience of EMDR's positive value. For example, part of this story is the increased complications tied to increased accessibility, such as the experience of having clients move to other provinces with provincial regulations and no longer being able to practice with them, while still remaining involved with these clients as they transition to appropriate, locally-based therapy or counselling services. She also provides an account of some of her strengths as a therapist being lost through the video format:

> "I get a lot of cues from bodies…I can lose connection, or its more easy over Zoom to kind of like, you know, look, I'm looking at my notes, or writing and I realize- oh!

> They're, you know, doing a set and then I'm about to say, you know, take a deep breath and then I look up and I realize oh they're just like having this emotional wave or something, I don't want to interrupt, you lose more online" (427).

She offers several accounts of this losing the presence, either from viewing less of the client or from the risk of missing timing cues, that come up in her experience of practicing online.

She balances this, however, with an account of meeting with clients in-person wearing face masks, and how in some of her experiences, moving to video format after that provided *more* of the therapy experience through more accurate facial cues. She mentions:

> "I then met many clients in person, never having seen their whole face and they hadn't seen my whole face…So some people I'd only met in person with a mask on, I then met them via Zoom without a mask on. And, and both the people, the two clients that, that were in that case and I said, and we both were like, "that, that it was really nice". In many ways it was, it was the first time we really just had a session, we could see all the expressions in the face- and the one had even miscued one of my facial expressions in person" (454).

The balance this comment offers is how, despite the difficulties of online services, the alternative of meeting and wearing masks was also challenging, and even more than video services in the case of some clients. This comment frames practicing EMDR through video within the larger scope of unprecedented practice needs and the imperfect solutions used to meet those needs (such as wearing masks in-person to reduce the transmission of the COVID-19 virus). This serves to normalize the practice of video therapy within the larger environment of difficult circumstances.

Participant 1 offers comments that summarize more the transition to video services, and offers further balance to her personal account by considering the drawbacks of video EMDR. She states:

> "Even before this happened, there was certainly, there was a, there was a whole subset of EMDR therapists who were pushing online therapy and virtual therapy and all these things. And I, I had a deep resistance to it…I believed then that, that this in-person, I'm very much energetic, I feel peoples' energy, I intuit their body language and I just thought, we're going to miss that, we're going to lose that and then the, the danger piece of like I have, I have no control if they decide they're going to go, you know, whatever

> and what happens. And I think there was a piece of that that sort of like, it was theoretical, that theoretical ethical piece, what if they go, I'm out of here, I'm going to go off myself, uh what do we do...So then its like, you go into practice and you're like, it's, it's out of necessity…And now I have clients who it actually benefits us to start and stay. Yes, I would still suggest that every single one of my Zoom clients- would I like to have them in the room with me with a mask off?- absolutely…Do I think I can give better therapy that way?…yes. But good enough therapy is better than no therapy" (1219).

With this comment, she deepens her story as lived experience by sharing personally her apprehension about changing her therapy format. She continually positions herself within the greater COVID-19 pandemic environment, highlighting the "necessity" of the transition, and strengthens her framing of the value of EMDR by recognizing its importance when ideal options are not available. This section adds to her story and further frames EMDR as valuable in the current social and environmental context.

Participant 2's narrative also offers a balanced, lived experience story that includes the challenges encountered in practicing EMDR through video formatting. This offers a richness and complexity to her account that illuminates the realities of transitioning EMDR formats during a time of uncertainty and sudden change. Like the first participant, this is noticeable in her limited ability to gather information about the client's physical presentation and emotional or nervous system experience. She describes here some of the missing cues:

> "Well, you can't see the person's body… I like to track the person's activation along with asking them to do that for themselves, so I can't see the facial expressions quite as well. I can't really notice if they're, I can see their pulse as much in their neck or if they're fiddling or you know um just you know picking or twitching or can't tell as much what they're doing... There's times I can see much more of a person's body, like at last half, but you still can't see the skin tone or dilation of the pupils or something like that, but you can sort of tell from that, you still get an overall sense of the person's state and asking that but, but still you, you still have to work with not seeing them as well and yeah, its not the same as being in the same room as them"(417).

When describing how she accounts for these absences, her story turned to recognizing the positive aspects present for clients and echoes the issues of accessibility that are erased when clients can be doing trauma treatment work in their homes. These include having access to their

comforting surroundings, no longer experiencing potential stressors or barriers such as the time and cost of commuting, weather, and physical personal differences (such as injury or illness that may prevent people from leaving their home).

Participant 3 offered an interesting account that complicates her experience of beginning EMDR, and adds a level of nuance to her particular story. A thread throughout her sharing is the dynamic of confidence and fear in practicing EMDR, both at the beginning of her career and in adapting to distance therapy at the onset of the COVID-19 pandemic. She introduces this concept at the stage of her training, stating how her trainer emphasized caution and intervention fidelity when practicing EMDR, to a degree that lessened this participant's interest in taking educated risks with the modality and shaping it to fit a range of client presentations. She described the power of EMDR as a tool that she had to learn to trust herself with, and that through further training and experience working with clients, she expanded that trust with herself as a professional. For example, she has now used EMDR to support the healing of clients through eating disorders, depression, anxiety, and postpartum homicidal ideation with success, and that required her to expand beyond her initial ideas that she would fail or harm clients if she made adjustments to her original training and full protocol.

She bridges this idea of confidence to another comment, similar to other therapists, about the challenges of distance therapy. She states, "in the room, I feel like I get a better sense of the physiological discharge of the emotional window of tolerance and where they're at within that, and virtually or by phone just feels like I don't trust my sense of the person's capacity if I've never met them enough to do that" (264). Here, she restates what the other participants have noted, which is the challenge of accurately reading clients' body cues and emotions without the felt-sense experience of being present in the same room as them.

Further to others, Participant 3 describes the lack of self-trust she feels in her otherwise-present skills as a perceptive therapist when having to use phone or video, which she feels has limited her desire to do EMDR through video with clients she does not yet have an established relationship with. She describes some of her experience of distance sessions and the disconnect in expectations, and offers this story to demonstrate the relationship between the need for presence in EMDR practice and her challenges in feeling she can trust the cues she receives from clients:

> "I'm like, oh, I think EMDR would bring you such relief, but I call you and you're in your backyard picking up dog shit while we're having a session! …I can't do EMDR with you unless I have all of you present and engaged with me (chuckle)…And yeah, if I don't know somebody, maybe there's a crack in their voice that I miss because I don't know them well enough to know that that crack in their voice means "I'm devastated"…But if they're sitting in front of me, you know, maybe their face blushes, maybe a tear drops, you know? Like there's other clues that I could read to really get a sense of emotionally where they're at" (390).

This theme of presence in the room, which becomes lacking through distance strategies, followed throughout her story. These accounts of challenges in confidence with video therapy continue throughout the account, and build to shape a strong example of the challenges of using EMDR through video. The balance between the participant's appreciation of EMDR and her perception of the difficulties of video therapy offer not only a detailed lived experience account as a therapist seeking to adjust to changing circumstances, but demonstrate the power of the therapeutic tools used in person. In this first example, she recognizes the micro-disruptions that impact video services:

> "on video, especially with new people I don't know right, like if someone's quiet, my own anxiety creeps up and I'm like, is the screen frozen? is he done talking? should I say..? …I ended up talking just when they were about to say something! Anyways, so figuring out the rhythm and the pace takes a little bit longer, so what I kind of took away from those bad experiences was again, patience right, just stay quiet longer than you think that you need to be quiet (chuckle). You know 'cause if they're really not going to say anything they're going to wonder the same thing, is the screen frozen? Like they're going to prompt you to, oh I'm done talking, go ahead right. So like, I think those like, little micro interactions are so much harder to gage" (614).

The next building moment in this narrative adds language to the therapeutic skills she drew on best in-person, identifying the role of neuroception:

> "You know that idea of, you walk into a room and somebody's just had a big conflict and even though they're smiling at each other, you can sense the tension in the room? Neuroception is missing from virtual therapy, I have no access to what I feel like is my strongest tool, which is neuroception… I don't feel like I know I'm in rapport with the

> person I'm working with in the same way I am when I'm sitting across from them…And this takes me back to my early training in attachment right… I truly believe you're creating an attachment with the client that's sitting in front of you, they are telling you their most you know intense vulnerabilities, their most horrible experiences, the most shameful parts of themselves…like you're giving them that unconditional care, regard, respect, and video doesn't let you engage in that way in the same way as being in the room with the person" (878).

