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Perceptions Of EMDR Amongst Practicing Clinicians:
Preliminary Findings And Implications For Practice Settings

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Abstract

The efficacy of Eye Movement Desensitization and Reprocessing (EMDR) has been established through randomized controlled research and recognized by reputable clinical bodies. This article uses a mixed methodology to determine the knowledge and perceptual base of EMDR amongst a sampling of practicing clinicians, and to ascertain any significant correlations between clinician variables and their perceptions of EMDR. The qualitative component explores how a psychoeducational workshop on EMDR impacted the samplings' perceptions of EMDR. The overall receptivity to the use of EMDR in clinical settings was positive, with very few of the participants indicating previous reception of negative material on EMDR. This article offers implications for implementing EMDR in public practice settings since the majority of the study's participants practice in such settings.

KEYWORDS: EMDR, clinicians, perceptions, knowledge, correlation, mixed methodology, public practice

Perceptions of EMDR Amongst Practicing Clinicians: Preliminary Findings And Implications

For Practice Settings

Introduction

Eye Movement Desensitization and Reprocessing (EMDR) has garnered some form of clinical endorsement as an efficacious therapy for the treatment of Posttraumatic stress disorder (PTSD) by the following bodies of high clinical repute: the American Psychiatric Association (2004), the American Psychological Association (Chambless, 1998), the Department of Defense and Veterans Administration (2004), and the International Society for Traumatic Stress Studies (Foa, Keane, & Friedman, 2000). Additionally, EMDR has received clinical endorsements from organizations in other countries, such as Israel (Bleitz, Kotler, Kutz, & Shalev, 2002), Northern Ireland (CREST, 2003), the Netherlands (Dutch National Steering Committee Guidelines Mental Health Care, 2003), and Sweden (Sjöblom, Andréewitch, Bejerot, Mörtberg, Brinck, Ruck, & Körlin, 2007).

In his recent textbook that has ushered in a new area of inquiry about EMDR, Dworkin (2005) directly concluded that the efficacy of EMDR has been established. Dworkin's recent work on the relational imperative in EMDR has ventured into a new area of inquiry and examination of EMDR in which the therapeutic relationship is further examined. Dworkin has not concerned himself with efficacy, unlike the numerous amounts of research articles on EMDR. This research study takes a similar stance in that efficacy is not the focal point of the study. Rather, the perceptual element of EMDR amongst practicing clinicians serves as the central theme. The idea of conducting EMDR research that is not concerned with efficacy represents a new area of ground to be covered in the field of EMDR. This new form of research,

as will be demonstrated in this research article, offers multiple implications for practice and for policy within clinical communities. Dworkin and others have recognized that EMDR research has not kept up with clinical practice (Maxfield, 2007).

Literature Review

The approval of EMDR by major clinical organizations has resulted from the volume of research that has been conducted on EMDR since its discovery by Francine Shapiro in 1987, research that has demonstrated efficacious results. The efficacy of EMDR in treating PTSD has been established through sixteen randomized controlled studies published since 1989 (Maxfield, 2007). Two major research projects were published in 2007 that offered further validation of EMDR efficacy: a meta-analysis by Bisson and Andrew (2007) and a randomized clinical trial by van der Kolk, et al. (2007). Additionally, a wealth of case studies presented by clinicians practicing EMDR demonstrates the broad applicability of its clinical effectiveness with specialized treatment populations: battered women (Stapleton, Taylor, & Asmundson, 2007), sexual compulsivity (Cox & Howard, 2007), adults experiencing residual effects of childhood medical trauma (Broad & Wheeler, 2006), battlefield casualties from the Iraq war (Russell, 2006), dental phobia (DeJongh, van den Oord, & ten Brooke, 2002), reactive attachment disorder (Taylor, 2002), homicide perpetrator (Pollock, 2000), morbid jealousy (Keenan & Farrell, 2000), choking phobias (de Jongh & ten Brooke, 1998), body dysmorphic disorder, and grief (Young, 1995). Clinical case reports in substance use disorder treatment have also been synthesized and presented (Shapiro, Vogelmann-Sine, & Sine, 1994; Shapiro & Forrest, 1997; Zweben & Yeary, 2006). Manfield (2003) has edited a case book of EMDR clinical reports from many clinicians throughout the world treating a variety of clinical presentations.

