

The Decision to Use Eye Movement Integration Therapy: Exploring Clinicians'
Experiences through a Narrative Inquiry

A Thesis

Submitted to The Faculty of Graduate Studies and Research

In Partial Fulfillment of the Requirements

For the Degree of

Master of Social Work

in

Social Work

University of Regina

by

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Regina, Saskatchewan

May, 2019

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UNIVERSITY OF REGINA
FACULTY OF GRADUATE STUDIES AND RESEARCH
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Patricia Joy Dekowny, candidate for the degree of Master of Social Work, has presented a thesis titled, ***The Decision to Use Eye Movement Integration Therapy: Exploring Clinicians' Experiences Through A Narrative Inquiry***, in an oral examination held on May 6, 2019. The following committee members have found the thesis acceptable in form and content, and that the candidate demonstrated satisfactory knowledge of the subject material.

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Abstract

Evidence based practice (EBP) suggests that the best source of evidence to guide clinical decisions comes from randomized control trials; however, many practicing clinicians view client outcomes, clinical experience and their feelings of confidence using an intervention as the best sources to make clinical decisions. In the treatment of Post Traumatic Stress Disorder (PTSD) there are interventions that have been deemed to be EBP however, what has been found is many clinicians do not use EBP to treat trauma. Eye Movement Integration Therapy (EMI) is an example of an intervention used to treat PTSD that is not deemed an EBP. Current research also suggests that when treating trauma related symptoms clinicians need to, at times, go beyond traditional talk therapy approaches and consider approaches that incorporate the neurobiological aspects of trauma. This narrative inquiry sought to depict the experiences of four clinicians who use EMI in their clinical practice and to understand these clinician's decision-making process for their continued use of EMI. Six themes emerged from this study: (a) dissatisfaction with talk therapy for clients with trauma related symptoms; (b) clinicians' feelings; (c) the importance of what the client wants; (d) client outcomes; (e) client self-report and clinician observation, and (f) trauma memories are stored in the body.

Acknowledgements

I felt very supported during this research and would like to acknowledge all that helped me in this journey. I would like to extend my greatest appreciation to Dr. Kara Fletcher, my thesis supervisor. Your guidance, patience and ability to challenge me enriched my work greatly. I would also like to extend my appreciation to my thesis committee, Dr. Gabriela Novotna and Dr. Randy Johnner. Your guidance and experience was appreciated during this entire process.

To my family, thank-you for their love and support during this entire process. I would not have been able to do this without your unconditional support.

I would like to extend my deepest gratitude to the participants who participated in this study. Thank-you for sharing your experiences as this led me to greater understanding of this topic in so many ways.

I felt very honoured to be awarded three scholarships during my Master of Social Work. I would like to thank Aboriginal Graduate Award Program and the FGSR Indigenous Graduate Scholarship – Kaskihtamasowak. This funding assisted me to take the time and travel needed to complete my Master of Social Work.

Dedication

I would like to dedicate this thesis to my family. Your love and support inspired me to complete this thesis. I celebrate this accomplishment with you.

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Chapter 1: Introduction

1.1 Nature and Scope

In the field of mental health counselling, there are numerous treatment interventions clinicians can use in their practice with clients. Treatment interventions that are empirically validated through research are classified as evidence-based and have become highly valued due to being able to provide quantifiable data (Nelson, Steele & Mize, 2006). The adoption of empirically validated interventions by clinicians has led to this type of practice being referred to as evidence-based practice (EBP) (Nelson et al., 2006). Clinicians are not necessarily using EBP as they have found from their own clinical experience that other interventions can be more effective in practice (Pignotti & Thyer, 2009). One example of such an intervention is the therapeutic intervention Eye Movement Integration Therapy (EMI).

EMI is a counselling technique used to treat clients with trauma-related symptoms (Struwig & van Breda, 2012). EMI is a brief therapy in which eye movements are used to process traumatic memories that has resulted in some clients experiencing relief from their traumatic symptoms after one session (Beaulieu, 2003; Struwig & van Breda, 2012). EMI was created by Steve and Connirae Andreas in the late 1980's based on their work in Neuro-Linguistic Programming (NLP) (Beaulieu, 2005). EMI builds on NLP's idea that eye movements are used by individuals to access information, so eye movements could possibly be used to resolve problems (Beaulieu, 2003). The considerable drawback with EMI is that there is limited research on the intervention and no empirical evidence of its efficacy (Struwig & van Breda, 2012). EMI's progenitor Danie Beaulieu (personal communication, July 7, 2018) purported

EMI as an effective treatment intervention for individuals experiencing trauma related symptoms.

The prevalence of trauma in clients accessing mental health services has become more apparent. The American Psychological Association (APA) (2017) defines trauma as “events that pose significant threat (physical, emotional, or psychological) to the safety of the victim or loved ones/friends and are overwhelming and shocking” (p. 4). It is estimated that 76% of the population in Canada will experience one traumatic experience in their lifetime and nine percent will experience enduring symptoms from the traumatic event (Van Ameringen, Mancini, Patterson & Boyle, 2008). Statistics Canada (2013) estimates that approximately 475,000 Canadians have a diagnosis of Post-Traumatic Stress Disorder (PTSD). Given the prevalence of trauma in clients accessing mental health services, it is necessary for mental health clinicians to have therapeutic techniques to be able to treat trauma related symptoms effectively.

1.2 Focus

The focus of this narrative study was to better understand the reasons clinicians in Saskatchewan use EMI and what clinicians appreciate as valid evidence for their decision to continue to use EMI. Researchers in the area of neurobiology have highlighted the importance of further exploration of alternative or novel therapies that address the neurobiological aspects of trauma (Racco & Vis, 2015). A narrative inquiry seeks to learn from participants through their stories of their experience as well as their experience in interacting with others (Ollerenshaw & Creswell, 2002). Due to the minimal literature on EMI, there currently is not an adequate representation of clinicians’ rationale for using EMI. This narrative study will address this current gap in literature.

From addressing this gap in the current literature, this will provide researchers and clinicians with a better understanding of EMI, provide additional research on the intervention, practice implications for the use of EMI and how these factors affect decision making in clinical practice. This narrative inquiry sought to explore clinicians' experience with EMI, their decision-making process in using EMI and the effects of EMI they witness with clients, in order to better understand the perceived clinical value of EMI.

1.3 My Story

As Creswell (2013) stated, qualitative researchers position themselves by providing background information to provide readers with an understanding of how the researcher's experience informs interpretations as well as what the researcher will gain from the study. I am a Caucasian, married female from a middle-class family. I am a registered social worker working in the Saskatchewan Health Authority. I have been working in the area of mental health and addictions for the past 18 years. I am currently the clinical supervisor of the adult mental health team in Swift Current, Saskatchewan.

I was certified in level 1 of EMI in September 2015 and have been using EMI since this time with clients who are experiencing trauma related symptoms. The reason I chose this research was to be able to gain a wealth of information on the topic of trauma and EMI. I chose to become certified in EMI as I was looking for a therapeutic technique I could use that I found to be helpful to clients. I was trained in Trauma Focused Cognitive Behavioral Therapy (TFCBT) which is primarily for youth, but I would adapt it for adults. I found the treatment process slow with many clients dropping out prior to completion. When EMI training first came to Saskatchewan, I was unable to

take it. However, two of my co-workers received EMI training and within a year had started to use the technique. Their experience in using EMI piqued my interest. When the EMI training returned to Saskatchewan, I enrolled.

I have been practicing EMI since I took this training along with several of my co-workers. The stories we share with each other about the experiences we have with clients and using EMI led me to want to complete this research. I learn best through stories and am always interested in hearing how others practice. I am pursuing this research as part of my own learning as well to add to the research on this topic. I want to understand how clinicians are using EMI in practice and the reasons, they are using it despite the current lack of research.

My curiosity of what others have experienced using EMI was solidified after two sessions I had with one client. This client was in so much distress that he was not functioning well, his level of anxiety interfered with his daily functioning and quality of life. After two sessions of EMI, this client completely changed and was able return to the things he was doing in the past. This client's experience was the beginning indication for me that EMI could be an effective treatment for some trauma clients and eventually led me to this research. I value clinicians' stories about their experiences with clients and find this source of information beneficial for learning. I chose a narrative inquiry to capture the experiences of using of EMI and to provide rich descriptions to gain a better understanding of the utility of EMI.

1.4 Purpose of Research and Research Questions

The purpose of this research was to explore clinicians' experiences in using Eye Movement Integration Therapy (EMI) with clients. Understanding why clinicians

continue to use EMI with clients despite a dearth of empirical evidence may provide important information on its utility as a treatment intervention. Thyer and Pignotti (2011) are advocates of EBP and suggested in the absence of empirical research (i.e. randomized control trials), clinicians look for the best available research. This best available research may include narrative case studies, expert clinical opinions or opinions of professional colleagues (Thyer & Pignotti, 2011).

Clinicians who use EMI describe noticeable improvements for their clients who are dealing with trauma related symptoms and report these benefits as evidence for their continued use of EMI (Beaulieu, 2003). Further exploration of EMI as a counselling technique for clients who have trauma-related symptoms is needed. EMI could be a valuable and brief therapeutic intervention for clients experiencing traumatic stress but is easily dismissed due to the lack of research. These treatment effects may be desirable to clients, clinicians and agencies (Mireau & Inch, 2009; Nelson et al., 2006)

The creation and development of EMI was based purely on the clinical experience of Steve Andreas with clients who had persistent problems that were not being solved (Beaulieu, 2003). Beaulieu continued to refine and create protocols for EMI through her clinical experience over eight years with reportedly remarkable results. During this study, I contacted Danie Beaulieu to interview her to provide any updated information on EMI and to answer questions I had on the research on EMI for the literature review. A 30-minute telephone interview was conducted on July 7, 2018 with Beaulieu. Beaulieu (personal communication, July 7, 2018) stated she is a clinician not a researcher; and she values the reported experiences of the thousands of clinicians across the globe who are having positive outcomes with EMI. Beaulieu (personal

communication July 7, 2018) believes effective results obtained from these clinicians is what should be valued as evidence for the effectiveness and value of EMI. Studies have found many clinicians chose a therapeutic technique based on their own clinical experiences and from the experiences of role models (Nelson et al., 2006). Even though clinical experience of using EMI has reported effective improvements, there is currently no scientific evidence that supports it.

Since there is an absence of scientific evidence for EMI, the objective of this narrative study was to understand clinicians' decisions to use EMI with clients with trauma-related symptoms. The experiences of utilizing EMI were gathered through the stories of clinicians who use EMI in their therapeutic practice with clients. The research question that guided this project was:

1. What are the experiences of clinicians who use Eye Movement Integration Therapy (EMI) in their clinical practice?

This study also explored five sub-questions:

- How do clinicians decide to use EMI in their clinical practice?
- What do clinicians view as evidence for the use of EMI?
- How do clinicians present EMI to their clients?
- How do clinicians decide EMI is effective with clients?
- What are the reasons clinicians continue to use EMI?

The following chapter discusses the reviewed literature that was relevant to this study. The literature review first covered evidence-based practice (EBP) and clinical decision making. This section discusses the use of EBP and what factors clinicians use in their clinical decision making. The use of client self-report and outcome measures is

also discussed. Next the literature on trauma is reviewed, discussing the EBP for trauma and the neurobiological component of trauma and trauma treatment. Lastly, other important components to therapy such as brief therapy, common factors and common elements are reviewed.

Chapter 2: Literature Review

2.1 Evidence Based Practice and Decision Making

Gray and McDonald (2006) defined evidence-based practice (EBP) as “basing intervention on proven effectiveness derived from empirical research” (p. 7). Empirical research is based on a positivist scientific orientation and a highly valued example of this type of research is randomized controlled trials (RCTs) (Anastas, 2014; Gray & McDonald, 2006). The underlying conjecture with EBP is that the best evidence is mainly RCTs demonstrating an effectiveness of a treatment and if this treatment is utilized the outcome will be better for the client (Levant, 2004). In mental health counselling the most common time EBP is used is in the treatment planning stage when the therapeutic intervention is usually selected (Drisko, 2014). The American Psychological Association (APA) is one organization that has set treatment guidelines for mental health issues based on systematic reviews of RCTs on specific diagnoses (APA, 2017). Proponents of EBP have stated RCTs, systematic reviews and meta-analyses are the gold standard in research and are deemed to be the best sources of evidence (Anastas, 2014). What has been shown is clinicians in direct clinical practice do not place the same value on this type of evidence as researchers do and also view other sources of information such as client self-report and clinical experience as evidence for the therapeutic interventions they use (Anastas, 2014; Gray, Elhai & Schmidt, 2007).