She uses the therapy term 'neuroception', defined in her own words, and then contrasts her earlier statement focused on video disruptions with the sense of attachment work being missing from video and the strength that added to her in-person work. Here, interestingly, she connects to a well-established lens of attachment that can be applicable with many therapy modalities, and uses her narrative to assert that EMDR therapists and 'talk therapists' alike are missing important aspects of in-person therapy. These distinct accounts from Participant 3's narrative serve to position EMDR as similar to other therapies in this account, rather than the other passages in which EMDR's differences from other modalities are the focus.

Participant 5 tells a story of the strategies that she uses as a EMDR therapist that combines the challenges of video services with the role of trust between practitioner and client. She describes an extended process of informed consent, due to the uniqueness of the modality, such as offering clients a demonstration of the movements on herself, encouraging clients to use YouTube resources, and getting clients familiar with the bilateral stimulation handheld buzzing tools she uses. She states, "my decision-making involves, kind of, discussion with client, their informed consent and how much they're already suffering, because EMDR can be difficult and painful, but its pain with a purpose…versus being stuck reliving that terrible thing or being stuck in the pain right now…clients have been open to doing it and it's been really helpful" (441). She offers a nuanced account of the risk of intervention (with EMDR) compared to the risk of client suffering with a less effective approach. Her comments reinforce the importance of therapist lived experience perspectives of EMDR when she states, "I think the therapist is really the tool" (94). This line reminds the audience of how hearing therapists describe their own EMDR use in their own words illuminates the value of this modality and strengthens the arguments of its power in the current context. She connects the therapist as the tool to the theme of trust when she says later on (about video therapy):

> "its so, like, a little bit trickier, and you really have to trust the client (even more so than you already do with EMDR) to let you know, you know, to let you know what's going on their end. So it's a bit humbling, I think you have to have even less kind of ego, ego in the game, because I think you're going to get it wrong more than you would in person…you're going to overshoot their window of tolerance, you're going to miss something, so I think you have to, you know, trust the client" (290).

This complicates her experience by connecting to the figure of the EMDR therapist as inevitably flawed and capable of misjudgement, and how self-awareness, communication and trust offer a solution to the challenge within this narrative.

Concluding the Interview Analysis

The analysis highlights where, in the five interviews, the participating therapists use narrative devices to perform the value of EMDR. This includes how they construct their experiences of EMDR through specific practice strategies, demonstrating the value they place on this modality. When I ask, approaching each interview, "why was this story told this way?", the language choices, temporal cues, and other people, places and events mentioned serve to convince the audience of EMDR's value throughout the COVID-19 pandemic restrictions as a trauma treatment modality. Throughout the accounts, they frame EMDR in a multifaceted way, highlighting its strengths, incorporating the challenges, and navigating the similarities and differences between EMDR and the larger context of 'talk therapy'. The participants show the value they place on EMDR as a distinct practice but also offer an honest portrayal, resisting a monolithic narrative of their experiences. This analysis shapes a larger narrative of EMDR's value.

Findings- Five Themes of Probing-Question Analysis

The 14 possible probing questions explored therapist narratives and views on five main categories: qualities of a strong therapist (within the context of doing video EMDR therapy with trauma-impacted individuals), determining appropriate EMDR services, video-specific considerations, working with differences and oppression, and the supports needed for therapists to be effective. These five areas will be explored using direct quotes from specific participants that reflect each theme to conceptualize the narratives of the therapists interviewed.

Qualities of a Strong Therapist

"A robot could do it…except I don't think it works that way" (1, 762)

The five participants offered a variety of qualities they feel make a strong therapist (within the context of EMDR video therapy with trauma-impacted clients), with a final list including the following words and phrases: attunement, intuition, creativity, mental flexibility, trust, regulation, presence, emotional non-judgement, working on self, awareness of attachment, ability to assess for dissociation, mental health skills, ability to build rapport, ability to balance directive and collaborative qualities, ability to work with technology, patience, interpreting of micro-interactions through video, determining rhythm and pacing, proficiency in standard protocol, ability to tolerate emotional affect, knowledge of other trauma modalities, bravery, confidence, curiosity, strong learners, and being open to changing techniques.

These various qualities can be divided, as participant 2 articulated, between *directive* and *collaborative* roles, and many participants spoke to a real-time balancing of these within the therapy space to practice EMDR safely and mindfully. Participant 1 stated, "A robot could do it…except I don't think it works that way" (1, 762), referring to the paradox of standardized protocol and human intuition needed for trauma-informed practice. In connection to the 'directive' or 'robot' side, as participants named in their narratives, they also emphasized the ability to learn detailed information in a succinct manner as an important skill needed for EMDR. The participants spoke to a need to relate to the information-rich training process effectively, such as a need to have "really made sense out of it" (2, 379) or to be a "good learner" (5, 242), and a heightened need for proficiency compared to other therapy models which may not require the same level of intervention fidelity. Therapists spoke of this lending support and meaning to the practice, such as when one therapist stated, "We don't do willy nilly processing, we don't do willy nilly therapy, we have to have a reason for everything that we do" (4, 471).

On the other hand, each participant mentioned the 'soft skills', that Participant 1 felt require a human response, which are critical to practice. Similar to the emphasis in general therapy practice, all five participants included the words 'rapport' or 'trust' in their comments on strong therapists, indicating the importance of relationship in EMDR practice. Self-awareness was often linked to mindful practice, and all therapists indicated at some point the necessity of personal mental health work in being able to engage meaningfully with clients. One client connected self-awareness to being able to accurately assess clients by stating, "I think somebody that can untangle…with the EMDR its important to know what's your stuff and what's their stuff in terms of assessing physiological discharge or intensity of energy in the room" (3, 563). This

need to track self-as-therapist is seen as critical to perceiving and analyzing the client situation with more understanding. As one participant put it, "therapists are human too, but you really do need to be as solid as, as you can…but have a sense when you're not solid" (5, 279). These statements capture the *human* side of qualities viewed by participants as integral to strong practice, and a need to acknowledge the human vulnerabilities of therapists.

Determining Appropriate EMDR Services

"some people can go swimming, other people can just maybe dip their toe in, other people need to hang on at the shore" (1, 896)

Participants had a wide range of comments regarding how they determine appropriate EMDR treatment for clients, and challenged the nature of the question regarding *if* EMDR would be appropriate, stating instead that a version of EMDR is appropriate with most or all consenting clients to different degrees. This challenging was indicated with various language choices framing their use of EMDR, such as describing it as a philosophy, overall framework, set of tools, or, as one therapist said, "I'm still an EMDR therapist and I'm thinking out of my EMDR hat" (4, 518).

Strikingly, all five participants stated assessment for dissociation (whether formal or informal assessing) as one of the main indicators they use to determine how far into standard EMDR protocol is safe and appropriate. This was sometimes described in the interviews as divided into the resourcing and processing portions of protocol, the first of which therapists felt were appropriate with anyone interested and the second of which required significant consideration before moving forward. One therapist used the metaphor of the ocean to describe the relevance of EMDR practice to all, in a range of ways depending on the client, adding, "some people can go swimming, other people can just maybe dip their toe in, other people need to hang on at the shore" (1, 896). This quote not only demonstrates the range of experiences possible, but highlights the various ways safety and support can be accessed to fit any one client's particular trauma history experience and how they are able to engage with therapy.