Nonetheless, a recent article published by Lilienfield and Arkowitz (2006) in the periodical *Scientific American Mind* presented a highly skeptical view of EMDR that seemed to ignore the clinical evidence that had been evaluated by the aforementioned clinical bodies. The EMDR International Association (EMDRIA) (2008) has also recently issued a reply to a publication by the Institute of Medicine of the National Academies EMDR. In this publication, the Institute of Medicine contends that evidence is inadequate to determine the efficacy of EMDR. The EMDRIA response clearly points out several key studies, including many of the studies included in this literature review, that the Institute of Medicine failed to consider. EMDR has not been without its share of critics since its discovery and development. The literature contains several theoretical and practical criticisms of EMDR even though there is clinical evidence supporting EMDR's efficacy. In addition to the Lilienfield and Arkowitz (2006) article, Devilly (2005) classifies EMDR, along with several other innovative clinical treatments, as *power therapies* that are pseudoscientific and that threaten the integrity of psychiatry and psychology. Lilienfield, Arkowitz, and Devilly seem to be bothered by the notion that EMDR is a combination of various therapeutic approaches, and that founder Francine Shapiro is merely a clever marketer, or *spin doctor*, as Devilly labeled her.

The debate over EMDR's efficacy and effectiveness could serve as a basis for its own integrated literature review, a task that Perkins and Rouanzoin (2002) completed in analyzing the early criticisms of EMDR from the viewpoint of EMDR clinicians. Perkins and Rouanzoin identify five major points of misconception and confusion that are present in the criticisms of EMDR: (1) "the lack of an empirically validated model capable of convincingly explaining the effects of the EMDR method; (2) inaccurate and selective reporting of research; (3) some poorly

designed empirical studies; (4) inadequate treatment fidelity in some outcome research; and (5) multiple biased or inaccurate reviews by a relatively small group of authors” (p.77).

Purpose

The purpose of this research article is not to further perpetuate or to analyze the debate in the literature, rather, to measure the perceptions of EMDR by practicing clinicians in the year 2007, 18 years after Shapiro’s (1989) first article on EMDR was published in the *Journal of Traumatic Stress Studies*. Investigating how professionals perceive EMDR is a vital part of determining how well accurate information about the treatment has been disseminated into clinical settings (Marich, 2007). Moreover, this investigation can demonstrate what erroneous or negative material has been received about EMDR by clinicians and to determine where clinicians have obtained their information about EMDR, either positive or negative. Information on professional perception can be of importance to implementing or not implementing EMDR in practice settings.

This descriptive component, representing the primary purpose of this research article, seeks to answer five major research questions: (a) How much does a group of practicing clinicians know about the basic theory behind EMDR practice?, (b) What type of information has the same group of practicing clinicians received about EMDR?, (c) Where did this group of practicing clinicians obtain their working knowledge of EMDR?, (d) Based on existing knowledge and perceptions, do clinicians favor the use of EMDR in clinical setting?, and (e) Are there any significant correlations between certain clinician variables (e.g., years in practice, highest degree obtained, knowledge of trauma) and their knowledge and/or perceptions of EMDR?

A secondary purpose of this research article is to qualitatively assess how the same group of practicing clinicians, who were quantitatively surveyed to achieve the primary purpose, were impacted by participating in a three-hour continuing education workshop entitled *EMDR in the Clinical Setting*. This workshop was conducted after their initial knowledge and perceptions were measured. This qualitative data was collected to extrapolate any residual reactions that could not be captured by the quantitative measures, and to determine future directions for research on clinicians' perceptions of EMDR and on the impact of education about EMDR on such perceptions.

Methodology

Research Design

This exploratory, survey research project is a continuation of a poster that was presented by the investigator at the 2007 EMDR International Association annual conference in Dallas, Texas entitled, *Perceptions of EMDR in the Clinical Setting: Case Study of a Northeastern Ohio Community Agency*. In this anecdotal research, the investigator constructed her own, 19-item survey that was given to the 16 clinicians at her own agency (excluding herself) prior to conducting a continuing education workshop on EMDR at the agency. Since the author was in the process of formally introducing EMDR as a referral option at the agency, her intent was to gauge the receptivity of her fellow clinicians by investigating what they already knew about EMDR, how they obtained this information, and how they felt about using EMDR as a therapy in the clinical setting.