EBP developed out of evidence-based medicine as a rational way to make decisions on selecting a therapeutic technique (Keenan & Grady, 2014). In many community mental health clinics, there has been an increased expectation that mental health clinicians use EBP, however, this has not necessarily translated into mental health

clinicians using evidenced-based therapies (Nelson et al., 2006). One reason for this is the resistance from mental health clinicians in utilizing EBP (Keenan & Grady, 2014). Mental health clinicians view EBP as not applicable to the needs of clients in community mental health clinics (Gray & McDonald, 2006). As Gray and McDonald (2006) argued, social work is a complex set of interventions and EBP is limiting as it is too narrowly focused. Mental health clinicians view the highly controlled conditions and the ability to screen participants out of clinical trials as something that does not translate to the community setting (Nelson et al., 2006; Zayas, Drake & Jonson-Reid, 2011). As Keenan and Grady (2014) discussed, many social workers do not like the use of research in deciding on a therapeutic intervention as they believe this means ignoring clinical expertise.

2.1.1 Factors used to make decisions. Research has explored how clinicians make decisions on treatment interventions. What has been reported is that clinicians find their own clinical experiences more valuable than research (Dozois, 2013). Colleague consultation was the most frequent source of information clinicians in direct practice reported using when making clinical decisions and the most efficient way to obtain the information needed to guide their decisions (McLaughlin, Rothery, Babins-Wagner & Schleifer, 2010; Nelson et al., 2006). Cook, Schnurr, Biyanova and Coyne's (2009) research surveyed 2739 psychotherapists and found that supervision, discussion with colleagues, and a clinician's own history with counselling and work with clients are the main factors that a clinician uses to determine a therapeutic approach. Wampold (2015) argued that when clinicians make treatment decisions they need to look beyond theory and diagnosis; they need to choose the therapeutic intervention that is right for the client.

Clinicians also identified they used treatment techniques they have had success with in the past and that emphasized the therapeutic relationship (Nelson et al., 2006). It appears the debate between researchers and clinicians was the difference in opinions to what was considered evidence for therapeutic interventions and this debate also extends to how outcomes in therapy are measured.

2.1.2 Measuring client change. Partners for Change Outcome Management system (PCOMS) is an evidence-based outcome measurement tool that has been validated through RCTs (Duncan, 2010). PCOMS uses an outcome rating scale (ORS) to measure the client's progress through the measurement of four items (Duncan, 2010). PCOMS also uses the session rating scale (SRS) to measure the therapeutic alliance (Duncan, 2010). There are five RCTs that support the "efficacy of PCOMS in individual ...therapy with adults" (Duncan & Reese, 2015, p. 393). The ORS measures client improvement session to session and identifies when the client has made clinically significant or reliable change (Duncan & Reese, 2015). PCOMS "directly involves the clinicians and clients in an ongoing process of measuring and discussing both the progress and the alliance" (Duncan & Reese, 2015, p. 391). This means that when using a tool such as PCOMS a change in a clients functioning is identified and the client is consulted to discuss their interpretation of the change. Many clinicians do not use outcome measurement tools and prefer to rely on their own judgement and client self-report (Ionita & Fitzpatrick, 2014).

Many clinicians reported the use of clinical expertise, experience and intuition to inform treatment decisions (McLaughlin et al., 2010). In Ionita and Fitzpatrick's (2014) study of 1668 registered psychologists in Canada, two thirds of the respondents were not

using progress monitoring measures like PCOMS. The respondents in this category cited the main approach they used to assess client progress was clinical judgement, observation of the client, client's self-report of improvement, feed-back from others and achieving therapeutic goals (Ionita & Fitzpatrick, 2014). Lilienfeld, Ritschel, Lynn, Cautin and Latzman (2014) reported that the inclination of many clinicians was to use informal clinical observations to assess an interventions effectiveness with clients. Lilienfeld et al. (2014) argued these observations at times were correct but should not be the sole source of evidence.

Lilienfeld et al. (2014) discussed several reasons why clinicians need to have more objective evidence other than observation. One reason is the term confirmation bias which means "to seek out evidence consistent with one's hypothesis and to deny, dismiss or distort evidence that is not" (Lilienfeld, 2014, p. 359). What studies have shown was that clinicians were not necessarily always accurate in their determination of a client's improvement or deterioration when solely using clinical experience or clinical intuition (Hatfield, McCullough, Frantz, & Krieger, 2010). Hatfield et al.'s (2010) study surveyed 36 psychologists in regard to when and how they know their clients have deteriorated. Their findings suggested that 70% of the time, these clinicians had difficulty noticing when their client's symptoms were declining based solely on clinical judgement (Hatfield et al., 2010). An implication for practice that Hatfield et al. (2010) suggested was not recognizing a client's worsening of symptoms may lead to failure in treatment outcomes.

Furthermore, Meyers (2002) argued that human judgement was usually not as accurate as statistical measurements to measure clinical outcomes. Meyers (2002)

argued that a client's memory of how they were before was often inaccurate and was a questionable way to measure progress in therapy. Meyers (2002) stated clients often overestimate their improvement in therapy when using self-report as memories were often constructed based on how a client was feeling at the time. Lilienfeld et al. (2014) suggested that client's improvement can also come from a client's perception. Lilienfeld et al. (2014) discussed two effects that can affect the client perception of change. These are improvements based on a client's expectation which is the placebo effect and the novelty effect which is the improvement due to the enthusiasm of trying something different (Lilienfeld et al., 2014). Ionita and Fitzpatrick (2014) argued that an evidence-based outcome measurement tool such as PCOMS used along with clinical judgement may improve clinical outcome.

2.1.3 Summary. Studies have found professional literature and research are not a main source of information for the participants in their decision-making process and empirical evidence alone had minimal impact when a clinician was determining a type of therapy to use (Cook et al., 2010; McLaughlin et al., 2010). Ionita and Fitzpatrick (2014) found the main approach used to assess client progress was clinical judgement, observation of the client, client's self-report of improvement, feed-back from others and achieving therapeutic goals. McAleavey, Nordberg, Kraus and Castonguay (2012) argued that along with client self-report and clinical observation that an outcome measurement scale be used.

Mental health clinicians have critiques of empirical evidence and researchers have critiques of clinical judgement, observation and client self-report to assess an intervention's effectiveness. As identified, there are flaws in making treatment decisions

based on solely on empirical research, clinical observation or client self-report (Anastas 2014). Given this, as Anastas (2014) stated in the absence of empirical research, mental health clinicians need to look for the best available evidence. The best available evidence at this time may be qualitative reports or case studies. Evidence of this nature should not be dismissed but means that the findings are subjective and cannot be generalizable (Anastas, 2014). As the interest of EBP grows, there has been more interest in EBP with specific treatment areas. One example of this, is identifying EBP for the treatment of trauma. This is due to the expanding research on understanding the impact of trauma on individuals, the varying treatment interventions for trauma and the variability from experts on how to treat trauma (Gray et al., 2007).

2.2 Trauma

The American Psychological Association (APA) (2017) defines trauma as “events that pose significant threat (physical, emotional, or psychological) to the safety of the victim or loved ones/friends and are overwhelming and shocking” (p. 4). Individuals who have experienced a trauma and experience mental health symptoms may be diagnosed with Post Traumatic Stress Disorder (PTSD). The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), defines the criteria for PTSD as consisting of symptoms from four areas which include: intrusive and recurrent memories of the trauma, avoidance of reminders related to the trauma, negative changes in mood or cognitions associated to the trauma, and worsening of levels of reactivity and arousal after the trauma (American Psychiatric Association, 2013). The impact of trauma can be significant as PTSD has many co-morbid disorders such as depression, anxiety and substance abuse as well as physical health conditions such as heart disease,

obesity and chronic pain disorders (van der Kolk et al., 2014). The emotional impact of trauma on a person could lead to disturbance in the regulation of their mood and impulses, and disturbing memories through flashbacks or nightmares (van der Kolk et al., 2014). These symptoms could lead to a person having difficulty with sleep and quality of life with family and work (van der Kolk et al., 2014). It also has been reported that untreated PTSD can lead to higher rates of suicide attempts and hospitalizations (Davidson, 2000). Given the enduring impact trauma could have on people's lives, clinicians who provide mental health services are looking for treatment techniques that are effective for their clients.

Bradley, Greene, Russ, Dutra and Westen (2005) in their meta-analysis reported there was evidence to support effective therapies for treating PTSD. Bradley et al.'s (2005) research also identified several difficulties in making any definite conclusions from the research such as strict exclusion criteria to exclude participants and research designs. These limitations also identified some of the reasons why experienced clinicians may not be convinced that laboratory results were better than what clinicians were doing in clinical practice (Bradley et al., 2005). Bradley et al. (2005) recommendation for future research were to only exclude participants that would normally be in clinical practice (i.e. psychosis) and to complete longer-term follow-up.

The most researched therapy for people experiencing trauma-related symptoms is Cognitive Behaviour Therapy (CBT) (Bradley et al., 2005). In their treatment guidelines for PTSD, the APA (2017) has deemed CBT, Prolonged Exposure Therapy (PE) and Eye Movement Desensitization and Reprocessing (EMDR) as EBPs. A limitation of the research reviewed for these guidelines is the researcher allegiance factor (APA, 2017).

Researcher allegiance is the researcher being biased to the approach being studied due to being involved in either the creation or modification of the technique (APA, 2017). The RCTs, particularly in the area of treatment for trauma and PTSD, have been mainly conducted by people who have created or modified the technique such as CBT (APA, 2017).

CBT and PE are methods in which the client learns to challenge their negative thinking and use exposure techniques to face their triggers and memories of the traumatic event (Foa, Hembree & Rothbaum, 2007). Prolonged Exposure Therapy (PE) is a form of CBT used to treat PTSD through exposure to traumatic memories and it is considered an EBP (Foa et al., 2007). Empirical research in the area of trauma has shown the most effective part of CBT is exposure therapy (Pignotti & Thyer, 2009). EMDR uses eye movement while remembering a distressing memory to process the memory (Dunne & Farrell, 2011). Even though these three therapies are listed as EBP in the treatment of trauma many clinicians continue to use other interventions in clinical practice (Gray et al., 2007; Pignotti & Thyer, 2009).

Several studies have found that clinicians held favourable attitudes towards the use of EBP in the area of trauma (Gray et al., 2007; Pignotti & Thyer, 2009). However, the attitudes towards EBP do not necessarily align with the practice of clinicians (Gray et al., 2007). Gray et al. (2007) surveyed mental health professionals who provide trauma-focused therapy and inquired about their attitudes toward using EBP in their work. Four hundred and sixty-one participants completed the survey. The majority of the respondents indicated they held favourable attitudes towards the use of EBP in the area of trauma but this did not correlate to these clinicians using EBP to treat trauma (Gray et

al., 2007). Pignotti and Thyer (2009) surveyed 193 licensed clinical social workers (LCSW) in the United States and their findings suggested that even though participants had favourable attitudes towards EBP, they also continued to use empirically unsupported therapeutic interventions (Pignotti & Thyer, 2009). Of interest in these findings, for the 193 LCSW who participated, only 9.4% reported using exposure therapy for trauma (Pignotti & Thyer, 2009). Similarly, Sprang, Craig and Clark (2008) found from the 1121 licensed or certified in behavioral health professionals they surveyed that the respondents who utilized CBT infrequently reported utilizing exposure therapy which is what the empirical research reports as the most crucial part of CBT.

In Sprang et al.'s (2008) study findings suggested that those who had training in trauma reported that EMDR was the therapeutic approach they were most likely to use (Sprang et al., 2008). Craig and Sprang (2010) in their study surveying 711 mental health clinicians found clinicians infrequently reported the use of EMDR even though there is a growing amount of empirical evidence for its efficacy. Dunne and Farrell (2011) investigated the experiences of 83 therapists in integrating EMDR into their clinical practice. This study outlined five challenges in integrating EMDR into practices which were time constraints, anxiety/confidence, workplace issues, changes in EMDR therapists' practices and client characteristics (Dunne & Farrell, 2011). The findings from these studies suggested participants in these studies were not regularly utilizing EBP such as EMDR to treat traumatic stress and identified several challenges in integrating EMDR into clinical practice.

2.2.1 Neurobiology of trauma. The area of neuroscience has expanded its research into understanding the effects of trauma on the brain and physiology and

finding there is a mind-body connection (Duros & Crowley, 2014). Stress is stored in the body and there is a connection between physiological symptoms and activity in the brain (Duros & Crowley, 2014). When an individual has experienced a traumatic event, the amygdala and the hippocampus are at times unable to process the memory and move it to the long-term memory in a verbal story mode which leaves the memories fragmented and experienced in the present rather than in the past (Beaulieu, 2005).

There are three main parts of the brain that are affected when experiencing traumatic events, the amygdala, thalamus and hippocampus (van der Kolk, 2014). When a traumatic event occurs, the amygdala, which is part of the limbic system, reacts by sending an alarm that sets off other physiological automatic reactions (Duros & Crowley, 2014). When this activation happens, the thalamus, the area of the brain that processes sensory information is activated by triggering the brain stem to release norepinephrine by the sympathetic nervous system (SNS) to get ready to fight or flight (Duros & Crowley, 2014). As Duros and Crowley (2014) stated, once this activation occurs the thalamus which regulates the endocrine system sends a signal for the stress hormones of cortisol and adrenaline to be released. Once this automatic alarm system is set off, the activation of the SNS occurs within seconds and a person experiences many physical symptoms. The hippocampus is the area of the brain responsible for processing traumatic memories from the short-term memory to the long-term memory (van der Kolk, 2014). van der Kolk (2014) suggested stress hormones cause the hippocampus to shrink and when this occurs it impairs the hippocampus' ability to process traumatic memories.