Some of the indications that participants described that they use as markers to know when their clients were ready for processing trauma include clients no longer being in acute crisis, having their basic physical needs met on a regular basis, being able to shift emotional affect within therapy sessions (for example, being able to have awareness of their emotions in the moment and having strong coping skills), and being open to psychoeducation about EMDR

within the therapy context. Assessment of these qualities speak to the ability to practice in a trauma-informed capacity. One therapist summarized the value of EMDR for anyone with significant or more minor trauma with the comment, "just bringing that EMDR lens…how we understand trauma, how we understand the nervous system, how we understand the body's ability and the brain's ability to deal…that's appropriate for everybody" (5, 323). Another therapist added to this, noting how the EMDR understanding of trauma can support people not only with 'big-T trauma', but with anyone experiencing a "sticky thought" (3, 670), a thinking pattern creating mental barriers between a client and their moving toward well-being.

Participants' views differed in this area of analysis most often in relation to therapists' practice situation. For example, one participant, working in a non-profit trauma therapy agency, described determining if EMDR was appropriate as "just a natural self-selecting process, it just happens" (2, 585). She noted that, for clients accessing a free trauma therapy program, offering them *choice* is paramount in having them feel satisfied with their therapy experience, in which they may not want to try EMDR treatment. This therapist highlighted how, for some program participants, their absolute goal of therapy is being able to share their story openly (perhaps for the first time) and be *heard,* and that remaining client-centred involves respecting this desire without imposing an expectation that they be open to different therapy modalities. With other clients, the therapist looks for natural opportunities for psychoeducation around EMDR, gauging the client's interest, and then experimenting with the resourcing tools of EMDR, such as the 'butterfly hug' (a version of the bilateral stimulation using tapping). If the client expresses interest in going further, the therapist then begins the standard, full protocol.

In contrast, another participant described being known in the community specifically for her EMDR expertise, meaning that the concept of EMDR and the potential value it has to new clients is already established before the relationship-building stage of therapy. Specific to this example and others working in the private therapy community, determining a treatment plan is connected to how frequently and for what duration of time clients can afford to access this type of resource. In this sense, therapists offered different narratives on the process of determining the use of EMDR for any one client and had contrasting storied experiences of this area of content analysis.

Video-Specific Considerations

"they can be the narrator of their experience and have a voice" (4, 895)

When discussing the experiences of video, participants offered a range of narratives, rich with their shifting notions on EMDR trauma video therapy, the positive and negative aspects they've experienced, and their strategies for working with this emerging format. While many therapists expressed how they experience being less overwhelmed now than at the onset of the COVID-19 pandemic, they varied in their current mindsets regarding video. These ranged from acceptance, such as when one therapist noticed, "at first it was like this humongous obstacle… and now it's like- of course it's happening"(2, 511), to continued reliance on phone-based methods, like the therapist who recognized, "there was hesitancy on their end, hesitancy on my end, and so I just offered the more traditional talk therapy support" (3, 345). Another still noted the difficulties with video therapy but asserted that, "good enough therapy is better than no therapy" (1, 1244).

Several therapists offered detailed accounts of utilizing the video method with control and precision, emphasizing the ability of video therapy to offer enhanced trauma-informed, client-centred treatment. One therapist noticed the ways in which video methods give clients a unique opportunity:

> "They have to be more of the narrator of their experience online, because you can't see all of them and you can't feel them like you would in the office. And so in the office you might feel some of their energy coming off of them, picking up on that. I'm going to guess that they're a little less sensitive on video, so the client has to develop more literacy, right? In somatic literacy, emotional literacy, and cognitive literacy, so that they can be the narrator of their experience and have a voice" (4, 895).

In this narrative, the therapist described the client having to verbalize information about themselves in the moment that, in person, the therapist might simply detect by being in the same room. Without that in-person experience, clients are strengthening their ability to notice themselves (physically, emotionally, and mentally) and then express that awareness out loud. Not only is this, in the participant's narrative, cultivating more self-awareness, but it is allowing clients to have *choice* in how their experience is understood in the session. In this way, the client has more of a voice in determining how they want to describe and identify their physical, emotional, and cognitive present.

This aspect of increased sense of choice, reflected in trauma-informed and client-centred practice, appeared in another participant's telling of her experience of simply determining how to set up her video camera view:

> "usually when I'm doing it, I'll also talk to, to clients about, like, how they're comfortable seeing me. So do they want a, a close-up of me on my face, or are they more comfortable if I'm sitting back, so we're kind of more like a traditional talk therapy session where they can kind of see my whole body. Sometimes for some folks that provides them a sense of more safety, they can kind of see me" (5, 513).

This participant emphasized not only how the client verbalizes their own experience, but how they can experiment with how they view the therapist, lending a sense of control to the experience that can enhance psychological safety for clients with trauma histories. Elsewhere in the interviews, participants emphasized the aspect of client control and safety as being strengths of video therapy with trauma-impacted clients, and this included clients making their own choices about where they have video sessions, how they prepare for them, and how they ground and soothe if the need arises. In video therapy, clients have opportunities to take the lead in their own coping, and rituals such as finding a comfortable, private location at home and gathering helpful supplies (tissues, blankets, grounding objects) can help clients take ownership of their own self-care. These skills may have an effect beyond the therapy space.

Working with Differences and Oppression

"the cultural pieces…are resources" (5, 642)

In discussing how the participating therapists work with differences and systemic oppression, the two forms of oppression mentioned were poverty and colonialism. One therapist told her story of trying to address financial barriers to EMDR therapy:

> "In private practice, I mean that's the thing right? Because if people can't afford to come for private practice, like they're marginalized automatically I suppose. But I mean (chuckle), so in my private practice I find that more challenging, although behind the scenes I'm forever trying to figure out, like you know, there's things like the Affordable Therapist's Network where they list people who are doing things on a sliding scale. I've approached the Canadian Association of Marriage and Family Therapists, trying to figure out if there's a way that we can, and we can't I found out, the government won't let us do this, but one of the ideas that I had was like, can't we give tax receipts to therapists who

> are willing to donate? Like let's say, let's say I come, like I design an intake process website online for families who need family therapy but can't afford it, so, and so let's say because I'm a therapist, I know 10 therapists, and all of them are willing to take on one family for 12 sessions. So I was thinking about creating a non-profit where I give them a tax receipt for their service right, for those 12 sessions, and they would provide therapy free to those families…In turn for a tax receipt, like a charitable donation receipt…But that's illegal because you can't offer a service as a charitable donation…only hard property. So that, anyways, I'm forever trying to figure out things like that and in my private practice I have not found a suitable way to do that" (3, 691).

Through her story, this participant shared about her attempts to address financial barriers beyond sliding-scale fee measures by wanting to organize, advocate and design a non-profit.

Another therapist focused more on addressing oppression and differences within sessions. In particular, therapist 5 connected the role of *social work* to her consciousness-raising within EMDR work with clients, and discussed how she frames trauma not as what is wrong, but as what wrongdoings have been done, in any client's view. From here, this therapist discussed how with some clients, she collaborates with them about what it is like for them that she is a "white settler" (5, 658) in the therapy room, allowing space to acknowledge difference. On the other hand, this therapist commented on working with differences in acknowledging forms of resourcing that are culturally appropriate when she stated, "the cultural pieces…are resources" (5, 642), and mentioned that she's had Indigenous clients identify their resource of humour as rooted in culture and Indigeneity. Celebrating this resource and centering culturally appropriate supports can be an important asset within using EMDR protocol. More generally, other therapists vocalized various versions of meeting clients where they are at and centering client knowledge as critical to trauma-informed practice, in person, and on video.

Supports for Effective Practice

"I think most therapists need their own therapists" (5, 676)

While participants offered a wide range of experiences of how they feel EMDR therapists working with trauma-impacted clients can support themselves to work effectively and avoid burnout, several themes emerged. Every participant mentioned the role of therapist-to-therapist connection as critical support, including connecting through EMDR Canada, regulating

professional bodies, EMDR and other training groups, consultation/supervision groups, collegue debriefing, and informal peer connections. Therapist 5 noted in her own narrative:

> "You need an EMDR supervisor or a consultant, because it's a very, it can be very protocol heavy, and it can be very very challenging therapy personally, but also there are just a lot of moving parts and a lot of tricky pieces to doing this therapy, so it's really helpful to have somewhere to talk through situation cases. What's been working, what's not working" (5, 700).