This current research project uses a modified version of the original survey to elicit descriptive and correlational data from another group of clinicians outside of the investigator's

original agency. Institutional Review Board (IRB) approval to use the survey instrument with clinicians was granted by Capella University on October 16, 2007 for the period of one year.

Survey Instrument

Following the poster presentation, the survey instrument was slightly altered. The new instrument added four more questions aimed at eliciting data about what types of negative material had been received by each clinician about EMDR and from where each clinician obtained this material. Moreover, two additional items were also added to determine clinician opinion about EMDR implementation and training in the clinical setting.

The survey instrument, which was labeled as a *Pre-Workshop Survey*, contained 23 multiple-choice items constructed by the investigator. The instrument was designed for use by clinicians in mental health and mental health-related fields, as the language in the instrument is geared to this population. This instrument was subdivided into three sections: (a) clinical demographic data about participants (e.g., years in practice, clinical specialties), (b) knowledge about EMDR and related concepts, and (c) perceptions about EMDR, including items to determine the origin of these perceptions and knowledge. It takes clinicians approximately 10 minutes to complete the instrument.

A *Post-Workshop Survey* was also developed, which is a duplicated post-test of section B of the *Pre-Workshop Survey* and an open-ended prompt for participants to answer about their experiences at the workshop. The multiple-choice post test was not used as a part of this particular research article, primarily due to the basic nature of the study's purpose. However, the open-ended prompt has been included as part of this research article in addressing the secondary purpose of this research, which is to qualitatively assess how each participant was affected by the workshop and to extrapolate any residual points regarding knowledge and perception that could

not be measured in the qualitative instrument. The open-ended question prompt read: *Please spend a few moments and indicate what impact this three-hour educational workshop had on your opinions about EMDR and your perceptions of EMDR as a legitimate therapy that can be implemented in clinical settings.*

Sampling

The author pre-arranged to have the surveys administered prior to a continuing education workshop that she gave entitled *EMDR in the Clinical Setting*. This workshop was given in Youngstown, Ohio on October 25, 2007 as part of a continuing education series offered by Neil Kennedy Recovery Clinic and related partners. The Neil Kennedy Recovery Clinic continuing education workshops are designed to address clinical issues related to substance abuse treatment and community-based treatment. Permission to distribute the surveys both before and after the workshop was granted by Doug Wentz, M.A., OCPS-II, the workshop organizer.

This research study thus employs purposive sampling. The sampled professional clinicians signed up for this workshop on EMDR for the purpose of obtaining their own professional continuing education credits. They represented a sampling of various drug/alcohol and mental health professionals in a two-county area in Northeastern Ohio. Each of the participants was given an informed consent prior to participation in the survey and the workshop. The participants were clearly informed that their participation in the workshop and the receipt of their continuing education credits would not be affected in any way if they declined to participate in the survey research. Twenty-three ($N = 23$) clinicians attended the workshop, and all chose to participate. One clinician was late, and she was only able to participate in the post-workshop survey; her open-ended response was included in the data set for the qualitative portion of this research.

The 22 clinicians participating in the pre-workshop survey and constituting the sampling pool consisted mostly of dually-licensed chemical dependency/mental health counselors ($n = 11$), followed by licensed chemical dependency counselors only ($n = 4$), licensed mental health counselors only ($n = 3$), certified chemical dependency counselors ($n = 3$), and a licensed independent social worker ($n = 1$). Two of the dually-licensed counselors also reported having level II, EMDR International Association-approved training in EMDR. Of the participating clinicians, the majority ($n = 15$) hold a Master's degree in a behavioral health field; the remaining clinicians reported having a Bachelor's degree in a behavioral health field ($n = 2$), followed by a Bachelor's degree in a non-behavioral health field ($n = 1$), an associate's degree in a non-behavioral health field ($n = 1$), a high school diploma ($n = 1$), a Ph.D. ($n = 1$), and one ($n = 1$) choosing not to respond.

The majority of the participants ($n = 12$) have reportedly spent 100% of their careers practicing in a community-based agency. Six of the remaining participants reported that they have spent 75-100% working in a community-based agency; only two participants reported spending less than 25% of their career in a community-based setting. The sampled clinicians are represented by variations in years of clinical practice and in clinical specialization. Seven of the participants have been practicing clinicians for 25 years or more, followed by one participant who has practiced 21-25 years, three participants who have practiced for 16-20 years, five participants who have practiced for 11-15 years, one participant who has practiced 6-10 years, and five relatively newer clinicians who have practiced for 0-5 years.