Two forms of memories are involved when a trauma occurs, explicit and implicit memories (Duros & Crowley, 2014). The explicit memory is the more complex memory

system that recalls situations and verbalizes the memory and the hippocampus is responsible for processing explicit memories (Duros & Crowley, 2014; Ogden, Minton, Pain, Siegal, & van der Kolk, 2006). The implicit memory is the memory system for unconscious memory and the amygdala is responsible for processing implicit memories (Struwig & van Breda, 2012). When trauma occurs, and the amygdala overstimulates the hippocampus, the hippocampus becomes suppressed and affects how an individual remembers and recalls the trauma (Struwig & van Breda, 2012). This traumatic memory can be fragmented and stored in the various senses in the form of physical sensations, sounds and images that are isolated from the actual memory and usually invoke a strong emotional reaction (van der Kolk, 2014). The implicit memory is part of the unconscious memory where there is no language attached to these memories. Therefore, the implicit memory has been deemed to be “speechless” (Struwig & van Breda, 2012). That said, a traumatic memory has no linguistic representation and the traumatic memory is remembered in the various sensory systems of the limbic system (Quillman, 2013).

According to van der Kolk (2014), neuroimaging studies have shown that when individuals relive their traumas, there is a decrease in activation in the part of the brain responsible for speech, called Broca’s area. Neuroimaging has also shown an increase in activation of the limbic system which is the emotional part of the brain (van der Kolk, 2014). What this suggested was when a person relived the trauma it was very difficult to put the memory into the verbal language of what they were experiencing. In van der Kolk and Fisler’s (1995) study on how people remember traumas, respondents reported differences between trauma memories and positive memories. van der Kolk and Fisler (1995) described trauma memories as disorganized with accompanying physical

reactions. What they gathered from this research was that traumatized people's memories are dissociated due to the memories being stored in the emotional and sensory systems and hence cannot be put together in a verbal complete story. Insights gained from neurobiology has led researchers to advocate for alternative therapies to be explored.

2.2.1.1 Neurobiology aspect to treatment. Clinicians reported using a variety of counselling techniques when working with clients with trauma-related symptoms (Gambrill, 2006). As discussed, many established and acknowledged techniques were unsupported by empirical research, but they were deemed acceptable based on clinical experience (Gambrill, 2006). One of the reasons for this may be the limitations to CBT or PE in addressing the neurobiological aspects of PTSD (van der Kolk, 2014). Racco and Vis (2015) reported even though CBT has been shown to be effective in studies, there continue to be cases of unsuccessful treatment outcomes. There has been research showing high dropout rates for clients being treated with PE (Emerson, Sharma, Chaudhry & Turner, 2009). Bradley et al.'s, (2005) meta-analysis reported that the majority of clients with PTSD who were in therapy remained substantially symptomatic after completing CBT and after six months, two-thirds of clients relapsed with symptoms of PTSD. Higher dropout rates with CBT-based treatments that focus on exposure may be due to the client feeling too overstimulated from reliving the traumas and not experiencing quick relief from their symptoms (van der Kolk, 2014).

The main limitation of CBT is that it cannot address the various levels of sensory functioning. This is due to CBT focusing on a cognitive level that uses the explicit memory as well as the higher level of thinking of the prefrontal cortex (Racco & Vis,

2015). The main component of PE or CBT is to put the memory into a verbal story (Foa et al., 2007). This is a limitation because when clients construct their narrative of their trauma memory it is based on what the client can remember (van der Kolk, 2014). This most times leaves out the important aspects of the trauma memory that are stored in the implicit memory such as sensations and emotions (van der Kolk, 2002). van der Kolk (2014) argued using words to describe a traumatic experience, which is the main conjecture of PE and CBT, does not process or resolve the trauma memories. Ogden and Fisher (2015) stated what has happened in the implicit memory cannot be put into language and only using talk therapy can lead to ineffective outcomes for the client. Talk therapy allows for insight and mastery but is unlikely to alter sensory experience stored in the limbic system (van der Kolk, 2002).

As the knowledge of trauma and the role of neurobiology increases, researchers are expanding their understanding of the importance of mind-body interventions (Duros & Crowley, 2014). As neuroscience has indicated, trauma related symptoms can affect individuals in multiple ways such as physical sensations, emotional dysregulation and dissociation (Racco & Vis, 2015). Neuroscience also suggests clinicians need to use therapeutic interventions that address these different areas of trauma related symptoms rather than only focusing on thoughts and behaviours (Racco & Vis, 2015). Wilkinson (2017) argued there needs to be a paradigm shift of how clinicians work with their clients experiencing symptoms of PTSD by utilizing an approach that addresses the mind-brain-body continuum. A mind-body approach allows the trauma memory to be activated in the multiple senses and then allows a more adaptive response to occur which then allows the trauma memory to be resolved (Masson, Bernoussi and Regourd-

Laizeau, 2016). Based on the neurobiology of trauma, EMI may be an option for integrating memories through a mind-brain-body approach.

Beaulieu (2005) maintained the goal of trauma treatment is to integrate the memories in the explicit memory from the hippocampus with the memories in the implicit memory from the amygdala. Beaulieu (2005) also stated the integration of the two memory systems is not possible through talk therapy alone as talk therapy only accesses conscious cognitive memories. According to Beaulieu (2005), EMI accesses traumatic memories stored in the multi-sensory systems, and this access allows these traumatic memories to be processed.

2.3 Eye Movement Integration Therapy

EMI is based on the neurobiology of trauma as this theory argues trauma memories are stored in our different senses and continue to affect our emotions and behaviours (Struwig & van Breda, 2012). In order to be certified and practice EMI, a clinician needs to attend 15 hours of training and receive 10 hours of supervision (Beaulieu, 2019). Level two certification requires an additional 15 hours of training and 10 hours of supervision (Beaulieu, 2019). EMI is considered by Beaulieu (2003) to be a neurotherapy rather than a type of psychotherapy. The different eye movements in EMI are used to integrate the memories by recovering the memories in the modalities (senses) in which they are stored (Beaulieu, 2005). These same eye movements are used to access positive resources in order to process the memory (Beaulieu, 2003). EMI sessions typically last 90 minutes and the number of sessions range from one to six (Beaulieu, 2003). Beaulieu (2003) recommends sessions being scheduled 10 to 14 days apart. EMI is often compared to Eye Movement Desensitization and Reprocessing

(EMDR) (van der Spuy & van Breda, 2018). In Chen et al.'s (2014) quantitative meta-analysis of EMDR, it was found that EMDR significantly reduced the symptoms of PTSD in clients.

The main difference between EMDR and EMI is EMDR uses only one eye movement whereas EMI uses 22 eye movements (Beaulieu, 2005). EMDR uses rapid eye movements, and EMI uses smooth pursuit eye movements (Beaulieu, 2003). Both therapy techniques use eye movements to treat traumatic memories, however, neither articulate the exact reason why these neurobiology techniques work (Solomon, Solomon, & Heide, 2009). EMDR was included in the APA's 2017 practice guidelines and is considered an EBP for the treatment of trauma. However, EMDR continues to be scrutinized by researchers due to the lack of understanding of the underlying mechanisms of the eye movements (Maxfield, 2007). Therefore, since it is questioned as to whether the eye movements are necessary in EMDR, the empirical evidence for EMDR effectiveness is not necessarily in relation to the eye movements. Therefore, any link between EBP and the use of another eye movement therapy such as EMI is questionable. Even though the mechanisms underlying how eye movements work are unknown, many clinicians continue to use EMI due to their perceived effectiveness of this therapy. Rajan (2001) argued it is an unreasonable notion to believe that interventions are invalid unless we understand their underlying mechanisms. van der Kolk (2014) suggested there are many interventions clinicians use where the underlying mechanisms are unknown such as "why talking to a trusted friend gives such profound relief" (p. 264). EMI is also a difficult therapeutic technique to explain to clients partly due to not understanding the underlying mechanisms.

Beaulieu wrote the book *Eye Movement Integration Therapy: The Comprehensive Clinical Guide* in 2003. In her preface, she pointed out researchers did not understand the mechanism of action of penicillin when the use of it became common; however, it was known to save lives. Building off of this example, Beaulieu (2003) argued that from her clinical experience, EMI worked even though the underlying change mechanisms were unknown. van der Kolk (2014) used the same analogy when discussing EMDR. His analogy was based on the use of Prozac and states it is still unclear why Prozac helps people to be less afraid. van der Kolk (2014) argued that clinical practice is a “hotbed for experimentation” (p. 264) on different types of therapies and that clinicians should not have to wait for research before using these therapies. Beaulieu reported the effectiveness of EMI was based on many “ifs and perhapses” (Beaulieu, 2003, p. 113). Beaulieu (2003) stated, “the motivation for writing a book at this stage of imperfect knowledge, however, comes from the convincing – even spectacular- clinical efficacy of EMI” (p.113) which was based on her clinical experience and client outcomes. At this time, Beaulieu (personal communication, July 7, 2018) recognizes there are few empirical research studies, however, from her own clinical experience and experience of supervising clinicians she believes this is an effective counselling technique for some clients reporting trauma-related symptoms. While Beaulieu’s focus has not been on providing empirical research, there are now two published studies that explore the effectiveness of EMI (Struwig & van Breda, 2012; van der Spuy & van Breda, 2018).

2.3.1 Research, effectiveness and EMI. There are now two published research studies on EMI and Beaulieu has completed two non-peer reviewed research reports

(Beaulieu, 2003; Struwig & van Breda, 2012; van der Spuy & van Breda, 2018). The first and only research done by Beaulieu (2003) was two research reports conducted on 57 adults where she collected data from seven practicing clinicians. Struwig and van Breda (2012) conducted mixed-method research on the use of EMI on 12 adolescents ages 14-16 who lived in a residential facility in South Africa. A replication study using a mixed method approach explored the use of EMI for treating trauma in early childhood and was completed by van der Spuy and van Breda (2018).

The findings from these two published studies indicated there was a significant improvement in trauma related symptoms after one session of EMI based pre and post-measurement using the Trauma Symptom Checklist for Children (TSCC) and the Trauma Symptom Checklist for Young Children (TSCYC) (Briere, 1996; Briere, 2005; Struwig & van Breda, 2012; van Breda & van der Spuy, 2018). The areas where the results indicated significant difference pre and post-test were: anxiety, depression, posttraumatic stress, and dissociation (Struwig & van Breda, 2012; van Breda & van der Spuy, 2018). In Beaulieu's (2003) report, she adapted the PTSD interview that was created by Watson, Juba, Manifold, Kucala and Anderson (1991). Beaulieu (2003) found in the first study there was a 43% reduction in self-reported trauma-related symptoms and in the second study there was an 83% reduction in trauma-related symptoms based on the self-reports from this small sample size.

Both studies of Struwig and van Breda (2012) and van Breda and van der Spuy (2018) conducted interviews with caregivers to obtain qualitative data of the observed effects of EMI. The qualitative data obtained two weeks after the single session of EMI described noticeable behaviour changes of the youth who had undergone one session of

EMI. The childcare workers reported improvements in behavior such as not crying as easily, sleeping in own bed, reduction in nightmares and reduction in anxiety and aggressive outbursts (Struwig & van Breda, 2012; van Breda & van der Spuy, 2018).

Struwig and van Breda (2012) also looked at qualitative data from the clinician by having the clinician keep a journal detailing their observations, their speculations of the responses of the children and possible advantages and disadvantages of using EMI with this population. Three themes emerged after analysis of the journal: challenges during EMI session, resources and support and, management of strong reactions during EMI (Struwig & van Breda, 2012).

There were several notable limitations to the research on EMI. Beaulieu's report was published in Beaulieu's book as an appendix and not published in a journal. In all the studies there is no use of a control group or controlled conditions (Beaulieu, 2003; Struwig & van Breda, 2012; van Breda & van der Spuy, 2018). Not using controlled conditions did not allow the researchers to take into account other variables that may have influenced the results of the two-week post measurement (Struwig & van Breda, 2012; van Breda & van der Spuy, 2018). Beaulieu's (2003) research did not use a standardized assessment tool used to measure trauma symptoms pre and post EMI. The sample population in Struwig and van Breda's (2012) and van Breda and van der Spuy's (2018) study was limited in that the age groups selected were narrow and the sample size was small with twelve in each study. These studies provided preliminary evidence of clinical improvement after EMI; however, no generalizable conclusions were able to be made from these studies due to the reviewed limitations.