Multiple therapists pointed to continued education as a support to not only remain competent in emerging ways of practicing EMDR, but to reconnect with the passion and purpose they feel in choosing this profession. Therapist 1 shared her story of how her previous ritual of attending professional development conferences has been impacted by the distance measures required in the COVID-19 pandemic:

> "In a weird way education is a big way I do self-care, and that's been a lot, because normally at least once a year I fly somewhere out of Winnipeg where I get to go away for a minimum of three days and like, stay in a hotel, and then learn about something super cool, usually EMDR with a bunch of other EMDR professionals around the world. And they're just cool people and they're like, like 80 percent of them are deeply spiritual people that I just like, yeah I just get so excited and I'm like, I'm like connecting and networking and learning and it gets me excited and that's been a big loss 'cause I haven't done that." (1, 1413)

In this passage, she highlights the *social* and *purpose-driven* aspects of the educational enhancement she chooses to support her EMDR practice and how this has been absent during COVID-19. Other therapists credited video-specific trainings completed during the pandemic as important educational supports during this time to ensure trauma-informed, competent practice during a time of adaptation.

As reflected throughout the probing question theme analysis and in the general story-telling of the interviews, all five participants offered emphasis on the need for therapists to work on their own mental health issues and experiences before engaging as therapist professionals themselves. This often connected to the theme of strong therapist qualities, such as being able to perceive personal triggers and acknowledge these and bias before connecting them to the client experience. Many therapists identified that ongoing therapy while practicing as a therapist is an

important tool for preserving mental health, and two even mentioned using EMDR on themselves after particularly impactful sessions with clients to process and discharge emotions associated with the session. This speaks to the ability of participants to use EMDR not only with trauma-impacted clients, but on self to minimize vicarious trauma.

Additional activities participants listed that support them personally to enhance their professional work include massage, acupuncture, walking, minimizing self-shaming, and connecting with family, friends and pets. In terms of video work specifically, participants identified taking mindful breaks from screen time and substituting other activities that allow for their eyes to rest (such as listening to audio books during leisure time).

Qualitative Criteria for Trustworthiness

Qualitative criteria for trustworthiness and transparency around limitations connect in the narrative research tradition. While trustworthiness is developed here through thick description and lengthy participant quoting in the presented narrative, this allows the audience to sense the participant stories (Morrow, 2005). Another level of trustworthiness can be attained through researcher reflections and reflexivity. The narrative framework, while strong in its flexibility, can support the possibilities of many interpretations and inquiries, meaning that committing to the expression of one narrative focus limits the exploration of infinite other possibilities. I organized the analysis one way, bearing in mind that narrative research resists the concept of a singular objective truth, and that while this narrative holds accuracy, this does not diminish the many other possible accuracies that may have been the narrative framing if I had pursued other options. Riessman summarizes this by stating, “the approach does not assume objectivity but, instead, privileges positionality and subjectivity” (Riessman, 2000, p. 3).

Researcher reflexivity is important in analyzing participant data for a larger audience and creating trust. My personal background shaped how I positioned myself as the researcher and may have shaped how participants interacted with me and the research topic. I have many identifying markers in common with the participants, including my gender and race, and interestingly, my multiple roles as both graduate student researcher and registered social worker employed in the field of clinical social work frame my understanding of the data. My passion for the trauma treatment field drew me to this research during times of significant practice format change, and throughout the interviews, my background as a practicing social worker and MSW student may have shaped how participants responded to me or how I framed the interviews for

them. For example, often participants asked if they could use certain terms, creating 'insider-speak' within the interviews that would require background in clinical practice to understand, and this may have shaped participants' perceptions of me and my formal education. On the other hand, sometimes my pursuing of this topic of EMDR research may insinuate that training and practicing EMDR is a personal goal, when I have not determined whether I share the same value of EMDR expressed by the participants, as I do not have this practice knowledge firsthand.

Limitations

This research was completed during a global period of change and uncertainty due to the onset and continuation of the COVID-19 pandemic. This impacted recruitment and data collection processes, such as the adaptation to video-based interviews. The narratives shared by participants and the methods and analysis frameworks used formulate only one academic perspective on the topic of EMDR, trauma therapy and video services, and more research is needed in this area. It is important to create transparency about the shortcomings of this project, and it was most meaningfully limited in its sample size and the homogeneity of the sample. While a smaller sample size was intended based on the length and depth of interviews in this narrative approach, this narrowed the variety of perspectives shared, and the existing participants identified as white and female. The response outcomes from potential participants can be speculated about, such as potentially reflecting the existing pool of individuals who meet the criteria of practicing EMDR through video in the Manitoba context. It is also possible to explore the potential unidentified barriers that limited the available responses to this study in the recruitment stage. However, this does not minimize the importance of further research in this area with greater attention to increasing the size and diversity of the sample.

Discussion- Therapists' Constructions of the Use and Value of EMDR

This project has explored the narrative accounts of therapist participants' experiences of EMDR, trauma treatment, and video services through both Riessman's analysis of personal narratives concepts and through analyzing the five themes of the probing question section (qualities of a strong EMDR therapist, determining appropriate EMDR services, video-specific considerations, working with differences and oppression, and supports for effective practice). The project moves away from a focus on EMDR's effectiveness and instead toward an understanding of how practitioners make meaning of EMDR as a therapeutic practice and the ways in which they construct the value of EMDR practice strategies. While significant literature

focuses on client outcomes, especially for clients impacted by trauma, this largely ignores the processes of therapists and therapy strategies found in practice guidelines and training that do not as readily appear in academic study. The COVID-19 pandemic provided a unique situation in which therapists were not only tasked to adapt their modes of clinical practice, they were living through the same global pandemic as anyone else, and potentially coping with uncertainty, scarcity, threats to well-being and health, pain, and loss. In this context, narrative research provides therapist views at the intersections of professional and personal work, and the interviews explore the strategies, knowledge, and opinions that continually shape therapists' choices beyond the existing manualized versions of therapies. In Riessman's text, she asserts that narratives can by analyzed as a continuous negotiation of identity through performance, and the described interviews highlight the expressions, language choices, and examples that participants employed to describe their vision of EMDR's 'identity' and practices.

Encountering EMDR

The narratives demonstrate that all five participants specifically choose to be EMDR trained and that this choice was driven by their need to find a therapeutic approach that is effective in addressing client symptoms. Participants used the notion and image of 'talk therapy' as a construction to contrast EMDR with other therapeutic approaches, framing it as distinct within the range of modalities at therapists' potential disposal. This participant attraction to EMDR is best contrasted with the literature's tension between researchers and clinicians.

It is important to note that a significant group of literature on EMDR (Cuijpers et al., 2020, Ehring et al., 2014, Valiente-Gomez et al., 2017) remains focused on seeking empirical evidence to validate the claims of EMDR. Lebow & Jenkins (2018) suggest that the focus on efficacy has lead to controversy regarding the mechanisms behind EMDR, but also revealed the differing views between researchers and clinicians. Quoting from Cook and Coyne (2003), Lebow & Jenkins call for a more productive relationship between these two groups:

> "To the envy and dismay of its critics, EMDR has been enthusiastically received by many frontline practitioners. Critics would do well to think long and hard about just why clinicians have so readily seized upon EMDR and integrated it into routine treatment. Certainly, we have not seen the same excitement for conventional exposure therapies, despite all the scientific evidence supporting their effectiveness" (Lebow & Jenkins, 2018, p.132).

This commentary connects directly to the valuable information needed from EMDR clinicians themselves, as valuing EMDR does not necessarily rely on it being more evidence-based than other modalities. In connecting the literature to the narratives shared by participants, it became clear that practitioners' perceptions of EMDR are not dominantly shaped by the reports of EMDR effectiveness, but perhaps by the therapy communities they are supported by and their own individual experiences.

If participants' motivation to practice EMDR lies beyond its outcomes in rigorous academic research, these narratives, using Riessman's language of performance, frame different understandings of EMDR that contribute to a larger identity derived from the participation in EMDR training and then the use of EMDR strategies and tools in practice. The stories and explanations provided by the five interviewed therapists describe how EMDR was performed as a modality of client-led (and clinician-facilitated) experience. This involved having strong structure and knowledge needed to support the practice, offering satisfaction and efficiency, focusing on mindfulness, being able to be flexible and adaptable, and being aware of the human vulnerabilities of practitioners. It may be these qualities, rather than the concerns raised in the literature about best practice, that sustain clinician interest and practice in EMDR over time.