A variety of clinical specialties were represented by the sampled pool of clinicians; each clinician was asked to identify up to four areas of clinical specialty. The most widely represented specialties are drug and alcohol counseling ($n = 11$), mental health counseling ($n = 5$), marriage

and family counseling ($n = 4$), adolescent counseling ($n = 3$), clinical supervision ($n = 2$), trauma/abuse ($n = 2$) and dual diagnosis ($n = 2$). Individual clinicians reported specialties in mood disorders, case management, LGBT issues, eating disorders, cognitive-behavioral therapy, pastoral counseling, employee assistance counseling, and hypnotherapy. Eight of the clinicians considered themselves knowledgeable about trauma and nine considered themselves somewhat knowledgeable about trauma. At the extremes, three clinicians considered themselves very knowledgeable about trauma, and two clinicians considered themselves to be uninformed about trauma. The majority of the clinicians ($n = 16$) indicated that they conduct as least a reasonably thorough trauma screening as part of their assessments of clients.

Data Analysis

This research, which is exploratory in nature, does not involve hypothesis testing. Descriptive and correlational statistics will be the primary modality of analyzing the data set obtained through this research. A Pearson's correlation test was used for the correlational component; a two-tailed test of significance was used with statistical significance being accepted at the level of $< .05$.

There is room to incorporate a subtle qualitative component should any relevant information emerge in the open-ended response portion following the post-workshop survey. Moreover, in the multiple choice items, many of the items incorporate use of a participant-reported alternate response to the items of choice (e.g., "Other; please specify...") that will be considered in entering the data into SPSS 16.0 (Student Version). These data will be used to address quantitative researchs constituting the primary purpose of the research. For the secondary, qualitative component, a system of open, axial, and selective coding will be used to analyze the text-based responses, and conclusions will be drawn from this coded material.

Results

Quantitative Measures

Question 1: How much does a group of practicing clinicians know about the basic theory behind EMDR practice?

- (a) The majority of the surveyed clinicians ($n = 19$) correctly identified that EMDR stands for *Eye Movement Desensitization and Reprocessing*.
- (b) The majority of the surveyed clinicians ($n = 19$) correctly identified that EMDR is not a form of hypnosis.
- (c) The majority of surveyed clinicians ($n = 19$) correctly identified that the aims of EMDR therapy is to help people live a more adaptive life and to bring disturbing material to a more functional resolution. The other three clinicians were able to identify the aim of bringing disturbing material to a more functional resolution, but could not identify the first part of the complete answer.
- (d) The majority of the surveyed clinicians ($n = 14$) correctly identified that EMDR is appropriate for clients with appropriate emotional support resources and for clients who are able to maintain dual awareness of the past and present. The other clinicians chose a combination of the distractor items in the multiple choice scenario, with several of the clinicians ($n = 5$) choosing that EMDR is appropriate for all clients with a history of past trauma.
- (e) The majority of the surveyed clinicians ($n = 17$) correctly identified that EMDR is not an unrecognized, fringe therapy.
- (f) Most of the clinicians ($n = 11$) surveyed correctly identified that EMDR incorporates principles from a series of presented psychotherapeutic theories. Only one clinician

indicated that EMDR did not incorporate any principles from existing psychotherapeutic theories.

- (g) The majority of the clinicians ($n = 15$) correctly identified that small-t traumas, such as being called a dirty name, can be as clinically significant as Large-T traumas.

Question 2: What type of information has the same group of practicing clinicians received about EMDR?

- (a) Ten of the clinicians surveyed considered themselves to be uninformed about EMDR.

Six of the clinicians considered themselves to be somewhat knowledgeable about EMDR, with equal numbers of clinicians identifying themselves as very knowledgeable or knowledgeable.

- (b) The majority of the clinicians surveyed ($n = 12$) indicated that EMDR had been previously presented to them in a positive light, with seven indicating that it had been presented to them in a neutral light, and four offering no opinion. None of the clinicians indicated prior receipt of an overtly negative presentation of EMDR.

- (c) Five of the twenty-two clinicians surveyed reported that they had received some form of negative criticism about EMDR: Three of the clinicians heard that EMDR does not have sufficient empirical support, one of the clinicians heard that EMDR is just a form of hypnosis, and one wrote in: “The criticism was so ridiculous, I don’t even remember what it was.”