Even though there are only a few researchers who have studied the effectiveness of EMI, there are more and more clinicians utilizing EMI in North America, Europe, South Africa and Israel (D. Beaulieu, personal communication, July 7, 2018). Beaulieu (2005) stated, "for the public mental health care provider facing financial restrictions, rapid, effective treatments are equally high priority" (p. 7). Beaulieu (2003) argued EMI meets the needs of public agencies by being a brief and effective intervention. Beaulieu (2003) suggested clients also want a quick resolution to their trauma-related symptoms. As well as the demand for mental health services increases, there is also an increase in pressure for agencies to provide brief and effective services (Mireau & Inch, 2009). In addition to understanding the evidence for specific interventions such as EMI there is also an interest from researchers in the different components across therapeutic interventions that make therapy successful.

2.4 Important Components to Therapy

2.4.1 Briefness. Requests for counselling services are increasing and in order to meet this demand counselling agencies are wanting therapeutic interventions that are effective in as few sessions as possible (Mireau & Inch, 2009). In the current literature on brief therapy, solution-focused brief therapy (SFBT) is the most frequent type of therapy cited. Of interest, SFBT has not met the stringent criteria of being an EBP and has only been listed as promising from the agencies that report on EBP (Kim, Smock, Trepper, McCollum, & Franklin, 2010). In the Saskatchewan context, a brief therapy model has been developed in Saskatoon to help manage lengthy waitlists in a mental health clinic (Mireau & Inch, 2009). In this model, Mireau and Inch (2009) outlined that clients were limited to ten sessions of SFBT. Outcomes from this research indicated a

significant reduction in symptoms after four sessions (Mireau & Inch, 2009). As research continues to examine how services are provided, another area of research is the common factors across the different therapeutic approaches.

2.4.2 Common factors. As research continued into various therapeutic approaches, one other viewpoint researched is the common factors in counselling approach. Common factors are defined as those factors, “that are not specific to any particular treatment model but may contribute extensively to client outcomes” (Strand, Hansen & Courtney, 2013, p. 336). Barry Duncan has researched common factors in counselling across therapies and what predicts treatment outcomes (Duncan, 2010). Duncan (2010) reported in a counselling relationship there are several important factors that lead to client change. These factors include: therapeutic alliance, client and clinician’s belief in an intervention and, client feed-back (Duncan, 2010).

Beyond the common factors that affect client outcomes another approach in EBP is the common elements approach (Barth et al., 2012). The common elements approach “conceptualizes clinical practice in terms of generic components that cut across many distinct treatment protocols, and focuses heavily on identifying specific clinical procedures common to (Barth et al., 2012, p. 109). Strand et al. (2013) completed a qualitative study to explore the common elements in trauma evidence-based therapies. The study coded themes on eight different treatment manuals for trauma treatment that were either evidence based or were a promising practice. The findings offered nine different categories as common elements in the treatment of traumatic stress (Strand et al., 2013). Within these nine categories, intervention objectives and practice elements were provided. The categories were: safety, engagement, strengthening relationships,

core treatment interventions, social context, trauma processing, consolidation/post trauma growth and therapist self-care (Strand et al., 2013). The practice implications this research provided was to give clinicians common components to use when treating clients with traumatic symptoms regardless of the intervention or theoretical approach. The authors did make note that even though they coded treatment manuals that were evidence-based, the treatments were only evidence-based when used in entirety and hence the common factors were not necessarily empirically validated (Strand et al., 2013).

2.5 Summary

There are many different points of view when it came to the area of treating clients with trauma related symptoms. Proponents of EBP argued that clinicians should be using empirically validated treatment interventions such as Cognitive Behavior Therapy (CBT) or Prolonged Exposure Therapy (PE). On the other side of the argument, researchers found that CBT or PE were not effective in the treatment of trauma related symptoms.

The reason some researchers believed CBT was not effective in treating trauma related symptoms was due to the emerging research in neuroscience and neurobiology (van der Kolk, 2014). What this research suggested was there was a connection between people with trauma related symptoms and neurobiology. This research suggested that, people who experienced trauma related symptoms, their trauma memories were stored in the implicit memory and limbic systems (Duros & Crowley, 2014). Looking at the treatment of trauma through a neurobiological lens suggested that treatment of traumatic

memories must be done differently than traditional talk therapy treatments (Duros & Crowley, 2014).

EMI is a therapeutic technique that some clinicians in Saskatchewan are using to treat trauma related symptoms. EMI uses eye movements to integrate traumatic memories by accessing the memories in the different modalities (senses) or through the implicit memory system (Beaulieu, 2003). By doing this, Beaulieu (2003) suggested an individual was able to process their memory from the implicit memory to the explicit memory. As mental health clinicians are using EMI as a therapeutic approach many of the common factors to counselling are also utilized.

There are common factors to all therapies that are important components to positive outcomes in therapy. The therapeutic alliance is one important factor to successful outcomes (Duncan, 2010). Eliciting client feedback along with providing the client with hope are two other important components to counselling (Duncan, 2010). These common factors are important in any therapy used including EBPs.

Proponents of EBP believe that if a clinician uses a therapeutic technique that has been shown to be effective through RCTs than the client will have the best outcome (Plath, 2006). Beaulieu (personal communication July 7, 2018) and many mental health clinicians, as evidenced in the reviewed literature, do not necessarily prescribe to this notion and believe other forms of evidence for a therapeutic technique are more valuable. Many clinicians in direct practice value evidence based on outcomes with clients and their previous success with a therapeutic technique rather than empirical evidence (Nelson et al., 2006). If we only look at therapeutic interventions through empirical research than we may be missing out on valuable therapeutic techniques such as EMI (D.

Beaulieu, personal communication July 7, 2018). This study's goal is to address the gap in the literature by depicting the experience of clinicians using EMI. The next chapter discusses the methodology used to conduct this study.

Chapter 3: Methodology

The purpose of this narrative study was to better understand the reasons clinicians in Saskatchewan use EMI and what clinicians appreciate as valid evidence to EMI's perceived effectiveness. This chapter provides the rationale for choosing social constructivism as the interpretive framework for this study. A description of narrative inquiry is also reviewed and how narrative inquiry is suited for this research. I also discuss how data was collected, analyzed and how I achieved data integrity. This chapter ends with a discussion of how I addressed the ethical issues that arose in this study.

3.1 Social Constructivism

Social constructivism was the interpretive framework that guided this narrative study. Social constructivism is the perspective that suggests each individual has his or her own experience and that there are many possibilities for understanding behaviours, interactions or situations (O'Connor, 2015). A social constructivist researcher believes there is not one true reality for the topic of interest rather there are multiple valid perspectives and reality is relative based on multiple perspectives. Based on the participant's experience, the researcher co-constructs the meaning or reality of the topic being studied (Creswell, 2013). Social constructivist research is a way for social work researchers to extend their practice skills to research and to build knowledge within the field (O'Connor, 2015). O'Connor (2015) stated the main purpose of social constructivist research is to understand, and this understanding leads to knowledge. When one has knowledge, decisions can be based on this understanding.

The ontological framework of this study was that multiple realities are constructed through the participant's experiences (Creswell, 2013). The epistemological stance is that reality is based on experiences of both the participants and the researcher (Creswell, 2013). This epistemological stance fits with the premise that decision making for social workers is based on numerous facets. Each decision can be constructed based on a social worker's own experience, their colleague's experiences, and the experience or story of the client. The axiological belief is each person's experience is their own and needs to be respected, as we all have individual experiences and beliefs (Creswell, 2013). Based on social constructivist framework this study's aim was not to find generalizable results but to understand how clinicians decide to use EMI based on their experiences.

A social constructivist framework fits this research as the purpose of the research is to understand how the participants construct their decision to use EMI in their clinical practice. Given the minimal empirical research, this study aimed to explore what experiences the participants have had that they view as valuable and contribute to their decision to use EMI. At present, we do not know how EMI works. There is minimal research on the intervention and no empirically validated studies. Social worker's may co-construct their treatment decisions with clients based on multiple realities such as their own clinical experience, their history with counselling, experiences of colleagues and the client's own experiences and values (McLaughlin et al., 2010). This means there is not a single reality for each client's treatment needs and therefore social workers co-construct treatment decisions based on the multiple realities of the social worker and the client (O'Connor, 2015). This co-construction of decision-making fits with the intention of this research as this study looks at the experience of clinicians who use EMI and how

their experiences impact their decision-making process. This study addressed how participants constructed their decisions and what factors the participants value as evidence for the use of EMI.

3.2 Narrative Inquiry

A narrative inquiry is a methodological approach within qualitative research that “is a way to understand experience...it is a collaboration between researcher and participants” (Clandinin & Connelly, 2000, p. 20). Narrative inquiry is based on John Dewey’s philosophy that experiences can be understood by looking at the temporal, interaction and situation of the experience (Wang & Geale, 2015). When intentionally examining stories through the philosophy of experience the stories can then become educational (Lindsay & Schwind, 2016). Narrative inquirers are not looking for evidence or facts but are looking to “reveal the meanings of the individual’s experiences” (Wang & Geale, 2015, p. 196). A narrative inquiry suits the philosophical assumptions of social construction as a narrative inquiry seeks to understand multiple points of view through the understanding of the experiences of each participant (Wang & Geale, 2015).

Narrative inquirers value the stories of individuals and try to find the wisdom and meaning within their stories (Emden, 1998). As Wang and Geale (2015) stated, narrative inquiry allows the researcher to provide a rich, in-depth description of the experiences of individuals as well as to find the meaning behind the story. Narrative inquiry allows for a more comprehensive understanding of a participant’s viewpoint on the topic researched. Wang and Geale (2015) also stated narrative inquiry, “amplifies voices that may have been otherwise silent” (p.195). This fits with this study as EMI could easily be

dismissed due to the lack of scientific evidence and hence brought the voices of clinicians to bring awareness to EMI.

The purpose of narrative inquiry in this study was to understand the contexts in which a clinician decides to use EMI based on their experiences. Narrative inquiry allows the participant to tell their story on their use of EMI. By analyzing stories, this research captured the experience of using EMI in order to construct the meaning of this decision-making process. Social workers co-construct meanings from their client's stories typically in formulating the appropriate treatment approach (Gutierrez, Fox, Jones & Fallon, 2018). This same philosophy was used in this study by co-constructing the stories of participants in understanding their use of EMI. As Neuman and Blundo (2000) state, "social constructionists see narrative story as the primary process for personal knowledge and meaning making" (p. 24).

3.3 Sample

In social constructivist research both the researcher and the participants are co-constructing the meaning of the topic and hence there needs to be a mutual interest in the topic researched (O'Connor, 2015). Therefore, social constructivist research most often uses purposeful sampling (O'Connor, 2015). Purposeful sampling was used to select four clinicians to interview, which Creswell (2013) suggested is a sufficient number in a narrative study. Creswell (2013) stated a narrative inquiry uses a small number of participants in order to capture the complete experience of those interviewed.

The inclusion criteria included participants who have taken the Level 1 training for EMI (Beaulieu, 2019) and had used EMI as a therapeutic intervention for a minimum of two years. Clinicians with less than two years of experience, were excluded to ensure

participants have had sufficient experience using EMI. My co-workers were also excluded to avoid a conflict of interest and bias. Once ethics approval was obtained by the University of Regina Research Ethics Board (see appendix A), clinicians were contacted through the EMI clinician listing for Saskatchewan on the website <http://www.academieimpact.com/en/>. Using the list of Saskatchewan clinicians, I contacted each clinician via email and invited them to participate in the study (see appendix B). I accepted the first three participants who demonstrated interest in the study and met inclusion criteria. I was then contacted by a fourth participant and I decided to proceed with four participants. One of the participants dropped out unexpectedly, I then sent a subsequent recruitment email and received a response for a fourth participant.

3.4 Data Collection

Data was collected by conducting one semi-structured interview per participant lasting approximately 30 – 60 minutes (Bates, 2004). All participants were given the option to have the interview conducted face-to-face, via Skype or telephone. All four participants chose to be interviewed via telephone. Novick (2008) asserted that telephone interviews can bring very rich and detailed descriptions of the phenomena researched. Since Saskatchewan is a large geographical area, the benefit of the telephone interview allowed for any participant in Saskatchewan to participate and allowed for flexibility in scheduling interviews (Musselwhite, Cugg, McGregor & King 2007; Novick, 2008).

Prior to the interview, the consent form (see appendix C) was emailed to the participants to review. A semi-structured interview guide (see appendix D) was used

with all participants which consisted of open-ended questions to allow the participant to tell their story and capture what they believe was relevant to the topic (Bates, 2004). Neutral probes were used to elicit information in regard to uncovering meaningful or significant experiences (Bates, 2004). Throughout the interview, the researcher listened, paraphrased and asked clarifying questions to ensure the understanding of the participant's story (Lindsay & Schwind, 2016).

I recorded, took notes and transcribed the interviews verbatim. After the transcription was completed, all participants were sent their transcript to ensure accuracy of their story. After the first interviews, one participant made changes to their transcript to provide clarification and the other three made no changes to their transcript. All four participants participated in a second short telephone interview to further explore their story. Verbal consent was obtained by the four participants for the second interview. I recorded, took notes and transcribed the interviews verbatim. The participants were sent their transcripts and one participant made minor changes.