Expertise in Practice

Expertise in practice is more than just knowing, using, or being certified in therapeutic approaches or modalities. Expertise is also assessment skills, knowledge of trauma and trauma impacts, practice wisdom in being intuitive to know what will work with clients, and how to adapt skills and techniques for unique or diverse client situations.

All the participants emphasized the importance of therapeutic alliance in delivering effective and trauma-informed EMDR, as they discussed relational qualities as important in strong EMDR clinicians. While adherence to the EMDR protocols is emphasized, Marich (2012) articulates the need for rapport-building skills, which was also highlighted by these five therapists. When asked about qualities that make strong EMDR therapists, in person and on video, each participant highlighted collaborative qualities (earlier in this analysis contrasted with directive qualities), such as attunement, ability to normalize difficult emotions and tolerate their affect in session, and creativity or flexibility. Elsewhere in their narratives, each therapist also emphasized the human delivery (rather than the protocol-directed) lens of EMDR practice, such as the ability to utilize client cultural components as resources and the importance of therapists

tending to their own mental health needs personally. While much of the literature focuses on measurable outcomes and protocol aspects of EMDR (Cuijpers et al., 2020, Ehring et al., 2014, Valiente-Gomez et al., 2017), the participants' narratives of the lived experience of EMDR practice center the therapeutic alliance and relational qualities. In terms of how the participants vivified the theme of therapeutic alliance and EMDR in the literature, participant 5 offered examples of how transitioning to video EMDR services was an opportunity to increase the client-centred aspects of her work and emphasize relationship-building. She describes connecting with clients about the changes of distance-delivery, such as truly meeting clients where they are in seeing them in their homes on video. She uses the concept of resiliency to be present with clients in the changes of the pandemic and recognize the strengths this requires by stating, "that's really resilient to just agree to just do this, and try this, and try and make it work [video therapy]. So I think that can be a moment of like, catching and reflecting strength for clients". Here, the participant was able to build therapeutic rapport by actively addressing the human conditions of therapy in this context, beyond what would be instructed within EMDR protocol. She also shared about the change to video offering benefits to some clients, such as clients with health conditions, mental health conditions such as agoraphobia, and clients in rural settings. In her examples, video services offered additional ways to connect with clients and better prioritize their own needs, which can strengthen the therapeutic alliance.

The narrative accounts provided by the five participants demonstrate not only their understanding of trauma-informed literature and practices values, but also how these theories are realized in practice situations. For example, Szczygiel (2018) emphasizes that trauma is fundamentally a biological experience that then impacts psychosocial functioning, and that trauma-informed standards must be rooted in commitment to knowledge of the biological processes existing for clients recovering from traumatic events. However, the narratives of clinicians, rather than researchers, expose *how* that commitment to the biology and physiology of trauma shapes the experiences of therapy practice. Participant 1 articulated, "I always, one hundred percent, screen for dissociation. I, in my opinion, an EMDR therapist should always do that. They can start with just the DES, something simple, you'll often catch the red flags". Not only does this clinician identify the role of measuring the presence of dissociation in the beginning stages of EMDR in practicing safely, but she names the DES (Dissociative Experiences Scale, a 28-question screening tool), as the practice component contributing to

trauma-informed treatment. Several other participants highlighted screening for dissociation as paramount in navigating EMDR safely with clients, and participant 5 mentioned specifically that further education about dissociation shaped her practice beyond what was offered in EMDR Basic Training. This area illustrates the relationship between theoretical considerations (such as the studied biological impacts of trauma) and practice (dissociation as a neurobiological process that can be identified and accounted for when shaping a client EMDR treatment plan).

The texts emphasize clinician awareness of intersecting and compounding traumas as integral to client-centred EMDR practice, and this was especially outlined in studies focusing on clients with experiences of sexual trauma (Gilligan & Akhtar, 2006; Sanchez, Benbow, Hernandez-Martinez & Serrata, 2019). This points to questions faced by clinical social work and therapy generally, such as how practitioners individually and collectively recognize systemic impacts that may exasperate impact from traumatic events that create the clinical focus. This concern was reflected in Participant 3's navigation of the barriers to providing affordable practice, when she stated, "if people can't afford to come for private practice, like, they're marginalized automatically I suppose". This idea of automatic marginalization, as the participant articulated, identifies how much clients are impacted by barriers (here, financially) before even beginning the therapy process. These barriers may compound the existing trauma experienced by clients, due to the mental health impacts and additional stress of seeking professional support and finding it to be inaccessible. While the texts do not specify how individual clinicians can advocate for systemic change to the process of receiving private practice therapy (beyond individuals offering sliding scale pricing), this participant told her story of advocating for her regulating professional body to create a service in which therapists can donate sessions to low-income clients and receive tax receipts. The strategy of connecting with her regulating professional body was identified, and this description of how clinicians practice EMDR (including how they address systemic/financial inequalities) compliments the existing literature on the intersecting experience of marginalization and trauma-impacted clients.

Tools and Techniques

Theoretical discussion of EMDR focus on the eight phases of the protocol. These phases are outlined in the literature review section above. Through their narratives of how they practised EMDR, these five practitioners revealed how they followed the eight phases of treatment, as advocated by Shapiro and Laliotis (2011). They also described how they tailored their use of

these various phases and the tools and techniques recommended within each phase to specific clients, especially the strategies embedded in the fourth and fifth phases, which are the most unique and controversial aspects of EMDR. van den Hout and Engelhard (2012) described the techniques in these two phases:

> "theories about how a procedure such as EMDR works influence how the procedure is applied. The theories of 'bilateral stimulation' and 'increase of interhemispheric communication' inspired practitioners to replace eye movements with other forms of bilateral stimulation. A popular method is to have patients listen to alternating left and right beeps through headphones during the recall." (p. 731).

Although van den Hout and Engelhard observe the practice shift, their empirical investigation of these changes noted that "the effects of eye movements were about three times that of the beeps" (p. 731). While a practice strategy such as deciding between bilateral stimulation methods can be studied for effectiveness, this does not necessarily impact the decision-making process of therapists. When Participant 2 described her reasoning for preferring one method over another, she expressed valuing methods with a slower pace, as she noticed clients responding well to them. This was based on her practice experience, not her adherence to empirical evidence.

While the literature uses the phrase 'full protocol' throughout to signify the completion of all eight phases, this assumes that only using the preparation phases is incomplete or unsatisfactory to client and therapist. However, in describing the use of EMDR during times of crisis and environmental stressors such as the COVID-19 pandemic, each participant told a story of valuing the preparation phases as 'foundation' phases, and that sometimes this initial safety was the best focus overall in session. While the literature emphasizes the middle phases as the strength or 'meat' of EMDR work (the unique eye movements or bilateral simulation described above), the participants, and their stories of resourcing with clients (through calm place exercises, visualizations, sensory grounding) express the value of the initial phases. Here, participant 5 shared about finding cultural-based resources, such as the use of humour, and participant 2 described her 'healing vortex' and development of positive figures with each client. This rich area of work is minimized in the language describing the second phase of protocol in theoretical depictions of EMDR practice, but it is through the emphasis on these early and developmental phases in the interviews that the participants demonstrate their commitment to developing positive rapport, strengths-based, and client-centred practice. It is also in the phase of

preparation where therapists demonstrate the ability to adapt to video delivery and account for the challenge of distance services.

The technique, known as the Butterfly Hug, was also emphasized by many of the participants. This is a form of self-administered bilateral stimulation, developed by Artigas in 1998 (Jarero & Artigas, 2021) and appropriate for phases four through six in the standard EMDR protocol. At the therapist's instruction, the client crosses their arms over their chest and uses paced, alternating hand taps to mimic the other forms of bilateral stimulation. The authors suggest:

> "It is thought that the control obtained by clients over their bilateral stimulation may be an empowering factor that aids their retention of a sense of safety while processing pathogenic memories. EMDR clinicians reported that they have used the Butterfly Hug with more debilitated clients who easily get emotionally overwhelmed and dysregulated or with clients with a narrow window of tolerance" (p. 2).