Question 3: Where did this group of practicing clinicians obtain their working knowledge of EMDR?

- (a) Ten of the surveyed clinicians indicated that their previous exposure had been through a continuing education course, and seven reported that their prior exposure to

EMDR had been through a colleague or co-worker. Individual clinicians reported being exposed to EMDR through reading an article of book, a college course, and the news media.

- (b) Two of the clinicians reported that EMDR was mentioned in their graduate level courses, and both of these clinicians had completed their graduate training within five years before the time of the questionnaire.
- (c) Of those clinicians who had received negative information of EMDR, two reported hearing this information from a colleague or co-worker, two had received this information from the Internet (these were write-in responses by the participants), and one reported receiving negative information from the news media.

Question 4: Based on existing knowledge and perceptions, do clinicians favor the use of EMDR in clinical setting?

- (a) Prior to receiving the continuing education workshop on EMDR, eight clinicians reported that they favored using EMDR in the clinical setting (either drug and alcohol or mental health treatment); twelve clinicians offered no opinion. One clinician opposed using EMDR in the clinical setting, and one clinician offered the alternate opinion that she favors its use as long as the clinicians are properly trained. The clinician offering this alternate opinion is currently practicing as a level II- trained EMDR clinician.
- (b) Prior to receiving the continuing education workshop on EMDR, nine clinicians stated that based on their current knowledge, they would consider getting trained in EMDR. Ten clinicians offered no opinion, one clinician stated that he/she would not

get trained, and two clinicians indicated that they had already received EMDRIA-approved trainings in EMDR.

Question 5: Are there any significant correlations between certain clinician variables (e.g., years in practice, highest degree obtained, knowledge of trauma) and their knowledge and/or perceptions of EMDR?

In this study, a Pearson correlation formula was used, and statistical significance (two-tailed) was accepted at a level of $p < .05$:

- (a) Having EMDR presented to participants in a positive light is positively correlated to favoring the use of EMDR in the clinical setting ($r = .651, p = .01$).
- (b) Prior exposure to EMDR was correlated to clinician's self-assessed level of knowledge about EMDR ($r = -.790, p = .01$) and to their desire to seek training in the future ($r = .521, p = .05$).
- (c) Level of licensure (multiple licenses/licensure over certification) was correlated to participants' self-assessed knowledge of trauma ($r = .454, p = .05$) and participant's self-assessed ability to screen for trauma in conducting clinical evaluations ($r = .504, p = .05$).
- (d) Participant's self-assessed knowledge of EMDR is correlated with when the participating clinicians received their highest academic degree ($r = .439, p = .05$) and with their self-assessed knowledge of trauma ($r = .577, p = .01$).
- (e) Those participants reporting lesser knowledge of EMDR did not have definitive opinions about wanting to get trained in EMDR prior to the workshop ($r = -.503, p = .05$).

- (f) Clinicians with lower levels of licensure/certification or those clinicians holding only one license were less likely to be knowledgeable about EMDR ($r = -.552, p = .01$).
- (g) Clinicians with a lower academic degree were less likely to identify what the initials EMDR stand for ($r = -.861, p = .01$) and were more likely to identify EMDR as a fringe therapy without any clinical approval ($r = -.453, p = .05$). Additionally, those clinicians who self-assessed their screening for trauma to be less than thorough were more likely to identify EMDR as a fringe therapy without any clinical approval ($r = -.431, p = .05$).
- (h) Clinicians with a greater number of years of experience were more likely to identify clinical appropriateness for EMDR ($r = .463, p = .05$) and the theoretical principles incorporated into EMDR ($r = .575, p = .01$).
- (i) Clinicians who offered no opinion about how EMDR had been presented to them in the past were less likely to identify the theoretical principles incorporated into EMDR ($r = -.517, p = .05$).
- (j) Clinicians offering no opinion about favoring the use of EMDR in the clinical setting were less likely to identify the aims of EMDR ($r = -.499, p = .05$). Clinicians able to identify the aims of EMDR were also more likely to identify the theoretical principle incorporated into EMDR ($r = .521, p = .05$).