3.5 Data Analysis

The interviews were analyzed utilizing the approach from Clandinin and Connelly (2000) in looking for themes in the three-dimensional space and overall themes. In this narrative study, identified codes were related to interaction (personal and social), continuity (past, present and future), and situation (Wang & Geale, 2015). The three-dimensional space approach is based on Dewey's philosophy of experience, meaning to understand a person, a narrative inquiry looks at the personal experiences as well as the social experience of interacting with others (Ollerenshaw & Creswell, 2002). The steps taken followed Ollerenshaw and Creswell's (2002) analytic process in

“restorying” the participant’s story of reading the transcript, analyzing the story for experiences and then retelling the story.

The three-dimensional space was the lens for how data was analyzed (Ollerenshaw & Creswell, 2002). Interaction/social examines the experiences of the participant as well as interactions with other people. Interaction/social includes the personal, which is looking inward and social which is looking outward (Wang & Geale, 2015). Interaction/social may include other people’s meanings or opinions (Wang & Geale, 2015). Continuity considers experiences and stories of the participant from the past, present and future and this sense of time is central to narrative research (Ollerenshaw & Creswell, 2002). Chronology is central to narrative research as stories are often not in a particular sequence and placing stories in a chronological order allows researchers to make associations among ideas (Ollerenshaw & Creswell, 2002). Situation/place is the physical location the story takes place and how the situation affects the participant’s experience (Wang & Geale, 2015). Thematic codes were also identified through the analysis to find the common experiences amongst participants.

The process of analyzing data followed Ollerenshaw and Creswell’s (2002) suggested steps. For each set of steps, I worked with one participant’s story at a time in order to remain focused on capturing each participant’s story. Each participant’s story was coded and analyzed individually. First, the transcripts were read and re-read until there was a sense of the story of each participant, considering interaction, continuity and space (Ollerenshaw & Creswell, 2002). I then re-listened to each participant interview. Notes were taken in the margins as I read the stories to start identifying initial codes

specific to each story as suggested by Creswell (2013). Once I had a sense of the story, I grouped the codes into the three-dimensional space.

Next, the transcripts were downloaded to NVIVO computer software to begin the data analysis (Ollerenshaw & Creswell, 2002). Data analysis was completed using the three-dimensional approach. First, data was analyzed through the lens of the interaction in the story with the initial possible nodes. During this process possible nodes were used or grouped together, and new nodes were also identified. Next, the data was analyzed through the lens of continuity following the same process with initial and new nodes as above. Following this, the data was analyzed through the lens of situation or place. When this analysis was completed the final step was to step back from the transcript and ask, “What does this mean?” and “What is the significance?” (Ollerenshaw & Creswell, 2002). Once the data was analyzed the story of each participant was written in a chronological format reflecting their experience (Ollerenshaw & Creswell, 2002). Each story was written after each analysis to ensure the participant’s story was captured accurately.

Once all the stories were analyzed and written I then began the thematic process to identify the common themes between the four stories. All the identified nodes in NVIVO were put into one document. I grouped all the nodes into common categories within the three-dimensional lens. From there, I looked for common themes and further grouped the nodes into the themes until the final themes were produced.

3.6 Data Integrity

In order to ensure the quality and trustworthiness of the data analysis, the initial findings were shared with participants to ensure the narrative written was reflective of

their story (Ollerenshaw & Creswell, 2002). All of the stories were sent to the participants asking the following questions: *Is there anything in your story you would like corrected, changed or further developed?* (Emden, 1998). *Are you okay with the detail of the client experiences? Do you like your pseudonym, or would you like it changed?* Ollerenshaw and Creswell (2002) stated renegotiating the story with the participant is a collaborative process between the researcher and participant. Any changes sent back to me were changed in the participant's story. Out of the four participants, two participants made minor changes, one made significant changes for clarification and one made no changes to their story. This ensured that each participant's story was captured accurately. As Lincoln and Guba (1985) asserted, member checking is "the most critical technique for establishing credibility" (p. 314). Once the stories were approved by the participants, the identified themes were sent to the participants for review. Two participants required further clarification of the themes. One participant made wording suggestions for one theme that were incorporated. Having the participants review the findings ensured the researcher's own biases towards the study were not reflected.

I considered personal biases when conducting the research and analyzing the data. Reflexivity is the thoughtful consideration and reflection of how one's viewpoint could impact the research (Lietz & Zayas, 2010). Reflexivity was used to create self-awareness of biases and journaling was done to facilitate this self-awareness (Lietz & Zayas, 2010). At the beginning of this study my social location was laid out in order to position myself in this research as Creswell (2013) states is the first part of reflexivity. Effort was made to separate my own experiences and biases from the research. This was

done by being consciously aware of “the biases, values and experiences” (Creswell, 2013, p. 216) that I brought to this qualitative research. This was mitigated by reflexivity through journaling. I used journaling after each interview to reflect on my initial impressions and thoughts from each interview.

I used the journaling process mainly during the data analysis stage. When coding each story, I kept track of each node I created in NVIVO and the criteria I used to define this node. This process became more important after I coded the initial story. I wanted to ensure I was coding each story individually without trying to find similar codes. There were times I found during the analysis I was trying to find similarities based on the other stories. I journaled at these times to discuss my thoughts and ways I mitigated this response. This journal helped me put into perspective the reasons for code selection in order to separate personal assumptions and biases. As well, sharing findings with the participants also ensured the retelling of their stories was accurate.

As Creswell (2013) stated the second part to reflexivity is to reflect on how my own past experiences affected the interpretation of the phenomenon being studied. My initial reaction was of surprise to all the positive outcomes that were described by the participants. At first, it was difficult to not only focus on all the successes as the participants were quite passionate about the use of EMI. After reviewing the data many times and consultation with my supervisor, I was able to widen the scope of the findings to provide a more accurate picture. Being aware of my biases and then reflecting on my own experience helped with this as well. When co-constructing the stories of the participants, I was vigilant that I wanted their story to reflect their experience and not my

interpretation of their experience. Having the participants read their stories and make any changes allowed for this.

Using thick descriptions also ensured credibility in the data (Lietz & Zayas, 2010). Thick description is the process of providing detailed information about each theme by describing intentions and meanings to characterize the story (Creswell, 2013). Locating corroborating research to support main themes was sought in order to triangulate the findings (Creswell, 2013). Two strategies were used to obtain transferability: thick description and purposeful sampling (Jensen, 2008). Transferability ensures the findings can be transferred to another setting or context (Lietz & Zayas, 2010). Creswell (2013) stated qualitative researchers should engage in two validation strategies for each study to achieve credibility. Writing in detail and thick description along with member checking, triangulation and reflexivity achieved this recommendation from Creswell (2013) and provided credibility and transferability for this study.

3.7 Ethical Issues

There were possible ethical issues to be cognizant of when conducting this research. The first issue to be mindful of was to ensure confidentiality of participants. When retelling the story, I needed to be careful to not include any identifying information that could jeopardize the confidentiality of each participant. Pseudonyms were used to protect confidentiality as well as not using any identifying locations in their story. The participants also recounted stories of their interactions with clients that were within the limits of confidentiality. I was very careful when using this information in the stories to ensure client information was non-identifying. Since all the participants were

sent back their stories, this allowed each participant to consent to what was shared. Another ethical issue I had considered, was that I currently use EMI in clinical practice. As discussed, in the previous section on data integrity reflexive journaling was used try and mitigate any biases.

As approved by the University of Regina Research Ethics Board (see appendix A) all of the transcripts and recordings were stored on my personal computer that is password protected. Any written documentation was stored in a locked box in a locked office at my work. Only myself and my thesis supervisor had access to the raw data. All collected data will be destroyed after five years.

3.8 Summary

The research methodology chosen for this study was narrative inquiry. Four participants took part in this research and were selected through purposive sampling. My social location in this research was laid out to provide the reader my experiences with the subject matter. Clandinin and Connelly's (2000) three-dimensional analysis was used to analyze the data from the participants which provided an in-depth analysis. Thematic analysis was used to identify common themes amongst the participants stories. I used prolonged engagement with the participants as they reviewed their transcripts, stories and themes. The member checking at all stages provided validation and trustworthiness to this study. The next chapter discusses the findings from this research.

Chapter 4: Findings

This chapter provides the narratives of four clinicians from Saskatchewan who have been using EMI in their clinical practice. Each story is presented in a chronology of their experience as Clandinin and Connelly (2000) suggested that chronology is central to narrative research. Each story reflects the clinicians own experience in using EMI. The three-dimensional analysis allowed for an in-depth analysis of each story. Each story reflects interaction, continuity and space. At the end of each story is a reflection and analysis answering the question “what is the significance” of each story.

4.1 Margo’s Story

Margo began her career in education teaching in a small community in Saskatchewan. After two years she moved back to a larger city in order to complete a post graduate diploma in Special Education and Educational Psychology. For six years she taught in a classroom with students who had difficulty managing their emotions. The next twenty-four years she was in a counselling position with the school division and has since retired from the school division two years ago. In the past year she has started a private counselling practice primarily working with adults. Margo has recently been involved in two large scale traumatic incidents in Saskatchewan. Her involvement entailed doing debriefings with first responders and hospital workers.

Margo describes her theoretical orientation as being a “mish-mash” of approaches and draws mainly from Cognitive Behavioral Therapy (CBT) or Dialectical Behavior Therapy (DBT). Margo believes that change happens when a client has confidence in their counsellor. Margo’s approach to counselling is to understand what the client wants and needs from counselling and then tries to meet those wants and

needs. She is willing to consult with colleagues, draw on her past experiences or do research on her own to find the best therapeutic approach for each individual client.

Margo's experience with working with traumatized individuals began with her first teaching position in a small community in Saskatchewan. When reflecting on that time, Margo was able to identify many students who were dealing with the effects of trauma. She recognized that many of the parents also, due to their experience in Residential Schools, had a history of trauma. Margo also recognized many of her past students throughout her career were exhibiting symptoms of trauma.

When in her counselling position with the school division, Margo's primary therapeutic intervention for treating trauma was talk therapy including CBT. When she used CBT, she used exposure therapy to treat traumatic memories. Margo felt she obtained good results when using these therapeutic approaches but identifies these approaches were not always "quick," "efficient," did not "eradicate" all the trauma related symptoms and did not always address what the clients wanted. Margo describes using exposure therapy for students who were afraid of needles, thunderstorms and dogs. In one example, a student had been attacked by a dog and was left with a lot of emotional and physical scars from the experience and exposure therapy was helpful to the student. Margo felt though, there was always "residual stuff" when using talk therapies. In her experience this was because the current difficulties that the client presented with may be resolved with talk therapy, but other past issues would still be affecting the person.

In 2015 a flyer came to one of the school's Margo was working at about an upcoming training on Eye Movement Integration Therapy (EMI) to be held in

Saskatoon, SK. As she started to look more into this training, she started to think of all her past and current students EMI could meet the needs of. Margo's main motivation to take the EMI training was due to this reflection of all the past and present students that EMI could help. Margo states since she was working with the school division at the time, her supervisors were unsure if EMI training was relevant to her work so Margo had to pay for the training herself. Margo states she knows colleagues that use Eye Movement Desensitization and Reprocessing (EMDR) and had known about eye movement therapies so decided to take the training. She selected EMI because it was the one that was offered! Margo states had EMDR been offered at that time she may have taken it instead.

Initially, at the EMI training Margo identified the lack of research was a small issue for her. However, the trainer Dr. Danie Beaulieu's explanation of her experience and results she was achieving with EMI left Margo feeling less worried about the lack of research. After Margo had completed the training, she was feeling really unsure as to whether she would use EMI or not as she did not feel comfortable doing it. To increase her confidence in using EMI she began to meet with some colleagues who had also taken the training and practiced. After, she felt more comfortable and decided she was going to use it with some of her students. Margo made a case for it with her supervisor in the school division. Her supervisor told her she could use it on a few students, with parental consent, and then get back to them about the outcomes. Margo noted the school counsellors in her division were able to select the counselling interventions they use and there was not a "cookie cutter" approach to counselling. During Margo's last year of

working with the school division, she used EMI with five students all with positive outcomes.

Today, Margo loves using EMI! Margo is currently in private practice and mainly works with adults. Since starting her practice, a year ago, she has used EMI with approximately fourteen clients and all but one has had a successful outcome. Margo states she has used EMI for clients who report symptoms from traumatic events such as: car accidents, sexual abuse, physical abuse, emotional abuse, losing part of a limb and being burned. Clients will report a number of different trauma-related symptoms such as: depression, anxiety, sleep problems, nightmares and other trauma related symptoms.

In the initial meeting Margo invites the client to discuss what they are wanting to achieve in counselling and what she can offer for a treatment plan. Margo has found that some clients specifically come to her for EMI as she advertises this specialty on her profile on *Psychology Today*. Margo describes that as she “peels the layers of the onion” and finds out the traumas a client has endured and the client is expressing willingness to work on the past traumas, she will introduce EMI. The factors that affect when Margo brings up EMI to clients are: her relationship with the client, level of confidence the client has in her, when the client is discussing the trauma and whether the client is on medication. Margo does not use EMI with clients that are on medications for anxiety or depression as she states the “the pathways of the brain need to be open so that the brain can make the connections it needs to make to help in the trauma recovery.”