Throughout the interviews, participants credited the Butterfly Hug for offering clients something manageable when they were already in a state of overwhelm, stress, or in 'survival mode'. This echoes the experiences of clinicians mentioned in the Jarero & Artigas (2021) article, and this emphasis on client-centred treatment and establishing safety during unique or challenging circumstances reveals the value of exploring practice realities outside of empirical evidence.

Distance-Based Video EMDR Treatment

The literature on video delivery focused on hypothesized risks and ethical considerations and often pointed to social work regulating bodies to address these formally (Reamer, 2018). Reamer (2018) describes how professional bodies in the United States context have outlined, among other considerations, the area of designing and delivering services and the following competencies required of clinicians: the ability to assess risks and benefits to technology-based services, the ability to ensure acceptable levels of confidentiality and professionality, the ability to confirm easily the identity of the client at each point of contact, and ability to recognize different levels of client comfort with technology-based services (Reamer, 2018, pp. 260-261). The texts focus on the standards needed and being developed, but do not address the clinical practices of electronic service delivery that shape therapy treatment. While this area of literature may leave practice skills and strategies to training programs, the narratives from this project examine some strategies, rather than standards, that clinicians themselves are using within the

video therapy space. Participant 4 offered insight, through her story, into the strategies that support video-specific EMDR, such as using the space of the computer screen as a containing resource in the preparation phases, offering clients more options as to the types of bilateral stimulation they prefer, and encouraging clients to narrate their own experience beyond what the therapist can perceive through the screen (and then giving the client opportunities to develop stronger self- and body awareness). These strategies not only create safety and increased mindfulness for both client and clinician throughout the session, but they have the potential to challenge clients in taking a more active role in their therapy experience. In offering this practice-based description, the participant offers strategies beyond the ethical standards outlined in the literature, and emphasizes that, while regulation standards must respond to changing conditions such as the COVID-19 pandemic and distance delivery, practice strategies are critical to understanding how clinicians make sense of EMDR's value in the trauma treatment context.

This section connected the initial literature reviewed with the understandings presented in the participant narratives to compare and contrast the themes of trauma-informed practice, therapeutic rapport, video considerations, and giving value to EMDR. Often, contrast can be attributed to differing goals between the academic research community and clinicians in practice, and the contributions from therapists in their own words that offer an expanded vision or EMDR practice and how this therapeutic approach become integrated into their identities as therapists. This multifaceted performance of EMDR may comment on EMDR's rise in popularity for clinicians, while the literature continues to focus on the more abstract qualities of EMDR, such as mechanisms behind the eye movement, and on outcomes and the imitations of EMDR. Both the literature and the voices of practicing clinicians are critical as the modality evolves over time and as the social environment changes. Through the temporal event of clinicians having to transition therapy services to video based delivery from the onset and continuation of the COVID-19 pandemic, these narratives add to the growing body of knowledge on the values of EMDR beyond measured outcomes.

Expected Impact and Significance of the Research

This project sought to both collect therapists' narratives of how they practice EMDR and explore and identify the strengths and challenges of practicing EMDR through video. It comments on the overarching qualities of therapy services needed to provide flexible, inclusive, and informed clinical care in the social and environmental contexts of crisis and unrest. The data

affirms what therapists already understand to be trauma-informed work through content themes that already exist in the academic literature on trauma treatment, such as transparency, client-centered work, psychological safety through grounding, pacing, and boundaries (Elliot, Bjelajac, Fallor, Markoff & Reed, 2005). It also complicates and adds to therapist knowledge regarding methodical treatments such as EMDR.

The narratives suggest that video therapy requires specific education and training opportunities to enhance, rather than simply manage risk associated with this practice, and the interviews offer ways to connect the mechanisms of video services to EMDR concepts, such as resourcing, containment, and body awareness. These connections might best serve EMDR practitioners if explored formally in training to provide effective trauma treatment with this model. The stories from therapists emphasize how screening for dissociation using standardized tools is an important practice that demonstrates tangible trauma-informed treatment, and further research is needed to identify trauma-informed practices that are employed by clinicians and how these became known to them. The stories featured in this project all emphasized the role of relationship-building, but more research is needed to identify what practices strengthen therapeutic rapport in EMDR, according to both clinicians and clients. In these ways, this project can guide further research on EMDR practice, beyond efficacy, to best serve a wide range of individuals seeking trauma treatment and the EMDR clinicians who support them.

This project was limited most meaningfully in its small participant sample size, and the researcher urges for future work in this area with attention to the diverse clinical social work community. The homogeneity of the participant group limited the ability to add cultural context to the discussion of this study, which requires deeper consideration in future research. This research contributes to a larger body of emerging knowledge centred on the connections between mental health and technological advancements and opportunities and is critical within the context of the global COVID-19 pandemic.

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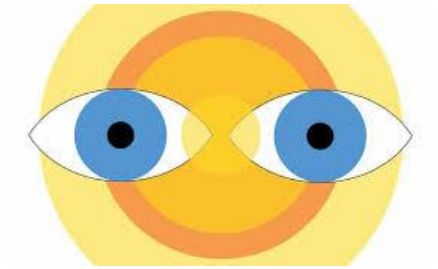
Therapist Volunteers Needed for Research Study on Video EMDR!



Project Title: Exploring EMDR (Eye Movement Desensitization and Reprocessing) with Trauma-Impacted Clients Using Video Therapy

To complete a Master of Social Work Thesis Project, I am seeking participants for a one to two hour in-depth (video) interview about EMDR practice. Depending on the interview, this might involve a follow-up interview several days later. If you are willing to voluntarily share your time with me, please contact me through phone or email:

Kathryn Niebuhr, BSW, RSW,
MSW Candidate
niebuhrk@myumanitoba.ca

Advisor:
Dr. Judith Hughes
judith.hughes@umanitoba.ca

The interview would happen at a time convenient for you through the video platform Doxy and a small honourarium would be provided to honour your time.

Could you be the right fit for this project? I am looking for therapists certified in EMDR who have been practicing this therapy modality for a minimum of 3 years, who have some experience using video EMDR during the COVID-19 pandemic (March 2020-present).

Purpose of the Research: This project aims to understand and explore narrative accounts of therapists practicing EMDR (Eye Movement Desensitization and Reprocessing) therapy with clients who have experienced trauma and who have shifted their practice to EMDR to video-based services. Data will be collected through individual interviews.

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Information Sheet

Project Title: Exploring EMDR with Trauma-Impacted Clients Using Video Therapy

To complete a Master of Social Work Thesis Project, I am seeking participants for a one to two hour in-depth interview (and potentially a follow-up interview if needed) about EMDR practice. If you are will to voluntarily share your time with me, please contact me at the email or phone number below:

Researcher Contact Information:

Kathryn Niebuhr, BSW, RSW,
MSW Candidate
niebuhrk@myumanitoba.ca

Advisor:

Dr. Judith Hughes
judith.hughes@umanitoba.ca

Purpose of the Research: This project aims to understand and explore narrative accounts of therapists practicing EMDR (Eye Movement Desensitization and Reprocessing) therapy with clients who have experienced trauma and who have shifted their practice of EMDR to video-based services. Data will be collected through individual interviews.

Participation: If you agree to participate in an interview:

1) You will take part in an interview of about 1-2 hours in length with the possibility of a follow-up interview.
2) With your permission, all interviews will be audio-recorded and transcribed.
3) You will be asked about your experiences with EMDR with clients who have experienced trauma and how you have shifted your EMDR practice to video-based services.
4) No one at your place of employment will be notified that you are participating.
5) You can refuse to answer one, some or all of the interview questions.
6) You can withdraw your consent to participate at any point – from the beginning of either interview and even after the consent form is signed. If you withdraw your consent, all information you have shared will be deleted.

7) After the interview, the recording will be transcribed. This transcription will be sent to you to alter, change, or remove any part that you want.
8) A transcribed but non-identifying copy of you transcript will be provided to an external panel of 2-3 members.
9) These forms will be kept until all data analysis is complete and papers describing the study have been submitted for publication, or a shorter amount of time if you direct us to delete the data.
10) You will receive a $50 honorarium. You will be able to keep this gift even if you decide not to complete the interview or refuse to answer some of the questions.