Qualitative Analysis

Eighteen of the twenty-three workshop participants chose to fill-out some form of response to the open-ended, post-survey questionnaire that constitutes this research's qualitative component. Some of the participants chose to write short responses, whereas other responses contained more detail from the participants. After analyzing the data with open and axial coding

procedures, six themes emerged from the data: the workshop *EMDR in the Clinical Setting* increased positive impression of EMDR as a legitimate therapy, participants obtained a better understanding of EMDR as a result of the workshop, EMDR seems to be useful/applicable with a wide variety of appropriate clients, participants interested in gaining more knowledge or training about EMDR, concerns about EMDR amongst participants, and comments made by participating clinicians who already use EMDR. The first four themes will be presented in the greatest detail since the majority of participant comments can be classified within these themes.

Four participants indicated that the workshop *EMDR in the Clinical Setting* increased their positive impressions of EMDR; these participants specifically used the words *legitimate* or *legitimacy* as a valid therapy. One participant, a licensed chemical dependency counselor, stated that EMDR is another referral source that can be used in his practice. Another participant commented that the workshop on EMDR increased his/her personal awareness about his/her history as a child of an alcoholic.

The majority of participants choosing to respond to the open-ended post-workshop questionnaire made some type of comment about the workshop enhancing their understanding of EMDR. Perhaps the most significant response was made by a participant who noted that he/she was skeptical of EMDR until he/she saw the demonstration of EMDR done as part of the workshop (the facilitator/investigator asked for a random volunteer from the audience to participate in a public demonstration of a low-level disturbance). This response supported the old adage that *seeing is believing*; a basic axiom, but one that may prove to be wonderfully practical in introducing new therapeutic approaches to colleagues. Another participant also indicated that the demonstration was helpful, and two different clinicians commented that they were struck by the quickness of the results and by the little work that was done on the part of the clinician in the

demonstration. One participant noted that EMDR “seemed magical.” Three participants made comments about how EMDR seems to play a critical role in moving the client past a “stuck” point, and another participant noted that EMDR seemed to “make sense.” One participant commented on the similarities he/she saw between EMDR and hypnosis when it comes to “accessing the past in order to put it to rest.”

Six total participants made some type of comment about the usefulness and applicability of EMDR in a variety of settings. Two participants specifically noted that EMDR would be useful with clients being treated for drug and alcohol problems. A third participant noted that EMDR would be applicable in his/her community mental health setting.

Comments of both enthusiasm for gaining more knowledge about EMDR and concern for the EMDR process surfaced in the open-ended data. Five participants made comments on obtaining more knowledge, including being excited about the EMDR method, wanting to gain more knowledge about the neurobiology behind EMDR, desiring to share EMDR with other clinicians, and noting that the presenter’s enthusiasm has and will inspire others to get trained. One participant expressed his/her concern that client’s with high anxiety would not be able to sufficiently focus in on the EMDR process for it to have any effect; the participant noted that, as an individual suffering from anxiety, her concern emerges from personal experience. For the two participants in the workshop who were already trained in EMDR, only general comments were made in the open-ended survey. One participant simply commented, “I already use it,” and the other participant who is already trained noted, “[The workshop] strengthens my already held belief that EMDR is a significant and appropriate treatment for many individuals with various issues/trauma.”

Discussion

The overall receptivity of workshop participants to the use of EMDR in clinical settings was positive. Very few of the participants indicated reception of any negative material on EMDR, which is surprising considering the force of the practice debate that has ensued since EMDR's discovery. Several possible explanations can be offered to explain this finding. First, those clinicians and researchers who have advocated for the uses of EMDR through their work and their studies have done an excellent job in disseminating accurate information about the therapy. Since there is significant correlation regarding knowledge about trauma and positive perception of EMDR, it can be asserted that EMDR makes good theoretical sense as an efficacious treatment for trauma. At minimum, there is a significant link between knowledge of trauma and positive perceptions of EMDR. The impact of proper education must also be duly noted. The majority of the clinicians surveyed had previously heard about EMDR through a continuing education course or through a colleague, and the majority of clinicians reported a solid knowledge base about EMDR and indicated perceptions of the therapy that were overall very positive. Only a small minority of the clinicians reported anything negatively received about EMDR.