When introducing EMI, Margo states she is very enthusiastic about it. Margo explains what EMI is and how the brain is affected by traumatic incidents. She discusses how a certain part of the brain stores pictures and emotions and how this is related to the

symptoms the client is requesting help with. Margo explains how the rest of the brain interacts with the area that stores pictures and emotions. She lets clients know that talk therapy cannot necessarily access this part of the brain and that EMI can be very helpful to them. Margo tries to give as much of a description of EMI to the client as possible without actually doing an EMI session. Margo really encourages her clients to do some of their own research on EMI through the internet or talking to others who have had EMI. Margo also emphasizes what EMI is not and used the example of telling clients it is not “voodoo” as some clients are concerned they are not going to be in control or that she is “playing with their mind.” Margo wants clients to understand that they are in complete control during EMI and can stop if they desire to and that Margo is there to lead them through the intervention.

Client responses have varied with most being more favourable or more curious about EMI. Margo has had clients respond that they are worried she is playing with their mind and will not go through with EMI. Other clients are open to it. Margo states one factor in how a client responds is based on how they feel about their own trauma. In Margo’s experience these clients are usually caregivers, the strong ones in the family, or first responders. Margo identifies some clients are embarrassed that they were not strong enough to manage the trauma and tell themselves they should be able to handle what they have endured.

Prior to starting any further EMI discussions, Margo works on coping skills to ensure the client has the skills to regulate themselves and will use some CBT strategies in the beginning. This is why she does not necessarily introduce EMI right at the start of therapy as Margo wants to ensure the client has some skills to manage their reactions.

Once the client and Margo are ready to proceed with EMI, Margo has a questionnaire she has developed herself to have clients rate their symptoms so she has baseline information. She asks a lot of questions in order to be thorough, so she is able to assess whether EMI has been effective. Margo always tells clients once they start this questionnaire that they may find their old feelings come up. At times some clients start to feel traumatized again from talking about their trauma.

The majority of Margo's clients have only had to have one session of EMI. During the sessions Margo observes that clients will report all sorts of emotions and pictures of the trauma. Margo states clients experience whatever physical or emotional response they had at the time of the trauma during the EMI session as well as other responses. During the EMI session clients may also bring up pictures from other things that have happened. An example of this is a client that had come in to see Margo due to conflict with their child and during the EMI session what kept coming up for this client was their ex-spouse. From this one EMI session the client was able to process other traumas related to the ex-spouse as well as the conflict with their child.

After the session, Margo always ensures the client will be driven home by someone else. The reasons for this are because of the EMI session, the client may not be paying attention to what is going on around them because they are processing in their mind. The other reason is so the client has someone to be with in case they are experiencing some strong reactions, and someone is there to help them through this. Margo checks in with the client by phone one to two days later to inquire how they are coping and what they are experiencing. Clients have reported that they are experiencing fatigue, pain, suicidal thoughts or strong emotions. Margo states clients can

reexperience any reaction such as physical, emotional, visual or thoughts that they experienced in relation to the trauma. This reexperiencing can continue on past the EMI session.

After a week, Margo has the client come back in and she will assess their symptoms based on the baseline information she received prior to EMI. She has the client rate their intensities of symptoms they identified prior to EMI. Margo relies heavily on client report on whether they feel there is an improvement in their symptoms. After one session of EMI, amongst the nineteen clients Margo has used EMI with, all but one reported a successful outcome. Margo defines a successful outcome as when the client is no longer rating intense symptoms related to their trauma. In the majority of cases, after EMI the clients have finished with therapy.

Once clients have gone through EMI as an intervention for their symptoms, in Margo's experience they no longer require counselling. Two clients have returned for service but that was to work on a different issue. When Margo has followed up two months later with some clients, they have told her they no longer require counselling. Margo's experience with EMI is that EMI is like an umbrella that can cover many different areas, not just the traumatic incident they have identified. Margo states after the client has gone through EMI their "whole body quiets down and they are able to access those answers they find within themselves." Margo reports that after EMI clients are able to use the coping skills they were taught because they are not experiencing the intense symptoms of trauma.

A client story that stands out for Margo is a young man who had lost half of a limb and when he came in, he was experiencing nightmares and phantom pain. After

one session of EMI he no longer was having these symptoms and Margo reported that it “worked so well and so fast...it worked so very well.” With this client, Margo states if she did not have EMI as a tool to use, she believes she would have felt very helpless and hopeless helping this man. She does not believe another therapeutic intervention would have been as effective with him.

Only one of Margo’s clients did not have a successful outcome. There were several factors that resulted in this. Margo states the young person experienced a severe trauma with being burnt. However, she was also dealing with ADHD and during the EMI session the feelings coming up were too overwhelming. It was decided by Margo, the client and her mother to take a break from EMI and try again in the future once the client addressed some other issues. Other than that Margo states this was the only client that was unable to finish an EMI session. What Margo loves about EMI is that she has not come across any difficulties in using it. She states in the past when using other therapy interventions, she has come across difficulties and had moments of wondering why the intervention was not working. She has not experienced this at all with EMI.

For Margo, the evidence for the effectiveness of EMI is based on the reactions of the client. Every time Margo uses EMI, she is proving to herself the effectiveness of the intervention and that is all she needs for evidence. Margo feels like she has an “Aha” moment every time she uses EMI as she sees both it working for the client and the client reporting significant improvements in their symptoms. It is exciting for Margo to see every time she uses EMI how well it is working for her clients. The effectiveness of EMI is shown through the results clients are reporting for themselves. As Margo sees

these results, she feels it validates the benefits of an EMI intervention. The results she sees and the client self-reports proves to her how well EMI works.

EMI has given Margo a lot of hope for clients who are experiencing the enduring effects of trauma. Margo feels she has a very effective tool to use now with clients and knows this from her own experience. Margo has found that EMI takes a lot less time than using a talk therapy approach. In Margo's experience, EMI has been very efficient, effective and eradicates client's symptoms better than her experience with talk therapy approaches. Margo identified after one session of EMI, clients have experienced symptom relief and many of the clients have been finished with therapy. EMI has allowed clients to work through their trauma memories faster. Margo feels this quickness is a benefit as once clients start talking about their traumas, they can be re-traumatized again. EMI allows clients to gain symptom relief quickly as they do not have to have keep talking about the trauma.

Margo's hope is that more clinicians in Saskatchewan become trained in EMI. After being involved in two large scale traumatic events in the province, she feels that all the people involved in these incidents should be receiving EMI. She feels trauma is going to be affecting these people for years to come. Margo would like to make a case for EMI to be used with all first responders – fire fighters, EMTs and police officers and in her opinion that they actually receive EMI every two to three years. Margo believes EMI would be a more effective intervention for first responders than the talk therapy that is being offered now. Margo states she will not hesitate to use EMI with anyone. "I love it! Clients love it!"

4.1.1 Reflection and analysis. In reflecting on Margo’s story through the three-dimensional lens, what stood out was the interaction of Margo looking inwards and outwards. At the beginning, Margo was skeptical to whether she would actually use EMI. As she began to practice and increased her confidence her feelings changed. Now Margo’s feelings about EMI were very evident in how she felt about using EMI and the results she was attaining with EMI. Margo talked about loving EMI and has a strong sense of wanting more people to use EMI and for EMI to be offered to more people especially first responders and hospital workers. Margo’s enthusiasm for EMI has given her hope that positive change can come for clients. This sense of hope has given her confidence about sharing EMI with her clients. Further, this hope has helped Margo to know that those involved with the two large scale traumatic incidents do not have to live with the effects of trauma. She believed EMI was an effective intervention to treating trauma related symptoms and anyone involved in those incidents who were experiencing these symptoms could be helped.

In looking outwards, Margo’s reliance on client feedback was the main evidence she needed to know EMI was an effective intervention. Margo proved to herself every time she used EMI that EMI was an effective intervention. This proof came from what she witnessed with clients. The clients’ self-report was based on the client reporting the level of intensity of distressing memories lowering in the EMI session as well as during the follow-up appointment. Margo uses a questionnaire she created to measure symptom reduction in clients. The feedback clients have given Margo on EMI was that they “love it” as well.

Continuing to look outwards, what was noted was that not all of Margo's clients were appropriate candidates for EMI. She noted that she does not use EMI with clients who are on medications, or clients who may be overwhelmed by EMI. This may lead to a number of clients Margo works with to be excluded from having EMI. It is also evident in Margo's story that it takes time to bring up using EMI with clients and that it is not something she usually starts with. Even though Margo is reporting positive outcomes for the clients she uses EMI with, there would be a number of clients that she is unable to use this technique with due to the client being on medications, being overwhelmed and the time it takes to broach the subject of it.

The situation/place of Margo's story was examined through the therapy she was utilizing. Whether she was using talk therapy or EMI, this provided the context to Margo's story. Margo discussed in the past using CBT to treat trauma and reported successful outcomes. She now prefers to use EMI to treat trauma when the client is an appropriate candidate. In terms of time, Margo identified several times how quickly EMI worked for clients, how few sessions were needed and how efficient EMI was for the clients she uses EMI with. She also made the comparison that EMI was more efficient than CBT.

When reflecting on "what is the significance" of Margo's story what stood out through the analysis was: the feelings of hope EMI gave to Margo to treat people with trauma related symptoms, EMI was brief, EMI was effective, the evidence for EMI was based on client outcomes and EMI was better than talk therapy. Margo's overall opinion of EMI is positive, however, an issue that is significant in Margo's story is EMI cannot be used on all clients with trauma related symptoms. Margo's passion for EMI was

evident throughout her story and her passion came from the direct outcomes she saw with clients who she could use EMI with.

4.2 Laura's Story

Laura is a Registered Psychiatric Nurse who has been working in healthcare for the past thirty-five years. Over the span of thirty-five years, Laura has worked in long term care, acute care and community-based care. She has worked with people from the ages of 0 to 99 in a variety of roles. For the past fourteen years, Laura has worked at a community mental health clinic working with both children, youth and adults. For the past year and a half Laura has been in the role of clinical supervisor. Prior to this she was seconded to work on integrating mental health with primary healthcare.

Laura practices from an eclectic approach as she really believes in client centred care in that the clients are the experts in their care. With client centred care, she believes in empowering the client and that they are the “masters of change.” Laura believes in the therapeutic alliance as well as eliciting client feedback. Her clinic uses the Partner's for Change Outcome Measurement System (PCOMS) and the training she took to use this system was transformational for her practice. PCOMS is a good fit for her because it elicits client feedback and she feels this honours the client. Eliciting client feedback allows the client to track their own perceived change and it is not reliant on what the therapist thinks is progress but rather what the client views as progress. PCOMS fits well with Laura's beliefs in client-centred care.

Over the past fourteen years, Laura estimates 75% of her work involved working with people who had been involved in domestic violence and the trauma associated with this. In her experience, the clients she has worked with who had experienced trauma

usually reported they were experiencing anxiety and depression. When treating trauma, she was primarily using supportive counselling or Cognitive Behavioural Therapy (CBT). These approaches left Laura feeling like she was not making a difference for her clients. She did not know whether she was helping or not when using talk therapy.

What she noticed when using CBT was, she taught them the skills of CBT but she found it did not help to alleviate their intrusive memories or the reliving of the trauma. She did not use the exposure part of CBT to treat traumatic memories. Laura describes feeling that CBT was inadequate and the counselling she was providing was “not enough.”

Laura did not have any training that was specific to trauma.

Laura was left wondering if there were more effective treatment options for clients who had trauma related symptoms. She first heard about Eye Movement Integration Therapy (EMI) through an email that was sent to her. This intrigued her and since her mental health clinic did not have any resources for trauma, Laura looked further into it. After reviewing Danie Beaulieu’s website and reading the provided information she was further intrigued as she liked the foundation of EMI. Laura applied for the training through her clinic and expected to be denied due to the cost of the training. Her director much to her surprise “moved it forward” and she was approved to attend the training in Saskatoon, Saskatchewan in 2015. She then took Level 2 training for EMI in Ontario which was a partnership between herself and her employer. Her employer paid for the training and she paid for the travel. After the Level 2 training she accessed supervision on EMI from a supervisor in SK as this is a requirement after the Level 2 training. Laura has a lot of confidence in Danie Beaulieu and really tried to take in Danie’s expertise and knowledge at both trainings she attended.

There was a small window after the initial training where Laura was in direct counselling and started to use EMI. Laura remembers the first time she used EMI with a client and described feeling scared. After the session, Laura had asked the client to call her in the morning and if she did not call Laura would. The next day, Laura waited and waited to hear from the client and started to tell herself that she had done something wrong. At first when Laura called, the client did not answer and when she finally answered she told Laura she had been sleeping. The client told Laura “this was the best sleep I’ve had in years.”