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Doxy.me Video Services Information Sheet

Project Title: Exploring EMDR with Trauma-Impacted Clients Using Video Therapy

Doxy.me is an online telemedicine solution that is simple and free to use. Throughout this project, participant interviews will take place through Doxy.me video technology, with the interviewer acting as the healthcare provider (through her own Doxy.me account used otherwise for clinical delivery purposes) and the research participant as the client/patient. This video delivery method is chosen for its security and minimal identifying requirements on the part of the client/patient (who does not need to create an account to participate). The information below details security and access, according to the Doxy.me website.

Security:

Is Doxy.me secure?

Written by Doxy.me Help Center

Maintaining a secure platform involves several factors, processes, and responsibilities.

Our responsibility to maintain security

Doxy.me complies with the security and privacy requirements of the healthcare industry. Here are the following ways we maintain security:

Protected Health Information Protection

1. Doxy.me **does not store patient health information** (PHI).
2. Doxy.me **does not record any video or audio calls** nor save any chat messages at anytime for any reason.
3. A **signed Business Associates Agreement** is provided for all providers on all plan levels.

4. We utilize **point-to-point NIST-approved AES 128 bit encryption along with SHA256 used for all video & audio communication**. All media and data streams (aka calls) along with signaling data is encrypted by default.
5. Doxy.me uses **full volume encryption and 256-bit AES encryption** used on all data stored at rest with secure backups and robust backup policies.
6. All access to the Doxy.me interface (e.g. the dashboard, waiting room, and any public webpages) is **secured over TLS (HTTPS)**, ensuring the information is encrypted.

Technical and Physical Security Controls

- **All Doxy.me data is stored within the highly secure Amazon Web Services (AWS) datacenter infrastructure with their industry standard physical controls.** The Doxy.me support system, help center, and public facing website are independently stored to ensure uptime and availability across the platform. For a list of all current security accreditations, see the AWS Compliance Programs page.
- **Only a select few senior administrators and developers have access to the servers where data is stored and code has to be approved by multiple parts and pass automated tests before deployment**. We go to great lengths to ensure the right balance between support and a secure infrastructure. Employees are only allowed access to provider-level data on a need-to-know basis in order to fulfill job function.
- During the provider sign up process, doxy.me will provide immediate feedback on password strength to **require strong passwords**. Any password classified as a 0, 1, or 2 (reflected in the number of dots on the strength indicator) is not allowed. Passwords must be unique and unguessable. Rather than stipulate the number of digits or special characters required for a secure password, doxy.me determines password strength based on 'guess-ability' using frequently used passwords, common character substitution patterns, and proper nouns found throughout the internet.
- All provider **passwords are stored using one-way cryptographic hashing functions** so even Doxy.me staff and developers can't see or abuse provider passwords. Patient's don't have accounts.
- Providers on any subscription plan including the Free plan may use "Login with Google" or "Login with Facebook" to implement MFA provided by those organizations. Providers on the **Clinic subscription plan may use their own IdP using SAML integration** with doxy.me.

Overall Security Practices

- **Doxy.me does not use proprietary technology or applications** but rather our platform is built on top of the open-source WebRTC standard for real-time communication.
- There is no proprietary or closed-source software to download and install. Patients, clients, and providers all access Doxy.me using **trusted and frequently updated and patched web browsers provided by Microsoft, Google, Mozilla, and Apple**.

Doxy.me does not ever have direct access or control over a physical device or any other application on that device. If your browser is out of date, you will be notified and may be unable to use the system.

- We **only use HIPAA/HITECH compliant servers** with active OSSEC intrusion detection, file integrity monitoring, log monitoring, root check, and process monitoring. We maintain a hardened, patched server OS with frequent security updates. And all workforce members are required to use anti-virus software and full-disk encryption on their devices.
- Doxy.me conducts **annual HIPAA/HITECH risk assessments** conducted by trusted third-party auditors along with regular penetration testing and vulnerability scans. After the assessment, we regularly review our policies and procedures and adjust them accordingly based on the findings. In the event of any vulnerabilities discovered, we work to address each in a timely manner relative to risk.
- Doxy.me runs a **bug bounty program** to assist in finding and reporting vulnerabilities with our platform. Once a vulnerability has been reported, our team works on implementing fixes as quickly as possible.
- We have **backup and disaster recovery policies and procedures** in place.
- Doxy.me maintains a **breach insurance policy** to help in the event of a security breach.

Third-Party Vendor and Service Provider Security

- We partner with Stripe to manage payments on Doxy.me. Stripe is **certified as a PCI Level 1 Service Provider**. Doxy.me does not have access to customers' credit card data **at all**.
- **All vendors** that assist in providing the Doxy.me platform **have signed BAAs with Doxy.me** specific to the service they provide. Many of these providers operate under Service Level Agreements to help ensure availability.

Your responsibility to maintain security

To comply with HIPAA/HITECH *you* also have some responsibilities while using Doxy.me:

- **Sign the Business Associates Agreement** found within your account dashboard.
- Do not share your login email and password with other providers; do not reuse old passwords that may have been compromised and use the provided password strength indicator to ensure your password is strong, complex, and not guessable.
- Keep your browser and operating system up to date to ensure the greatest protection and that the platform works as intended.
- Install and utilize antivirus and firewall programs suitable for your compliance and security needs.

- Properly authenticate the patients you meet with before you exchange any sensitive information during a call. This may be in the form of requesting the patient to present a form of identification or verifying information you have on file. Doxy.me does not store patient information so the provider is the best individual suited to verify a patient or client.

For any other privacy and security questions, contact our support team.

(from https://help.doxy.me/en/articles/95911-is-doxy-me-secure, December 2020)

Access:

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Project Title: Exploring EMDR with Trauma-Impacted Clients Using Video Therapy

Researcher Contact Information:

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Advisor:

Dr. Judith Hughes
judith.hughes@umanitoba.ca

Thesis project in partial fulfillment of the Master of Social Work degree.

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Purpose of the Research: You are being asked to participate in a research interview for a project that aims to understand and explore narrative accounts of therapists practicing EMDR (Eye Movement Desensitization and Reprocessing) therapy with clients who have experienced trauma and have adapted these practices to video-based services. I am interested in understanding your account of how you use EMDR methods and the value of this approach in addressing client trauma and how you shifted your practice to distance-based video EMDR treatment.

I am including participants who are certified to practice EMDR and have done so 1) for a minimum of 3 years with clients impacted by trauma, and 2) have EMDR practiced through video-based services at some point during the COVID-19 pandemic (March 2020-present).

Participation: If you agree to participate in an interview:

11) You will take part in an interview of about 1-2 hours in length with the possibility of a second interview, likely through video based technology (Doxy) depending on local COVID-19 protocols.
12) With your permission, your interview will be audio-recorded and transcribed.
13) You will be asked about your experiences with EMDR therapy, including delivery through video therapy.
14) Your participation will not be disclosed to your place of employment.
15) You can refuse to answer one or all of the interview questions.
16) You can withdraw your consent to participate at any point – from the beginning of the interview and even after the consent form is signed or up to two months after the interview is finished (at that point it will be difficult to remove your individual data from the analysis).
17) After the interview, the recording will be transcribed.
18) These forms will be kept until all data analysis is complete and papers describing the study have been submitted for publication (approximately Jan/22).
19) You will receive a $50 honorarium at the beginning of the interview. You will be able to keep this gift even if you decide not to answer all questions, complete the interview in full, or later ask to have all of your information removed from the study.

Confidentiality

1. If you voluntarily agree to participate, your name will be recorded on this form. These signed forms will be stored in a locked file cabinet belonging to me until all data analysis is complete and papers describing the study have been submitted for publication (approximately Jan/22).
2. At the beginning of the interview, you will be asked to sign another form that indicates that you have received the $50 honorarium. These forms will be stored in the same mannar as this confidentiality form.
3. The interview will take place through the telemedicine platform Doxy. An information sheet will be provided to you before the interview detailing the security measures included in this video platform, as well as how to access this platform. It does not require you to create an account or provide any indentifying information in order to participate. Signing of this form indicates that you have read the Doxy information form and understand the risks of video technology present.