The open-ended, qualitative portion of the study also gives support for the impact of proper education about EMDR in order to promote positive perception. Some of the most vibrant responses in this qualitative portion of the study focused on the importance of the workshop that they attended after completing the original survey in increasing their understanding of EMDR and enhancing their enthusiasm for the therapy. The comments made about the impact of being able to see a demonstration of EMDR suggest that this demonstration component is an important part of educational ventures related to EMDR.

Further reading of the open-ended responses can also assist clinicians or other individuals offering education about EMDR in determining which points need better clarified or covered further in future educational ventures. For instance, it is of some concern that one of the participants considered EMDR to be “magical,” since such claims can potentially discredit EMDR’s relevance. In future educational ventures, it will be helpful to the proposed idea that EMDR taps into an individual’s own potential for psychological self-healing (Shapiro, 2001) and that though it may seem *magical*, the process is very organic, according to the adaptive information processing model. It is also worth examining that a participant, who self-disclosed her own experiences with anxiety, believed that an individual’s anxiety would not allow him to sufficiently focus in order to complete a course of EMDR treatment. This suggests that further information and emphasis on the importance of preparation and resource development in EMDR treatment could enhance the educational presentation of EMDR. If individuals have concerns about the therapy, it is important that those educating others about EMDR adequately address such concerns.

Another major implication that emerges from this study is that overall perception and receptivity to EMDR is positive amongst a group of surveyed clinicians who strongly represent the community-based treatment settings. DeGraffenried (2007) noted that only 8.8% of EMDR-trained clinicians surveyed on an international level practice EMDR in a community health or agency setting. DeGraffenried posited that since community agencies are primary providers of a wide range of services to both child and adult populations, the EMDR method needs to be available to all types of people. He further stated that the EMDR community has an obligation to actively move EMDR into public practice. The clinicians surveyed for this study primarily constituted community agencies described by deGraffenried, and their receptivity to EMDR in

the clinical setting is noteworthy, perhaps demonstrative of community practitioner's acceptance of new trends in evidence-based practice. Having EMDR presented to clinicians in a positive light is positively, significantly correlated to favoring EMDR's use in the clinical setting, and prior, positive exposure to EMDR was positively and significantly correlated to desiring to get trained in the future. This study suggests that, even though forms of administrative reluctance exist in community agency settings, the clinicians themselves are receptive to more widespread use of EMDR and training in its methodology.

Limitations

The most obvious limitation of this study is that clinicians who were sampled for the pre-workshop and post-workshop survey had chosen, before they even knew about the study, to attend a workshop on EMDR. Though this could suggest that they wanted to learn more about the therapy and its implications in clinical settings, it is possible that those who registered for the workshop already came into it with a more positive perception of EMDR than their peers in the clinical community. The second major limitation is that this study utilized an original survey instrument that was used before, but has not been extensively tested for reliability and validity measures. Thirdly, the pool of clinicians sampled ($N = 23$) was relatively small and the geographical area of sampled clinicians was limited to a two-county area in Northeastern Ohio.

Future Directions for Research

All three of the noted limitations of the study offer exciting potential for modification that can be expanded into future research. As a manner of expansion, and as a measure to further strengthen generalizability, it is recommended to use the survey instruments implemented for this study with other pools of clinicians. Even though the clinical specialties of the clinicians surveyed in this study were broad, the surveyed clinicians primarily represented a community-

based pool. Moreover, all of the clinicians had chosen to enroll themselves in a workshop on EMDR. Conducting the survey with clinicians from all areas of practice (e.g., community/agency, private practice, hospital, military) would enhance the validity of this study's findings and contribute further to the knowledge base on perceptions of EMDR amongst practicing clinicians. More widespread use and development of the survey instrument developed and utilized for this study would contribute to reliability testing of the instrument and could perhaps offer the EMDR community a valid, reliable instrument that can be used to gauge receptivity of EMDR in certain clinical or academic settings. To effectively test the reliability of the instrument, a higher number of clinicians from a broader geographical area would need to be tested.

Another area of potential research interest is conducting formal pre-test/post-test designs with either this set of survey data or data collected from future administrations of the survey instrument. Such designs could be used to test the impact of workshop presentations or other educational ventures on clinical knowledge base. These studies will be important to determining what areas of instruction need to be strengthened and enhanced when it comes to educating those not familiar with EMDR about EMDR and its clinical applications. They can also give EMDR educators feedback on the effectiveness of their educational presentations to clinical audiences who consider themselves to be less than knowledgeable about EMDR.

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