When Laura moved to her clinical supervision role one of the conditions she made prior to accepting the position was that she could still practice EMI. Her employer agreed to this because of the client outcomes Laura was able to show from her work with EMI. There also is no one else trained in EMI at her mental health clinic which is a challenge for Laura. Laura would like someone else to have the training, so she could have a colleague she could debrief or consult with.

Laura describes when she uses EMI it is not with “fidelity.” She says it is without “fidelity” as she is not the primary therapist for the clients she uses EMI with. The client will have a primary therapist and Laura is only involved for the EMI sessions. Once this is completed the client returns to their primary therapist for follow-up. Laura states that she promotes the use of EMI through her supervision sessions with her staff when they are discussing cases they are stuck with or when things are not changing for a client. Laura will explore in the supervision session whether the client has a trauma, specific incident or stressor linked to their symptoms and then may discuss the option of her using EMI with the client. She then discusses with the primary therapist basic

coping skills the clients need to have to manage any acute distress. These skills include deep breathing, mindfulness or any skill they can use to regulate themselves. Having a support person or someone to turn to is another important resource that Laura wants the primary therapist to have established with the client.

Once these skills and resources are established, Laura sees the client to establish a therapeutic alliance, to do an assessment of the symptoms and to gather details of the traumatic incident. Laura states she explains EMI by going through an information sheet that was given to her by the supervisor she accessed for EMI. Laura strives to use very “client friendly” language and spends time discussing how traumatic memories are stored and how sights, smells or events can trigger memories for no apparent reason. Laura discusses Neurolinguistic Programming and how eye movements access stored memories. Laura teaches the client that traumatic memories are often stored in the short-term memory and that EMI helps to integrate the traumatic memories into long-term memory, so they do not have the same effect on a person any longer.

From working from a client-centred approach, Laura is always ensuring the client is understanding the process of EMI. She will check-in with them that they are understanding by asking them or having them repeat back what they heard. Laura wants the clients to give their feedback of what they are thinking about EMI. To instill hope in her clients that EMI can be an effective intervention she will show them deidentified checklist of the PTSD symptoms checklist pre and post from past clients. By doing this she is showing them the effectiveness as well as “instilling hope” which she knows hope is a factor in people getting better. Laura states she always lets people decide for themselves and wants them to have all the information to do so.

Laura has used EMI on approximately twenty clients and knows if she was in active practice the number would be a lot higher. The types of presenting problems she has used EMI with, are trauma symptoms associated with: domestic violence, victims of fire or motor vehicle accidents and childhood abuse. The presenting symptoms are mainly depression, anxiety, sleep disturbance, relapsing with addictions and intrusive memories. Laura has used EMI with both adults and children. Prior to an EMI session, Laura asks clients to avoid using as needed medication like Ativan or substances like marijuana 24 hours prior. For clients who have had a recent medication change she asks that they have a period of stability with the medication change. In Laura's opinion, this is because "when clients have begun a medication change, it is important to be at the therapeutic drug level and the is client stable as to not skew the impact (both positive and negative) of EMI versus medication change."

During an EMI session Laura has noticed that clients will reexperience the physical sensations they experienced during the trauma. Laura notes how the client responded during the trauma is usually what they will reexperience during EMI. For example, clients will try to avoid the memory or if they experienced panic at the time, they will reexperience the panic. Avoidance is one of the challenges of EMI Laura identified. Clients will try and avoid the traumatic memory by talking. This is in order to stay in their head versus allowing the memory to be part of the moment. Laura describes this as the client

wanting to stay in the periphery. They don't want to really be in the moment of the memory and so they actively try so they are cerebral and try to distract

through language and conversations rather they staying right in touch with that specific memory.

The other challenge Laura has experienced was when a client became very angry with her for Laura repeating the same thing over and over again. This client was unable to complete the EMI session as she did not want to work on the trauma that was that was causing her distress. The source of her trauma was childhood abuse which was coming out through EMI, but this client wanted the EMI to be about a more recent event. This was an example of how EMI can lead a client to the core of the problem, but a client has to be willing to “go there” and if they are not, then honouring that. Laura admits to worrying about her clients after they leave an EMI session as she is concerned that as memories are being processed that the effects will continue on or that new memories will come up for the client.

In Laura’s experience, memories that are retrieved through an EMI session can provide insights and epiphanies that are very helpful to clients. Laura finds the insights interesting that people develop during only one session of EMI. Laura told the story of one client who had an EMI session but did not experience relief from her symptoms. The insight the client gained during EMI was confirmation that her traumatic memory actually happened. This insight was very important to the client because she knew it happened and felt she could start dealing with it. This insight gave the client therapeutic improvement even though she still was exhibiting trauma related symptoms, and to the client EMI was a success. To Laura, the client’s perception of the treatment is what is most important.

Another client Laura discussed was a fellow who was struggling with addictions issues related to the guilt he felt over a friend's suicide over twenty-five years ago.

Laura described:

He was both a victim and a perpetrator of sexual abuse within the same experience. All these years he felt guilty because he had not stepped forward to report the incident, he minimized the abuse he perpetrated and experienced and his friend subsequently suicided. Through EMI he remembered he had reported the abuse to a person who was an authority and it was the person in authority who had said at the time of the reporting "I never heard you say that." He was able to forgive himself and move on as he remembered through EMI that he had in fact reported it, so he felt he had tried to get help for his friend and therefore was not responsible for his friend's suicide.

Laura described this as an epiphany for this client as through EMI he was able to remember what action he had taken. Laura was shocked that this fellow was able to arrive at this epiphany in one session after twenty-five years of blaming himself. This epiphany has allowed him to experience relief and he has since been able to work on his addiction issues and achieve sobriety.

During an EMI session, if a client brings up another memory and time allows Laura is able to do a "U-turn" and start working on the new memory. Laura states by doing this she has been able to address other memories which has alleviated the need for a subsequent EMI session. This insight comes from the client realizing that the traumatic symptoms they are experiencing are related to a traumatic event different than what they thought.

Laura states she will have the client come in two weeks after the EMI session. She has the client complete the post PTSD symptom checklist and compares it to the pretest. However, she mainly relies on the subjective report from the client as to whether EMI has been effective. Laura wants to know how people are feeling, what symptoms they are having and how they are coping in the absence of their symptoms. Laura notes because she is not the primary therapist, she does not use PCOMS with these clients. She reports that PCOMS is done with the client with their primary therapist, then there is a break in the PCOMS and then the PCOMS is used when the client returns to their primary clinician. Laura states that there is improvement noted in the PCOMSs score after returning to the primary therapist.

Laura states “I absolutely love it” when she describes using EMI and this feeling has come from the outcomes she has seen with clients and what clients have reported as improvements. With all but one client she has only done one session of EMI and with one client she did two sessions. Only having to do one EMI session is unbelievable to Laura. Even though Laura’s approach to using EMI is different than the traditional counselling relationship she is seeing therapeutic change in all the clients in which she has done EMI with. Laura reports that she sees therapeutic change in clients when she has only met with them for two sessions – one session of EMI and one session for follow-up.

Laura has a couple of key stories of positive outcomes for clients. One client came in who had been involved in a fire. Every time this client closed her eyes all she could see was the fire. After one session of EMI, the client asked Laura if she had “erased her memories.” The client stated she could no longer see the fire and even when

she tried to see the fire she could not. Another client after EMI came in to see Laura two weeks later and had announced she had gone off her antidepressant because she felt so good. This same client is now an advocate for EMI and promotes it to people she works with. One insight for Laura is after providing EMI she has not had anyone come in and tell her they had the urge to use substances.

Laura states she will continue to use EMI because of what she has seen from the clients. She states, “I have seen the [effectiveness], I’ve seen how quickly people can really receive relief from their symptoms.” Laura states she is not concerned about the lack of research on EMI. This is because she has seen improvements, clients report improvements, and this is what matters to her. Laura is far more comfortable and confident in treating trauma related symptoms now and knows that she is helping people. She wishes she had EMI as a tool for many of her past clients, so they could have had their needs addressed. Laura hopes EMI training becomes broader and that Danie Beaulieu will offer the online training in English. Laura states “being trained in EMI has been such a gift for me.... I just believe in it so much.”

4.2.1 Reflection and analysis. In looking at Laura’s story through the three-dimensional lens, interaction in Laura’s story stood out. Throughout Laura’s story she discussed looking outwards at the interaction she has with clients. Laura believed in client-centred care and this was evident through her use of EMI. From the beginning, Laura treats the client based on their self-report and assessed their symptoms in the same way. She does not require the client to have a diagnosis of PTSD to be treated using EMI. Her assessment of whether EMI was effective was also based on the client self-report. Along with the subjective self-report, Laura also uses the PTSD symptom

checklist which is a treatment outcome measurement tool developed by Danie Beaulieu (see appendix E). The client self-report was the reason she would continue to use EMI as the client outcomes were “miraculous.” These outcomes provided the evidence for her continued use of EMI.

Laura’s story did highlight some difficulties in using EMI. At times clients were unable to engage in the trauma memory as they tried to stay on the periphery or avoid the memory. Laura also noted she preferred clients to be stabilized on their medications prior to having EMI. These difficulties are important to draw attention to as it brings to light that EMI may not be an intervention that would be effective with all clients who have trauma related symptoms.

Continuing to look through the lens of interaction, the personal interaction of looking inwards also stood out. It was evident through Laura’s story her feelings about EMI motivated her to continue to use EMI. When she described EMI, she used words like: “unbelievable”, “love it”, “I believe in it”, “remarkable”, “mind-blowing”, “incredible” and “amazing”. Laura also discussed the fear she felt the first time she used EMI with a client and this fear was due to not knowing how the client responded to the EMI intervention. Continuing to look inwards these feelings about EMI provided her with motivation to promote EMI and to use it with clients. The description of EMI being “a gift” to her really explained her passion for EMI.

Talk therapy and EMI provided the space and the context of the story. The physical location or clients did not change but the therapeutic approach used did. When she used talk therapies like supportive therapy or CBT to treat trauma, Laura felt like these approaches were inadequate and she was always left wondering if she was helping

the client or not. She noticed some of the clients were still having intrusive memories or reexperiencing trauma. After being trained and using EMI it gave her a lot of confidence to treat trauma related symptoms. She also believed she has a very effective tool now to treat trauma. Laura also believed that using EMI has allowed clients to get to the core of their traumatic symptoms as they were able to gain insights and epiphanies when accessing their memories. This was something she has not found with talk therapies.

When looking at “what is the significance” of Laura’s story what was evident was: the positive outcomes for clients, the ease of using EMI, the positive feelings Laura has towards EMI, EMI as brief and effective. The other significant factor in Laura’s story was she identified some of the difficulties encountered with EMI and that EMI was not always the most appropriate intervention for clients. Laura was motivated to continue to use EMI because of the outcomes she was seeing with her clients. She relied on client’s self-report through the PTSD symptoms checklist and their verbal self-report. Even though Laura was not the primary therapist, she was still able to show effectiveness of using EMI as a therapeutic intervention.

4.3 Lisa’s Story

Lisa is a social worker who completed her BSW in 2010 and her MSW in 2014. She obtained her MSW through the Dalhousie online MSW program. Lisa has been working in mental health for eight years and works in a small community in Northern Saskatchewan. Lisa works with both adults and children but predominantly with adults. She describes her theoretical perspective as being very generalist. She draws mainly from Cognitive Behavior Therapy (CBT) and Dialectical Behavior Therapy (DBT).

Trauma is a huge interest of Lisa's and she ensures she practices using a trauma informed approach.

Lisa states a lot of people on her caseload experienced a traumatic incident(s) in their past. Prior to being trained in Eye Movement Integration Therapy (EMI) her practice for trauma mainly centred around being trauma informed. She did not use a particular therapy for treating trauma but would try and meet the client where they were at. Lisa would teach her clients with trauma related symptoms mindfulness techniques and grounding techniques. Lisa states a lot of the therapy interventions she would use were based on CBT. When drawing from CBT Lisa did not use exposure therapy to treat trauma but has used exposure therapy to treat anxiety.

Lisa's mental health clinic is diverse in the trainings they have taken. The clinic uses the Partner's for Change Outcome Management System (PCOMS). Lisa reports the mental health clinic has to take everyone that walks through the door. This is because in Lisa's community they are basically the only counselling service as they do not have, for example, a family services program. With using PCOMS, Lisa finds that the mental health clinic will use the therapies that are deemed quicker such as Reality Therapy that can be done in four to six sessions. What Lisa has noticed with talk therapies is that it is difficult to gauge the results of the therapeutic intervention for each client.

Lisa first heard about the EMI training through an email and this training opportunity really interested her as she was trying to take more trauma-based training. Lisa states she looked further into it and was also considering being trained in Eye Movement Reprocessing and Desensitization Therapy (EMDR). She compared the two

and decided to take the EMI training. One of the reasons was she liked how EMI uses the slow smooth eye movements rather than the rapid eye movements EMDR uses. The other reason she took the EMI training is she had heard good things about the trainer Danie Beaulieu as Danie incorporated Impact Therapy techniques into her training. Lisa feels there has been a lot of training on how to be trauma informed, however, not a lot on actually how to treat trauma. She states she wanted a training that focused specifically on how to work with clients with trauma. Lisa feels being trauma informed is a good start, but it is lacking the actual therapeutic techniques to put into practice. This then led Lisa to decide to take the EMI training in 2015 in Saskatoon, SK.