4. The digital recording of the interview will be password protected will be stored on a password protected laptop.
5. A transcribed but non-identifying copy of your transcript will be provided to an external panel of 2-3 members.
6. The external panel members and the person transcribing the interviews will sign an Oath of Confidentiality.
7.

Do you want to be identified by name in any final report or papers? Choosing yes means that others will know that you were interviewed and what information you shared.

YES ☐
NO ☐

If you answered no:

- Any information from you that I include in reports or publications will be identified by a pseudonym (different name).
- I will remove or alter any identifying names or details.

Risk and Benefits

There are a few risks to your participation in the study. Your agreement or refusal to participate in the research study will not impact your employment in any way. If you agree to participate and sign this form, only the researcher listed above who completed the interviews with you will know that you have participated in the study. If you agreed above to include your name or your interview and in any reports or publications, then others will know that you completed the interview and some of the information that you shared. Part of the research process is to have the transcribed interviews reviewed by a 2-3 member external panel. Members of this panel will only receive copies of your transcribed interview(s) only after you have received your own interview transcript and removed any information that you do not want shared. Any identifying information will be removed (i.e. names, agency names, etc). There is also the risk that members of the external panel will guess or try to guess your identity. Others who read a report or the final thesis or attend a presentation will try to guess what therapists participated in the research.

If what you share in the interview is upsetting, we can debrief and determine resources for support.

If you agree to participate, you will benefit by sharing your voice and taking part in a study that seeks to understand therapist experiences, strategies and accounts of delivering EMDR with clients who have experienced trauma and have shifted their EMDR practice to video services.

Dissemination

If you agree to participate, you will be provided with feedback about the results of the study.

You can receive the feedback by email or mail.

Please indicate your email and mail address below:
Email address: Mailing address:

I will share information from your interviews and the interviews of other participants through an MSW thesis paper to be published by the University of Manitoba. The findings may also be presented at an academic conference and will be disseminated in a report/paper.

Researcher Name	Participant Name
Researcher Signature	Participant Signature

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way. This research has been approved by the Research Ethics Board at the University of Manitoba,

Fort Garry campus. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Officer at 204-474-7122 or HumanEthics@umanitoba.ca. A copy of this consent form has been given to you to keep for your records and reference.

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Honorarium Form

Project Title: Exploring EMDR with Trauma-Impacted Clients Using Video Therapy

Thank you for your participation in this research study. By signing below, you are indicating that you have received the gift card honorarium as per the consent form you signed before your interview participation (mailed to the address recorded on your signed consent form). Please email a copy of this signed form to niebuhrk@myumanitoba.ca. This form will be stored in the same confidential manner as your consent form.

_____ _____

Signature Date

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Pre-Interview Questionnaire

Project Title: Exploring EMDR with Trauma-Impacted Clients Using Video Therapy

Thank you for participating in this project.

Before your interview with the researcher, please take a moment to complete this questionnaire with some potentially identifying information. Please note that this completed questionnaire will be stored separately from your consent form with your name, and separately from your interview recording, in accordance with the data storage policy stated on the consent form you have signed. The information given in this form will only be brought up in the interview if you choose to do so.

Only fill in the questions you feel comfortable answering. You can continue participating in the interview regardless of which questions you do and do not answer on this form.

Questionnaire

Gender:	
Race/Culture:	
Age:	
Educational Background:	
Years of therapy practice:	
Years of EMDR practice:	
Type of therapy practice (private, public, both):	

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Individual Interview Question Schedule

This interview will have three parts: 1) the telling of your story of EMDR experiences, 2) the clarification of any parts of the narrative provided in the first part; 3) an opportunity to respond to some specific questions connected to the first two parts. We will take a break after the first part and again, if needed after the second part.

Interview Subsession 1:

My research is about therapist narratives of EMDR and especially practicing EMDR through video services.

Starting wherever makes sense for you, please describe how your story of how you decided to become an EMDR therapist, your experiences with EMDR, and how you adapted the EMDR methods for video-based services? Please include as much detail as you feel willing to provide. There is no rush, I will not interrupt you.

Let me know when your story is complete.

I may take notes for points to clarify.

(Break)

Interview Subsession 2:

I want to be sure I have the proper sequence of what you have told me. Is the following sequence (the recorded/related order of events) the correct order in which these experiences occurred in your life? Are there any corrections you want me to make?

Interview Subsession 3 (Possible Prompts):

Reasons for becoming an EMDR therapist?

What are the strengths of EMDR?

What characteristics make a strong EMDR therapist, generally and through video services?

How do you decide that EMDR will be appropriate for a client in general and through video?

How do you adjust your services to meet the needs of a wide variety of clients who experience identity-based oppression in different ways?

How do you inform your clients about EMDR and explain the unique aspects to those who are not familiar with it?

How do you judge a client's comfort level with choosing this modality? What ethical considerations exist?

What confidentiality issues exist?

What challenges exist in video therapy more generally?

How do you adapt EMDR to video therapy?

How do you account for the aspects of in-person therapy that are absent from video-based therapy?

How do you assess safety in video therapy?

What supports do therapists need in delivering effective video therapy and effective EMDR therapy? What are the most important therapy skills needed?

How do you take care of yourself as a therapist in order to most effectively practice EMDR through video?

Wengraf, T. (2008). Short Guide to BNIM. Tomwengraf.com

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Debriefing Statement

Project Title: Exploring EMDR with Trauma-Impacted Clients Using Video Therapy

Researcher Contact Information:

Kathryn Niebuhr, BSW, RSW,
MSW Candidate
niebuhrk@myumanitoba.ca

Thank you for your participation in this research study.

The purpose of this study was to explore therapist narratives of practicing EMDR with clients who have experienced trauma and practicing EMDR through video services. The background leading to this area of study is my interest in adapting therapy to distance-based services and the range of possible experiences present, as well as an interest in the intersections of mental health and technology. The use, storage, and retaining of the data you provided is in accordance with the statements made on the confidentiality document you signed before participating.

If participating in the interview was upsetting, please contact the researcher to discuss appropriate resources for support.

If you would like to withdraw your data from this study, would like a copy of the final report once published, or if you have any questions about the study, please contact niebuhrk@myumanitoba.ca.

If you have questions about your rights as a participant of this study, please contact the University of Manitoba Office of Research Ethics & Compliance at humanethics@umanitoba.ca.

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Oath of Confidentiality

Project Title: Exploring EMDR with Trauma-Impacted Clients Using Video Therapy

I, _____(name of research collaborator), agree to collaborate on this research project by participating in the panel in the analysis process after data collection. I agree to maintain full confidentiality when performing any of the above tasks according to the confidentiality policy of the Research Ethic Board, University of Manitoba. Specifically, I agree to:

- keep all research information shared with me confidential by not discussing or sharing the information in any form or format;
- hold in strictest confidence the identification of any research participant that may be revealed during the course of performing the research tasks;
- not make copies of any raw data in any form or format (e.g., disks, tapes, transcripts, emails, and/or translations), unless specifically requested to do so by the researchers;
- keep all raw data that contains identifying information in any form or format (e.g., disks, tapes, transcripts, and/or translations) secure while it is in my possession, including:
    - keeping all digitized raw data in computer password-protected files and other raw data in a locked file;
    - closing any computer programs and documents of the raw data when temporarily away from the computer;
    - permanently deleting any e-mail communication containing the data; and
    - using closed headphones if transcribing recordings;
    - giving, all raw data in any form or format (e.g., disks, tapes, transcripts, and/or translations) to the site researchers when I have completed the research tasks by emailing them and placing them into a specified computer folder.
- erase or destroy all research information in any form or format that is not returnable to the site researchers (e.g., information stored on my computer hard drive) at the request of the researchers.

Printed Name of Research Assistant	Signature of Research Assistant:	Date:

Printed Name of Principal Researcher:	**Signature of Principal Researcher:**	**Date:**