Lisa's experience with EMI is based on the first two years after she was trained. For the past year, Lisa states the community has been in crisis mode and her agency has not really been providing regular counselling. Prior to the past year she has used EMI on approximately twenty clients, and she has also used EMI on some friends and families.

After the training, Lisa described being nervous about using EMI for the first time. She states she was worried and a little bit sceptical. Lisa was worried about something going wrong and questioning whether she would be able to fix it if something did go wrong. Living in Northern Saskatchewan, she did not know who she would have contacted if she needed to ask questions. Lisa states there was a list of people who were in the training to contact but they were not people in her community. Lisa was also worried about EMI not working for a client, and her own abilities to use EMI correctly. She worried about leaving the client feeling like it was ridiculous and not helpful. Lisa states she decided to try EMI at first with clients who had a less distressing memory in

order to build her confidence in using it. She was actually quite surprised at how effective it was the first time she used EMI.

Lisa is the only one at her mental health clinic who uses EMI. She uses EMI with her own clients as well as other clinicians' clients. She states other clinicians will ask her if she thinks a particular client is appropriate for EMI or she will receive referrals specifically for EMI at times referred by a physician. When working with other clinicians' clients, she will start with one to two longer sessions to find out if the client meets the criteria for EMI and an assessment of their coping and emotional stability. If the client is appropriate, she will then start to discuss EMI with them.

When deciding on whether EMI is appropriate for a client she assesses for a few things. The main factor is dependent on the client and what the client wants out of counselling. She assesses whether the client has some emotional stability, some grounding or coping skills. She then spends some time discussing with the client the traumatic event and she assesses how intense their level of distress is when they discuss it. Lisa will not use EMI with someone who is actively suicidal and unfortunately this is common in her clinic.

Based on the assessment of the client, if Lisa believes it will be beneficial to the client, she will bring EMI up as an option. If the client is interested in EMI, she will then speak more about it at the next session. She usually discusses how eye movements are used to try and change someone's perspective of the traumatic event. She discusses with the client how the memory will become more bearable and less distressing for them. When clients hear about EMI some are interested in more information and others are

interested in trying it. Lisa has not had a lot of resistance from clients and generally finds them open to EMI.

Lisa has used EMI with a variety of presenting problems. She has used EMI for grief, anxiety, depression and PTSD. She finds that a lot of her clients have a traumatic event in their past. She finds that clients may come into their EMI session quite nervous, anxious or scared about what may happen in the session. During the EMI session, Lisa has observed clients having somatic symptoms, nausea and emotional distress.

Whatever the reactions of the clients during the EMI session she has observed that at the end of the session the symptoms lessen in intensity.

Her most memorable experience with a client was someone who was experiencing a lot of anxiety, feeling overwhelmed, not coping well and these symptoms were affecting all areas of his life. These symptoms arose when the client was having significant dental work done. Lisa and the client were able to identify that this client had a past traumatic event of a violent assault and had a lot of trauma to the mouth area requiring surgery. The dental work had triggered the client who had not previously experienced any symptoms. During EMI, the client had a lot of strong physical reactions. When the client came for the follow-up session the client was no longer having anxious symptoms and was able to return to the dentist without being triggered.

For Lisa, evidence for the effectiveness of EMI is based on client outcomes. What she has noticed is that clients come to an emotional acceptance of the memory. This acceptance allows them to be able to remember the trauma without feeling the distress of it. She states EMI makes the memory more “bearable.” In her experience the client will continue to have emotions like sadness about the trauma but are better able to

be rational and logical about the memory. Client's memories move from being a triggering fearful memory to an emotional acceptance. She states clients are able to talk about the memory, cope with the memory or think about the memory without it being a really awful thing for the person. This acceptance helps the client understand their memory as opposed to not accepting it.

For the most part these outcomes have come after only one session of EMI. She has had one person who she did multiple sessions of EMI with. Lisa asks the client to come back for two follow-up sessions after EMI about a month apart. She assesses for any improvements in their mood, if they are feeling better or any changes the client reports. All of the clients Lisa has used EMI with report some improvement. Lisa assesses this improvement based primarily on the client's self-report and what the client reports others have noticed. Clients may also realize they are able to do things like go shopping without any anxiety, so she likes to discuss all aspects of the client's life. Another piece of evidence for Lisa is for the most part the clients she has used EMI with have not returned for service. Lisa states on average most clients with these outcomes have only received about three to four sessions in total.

Lisa's initial challenge with EMI was finding the right client to try EMI with. She states this was due to her feeling nervous or sceptical. She wanted to find a client who was not in a lot of distress about their trauma to begin with. She had one client who she found challenging as the client was sceptical and quite resistant to EMI, however, the client still wanted to try it. During the session, there were times when Lisa thought she really should not have done EMI but once she had started the eye movements, she needed to finish the session. She was able to finish the EMI session and when the client

returned two weeks later, he reported significant improvement. He, however, would not attribute it to the EMI session as he felt the improvement would have come anyways. Lisa cannot say for sure whether it was the EMI session that led to the improvement. She felt this was her only case that appeared to be unsuccessful as the client did not attribute the positive outcome to EMI.

Lisa states the biggest challenge for her to use EMI is the lack of time. Since she works in a northern community in Saskatchewan this brings the challenge of being the only counselling agency as well as they have been dealing with a crisis for the past year. She states in terms of time she does not always have the time to explore a client's past traumatic events. The other challenge for Lisa is when she thinks EMI is a good fit for the client, but they are resistant to it. Lisa accepts that clients have a right to choose what therapy they engage in.

When Lisa reflects on her current practice, she has come to recognize that talk therapies are not always as beneficial as once thought. She states since EMI is a neuro therapy, she feels it targets different parts of the brain, and that EMI gets "right to it" in terms of the problem rather than with talk therapy where you just talk about it. Lisa has used EMI with family and friends as she does have a belief in EMI and states, "if I didn't think it was beneficial, I probably wouldn't use it with anyone but especially [not with] your family and friends." Lisa felt that using EMI with family and friends did not pose an ethical issue due to how EMI is done.

Lisa believes one limitation of EMI is the lack of research on it. She states where she works, she wants to follow best practices and evidence-based practice. She can appreciate people not being "too keen or sceptical" about using EMI in their practice

because of the lack of research. Even though she acknowledges skepticism due to the minimal research on EMI, Lisa states the evidence to use EMI for her now comes from the positive outcomes with clients. Surprisingly, no one has ever asked her about the research on EMI.

As Lisa looks to the future, she wants to get back into using EMI more. In the past, when she was using EMI regularly, she felt quite confident using it. She now feels like she needs to refamiliarize herself with EMI and wants to make it a goal to use EMI more consistently. Lisa may enter private practice in the future and EMI is a technique she could use in private practice. Lisa has a belief in EMI and has been surprised at how quickly and effectively it appears to work.

4.3.1 Reflection and analysis. When reviewing Lisa's story in the three-dimensional space the space or the context stood out. The physical location of Lisa's story had an impact on her story. Lisa worked in a northern community mental health clinic where there was limited agency support. The location of her story had an impact on her use of EMI as there were constraints because of her location. In the community she worked in, there were a lot of clients who had a traumatic incident in their past. She was also seeing many clients with trauma related symptoms who were actively suicidal. This highlights that EMI is not an intervention that can be used with all clients with trauma related symptoms. Working in this community also led to her not being able to use EMI in the past year because they were managing clients who were in crisis and really not providing regular counselling services. Also, due to working in this isolated community a challenge for her was to have the time necessary to explore trauma with clients and to use EMI. At the beginning she nervous about using EMI which was based

on her feeling isolated from any support she could access.

When looking at Lisa's story through the continuity lens, the past was where her story was set. Lisa's story was set in the past as all her experiences with EMI were in the past. She has not used EMI in the past year, so her story was set in the experience she had in using EMI in the first two years after being trained. Lisa was also looking to the future in being able to get herself refamiliarized with EMI and trying to make it a goal to use it more consistently.

The interaction was another key theme to Lisa's story. Lisa's interaction with others was how she decided to use EMI and to know when EMI was working. She relied mainly on the client self-report as evidence for the effectiveness of the EMI as well as the evidence for its use. In the personal interaction, Lisa identified challenges that affected her in trying to use EMI. She also reflected on what she believed was happening with EMI. Lisa had an interest in trauma and had been looking for trainings on how to treat trauma. She used a trauma informed approach and realized this was a way to approach but not a therapeutic intervention. Lisa believed it was the acceptance of the trauma memory that allowed people to have the successful outcomes they were attaining from EMI.

When reflecting on Lisa's story and "what is the significance", there were several key themes. Lisa has used EMI and has found it to be: brief, effective, the outcomes were noticeable, and EMI helped to create emotional acceptance. Lisa also discussed using EMI with friends and family. This is worthwhile to point out as her friends and family may only have received EMI and no other therapeutic intervention. The other notable significance of Lisa's story was her discussion of the challenges of using EMI in

everyday clinical practice. Even though Lisa has not used EMI in the past year she continued to remember all the positive outcomes she has had with clients. Lisa used EMI with her own clients, with other clinicians' clients as well with friends and family. She believed EMI was an effective intervention for treating trauma.

4.4 Genevieve's Story

Genevieve is influenced by a number of scholars in her mental health practice. The work of Barry Duncan and Scott Miller has influenced her practice through their Partner's for Change Outcome Management System (PCOMS), which has led to the development of the Heart and Soul of Change Project, currently led by Barry Duncan. Their project has done a great deal of research on what works in counselling. Genevieve has been impacted by the research comparing different therapies to one another. The findings have indicated a term coined the do-do verdict in that no therapy is better than another and that all therapies are beneficial at times. Genevieve feels their research has led to her thinking that it is about finding the therapy that is the best fit for the client and clinician. Their research has also influenced her thinking that client change comes from various factors such as the client's hope and expectancy for therapy and the client's view on how change happens. PCOMS is a way of practicing and is considered itself an evidence-based practice. In the mental health clinic where Genevieve works, they strive to use PCOMS with all their clients as long as the client is agreeable to use it.

When Genevieve first began her practice in 2000, she used Cognitive Behavioural Therapy (CBT) as her primary therapeutic intervention for post-traumatic stress disorder (PTSD). During this time, she found CBT to be very hard work and that clients had to work very hard to cope. Genevieve would use exposure as part of CBT but

found this to be very “gruelling” on the client, that the client suffered for a very long time and that exposure therapy was incredibly slow. What she noticed with using CBT was clients were learning how to cope but they were not healing. Genevieve was becoming increasingly dissatisfied with the use of CBT to treat PTSD as her clients were not achieving the positive outcomes she and they were hoping for.

Genevieve then began to put a lot of effort into learning a somatic approach to treating clients with trauma. This therapy is called Self-Regulation Therapy which she learned from Dr. Edward Joseph and Dr. Lynn Zetl from the Canadian Foundation for Trauma Research and Education. Genevieve describes Self-Regulation Therapy as:

it takes the exposure slow, it more peels the onion off more slowly one layer at a time touching on the activation, or the stress that comes up as a person remembers the story and then shifts towards using resources to help them self-regulate and settle and experience what self-regulation therapy would call discharge in their nervous system like through crying or heat or shaking.

Genevieve’s experience with Self-Regulation Therapy was that it used exposure therapy, but it was much gentler, and clients were experiencing more positive results than what she was achieving with CBT. The difficulty she found with Self-Regulation Therapy was that it took a lot of time for the clients to improve.

Genevieve’s clinical practice has been influenced by Daniel Siegel’s work on interpersonal neurobiology, and Kurt Thompson and Norman Doidge’s research on the brain’s ability to change itself. These influences had her thinking more about neurotherapies as well as talk therapy alternatives. Genevieve was open to exploring other

forms of therapies that could influence the way people think which led to her first training with Danie Beaulieu.

Genevieve, along with some of her colleagues, attended a training on Impact Therapy with Danie Beaulieu. Genevieve describes Impact Therapy as a therapy that uses images to make an impact on the brain as the eyes impact on the brain is far greater than that of audio. Impact Therapy uses visual prompts, psycho drama and metaphors. While Danie was speaking about Impact Therapy she made a comment that took Genevieve aback. She said something along the lines of

Okay, if we come across someone who has trauma that is getting in the way and has post-traumatic stress that's triggering and interfering with the current therapy, then what we will do is this Eye Movement Integration or EMI we will clear it up and then we will move on.

Genevieve remembers being taken aback by this and thinking "what are you talking about, how can you possibly just clear it up and move on?" This comment led to Genevieve looking further into the use of the different eye movement therapies.

Genevieve spoke with Danie about EMI and Danie reported the 'amazing' results she and her team were accomplishing with EMI. What Genevieve learned from Danie was that she was trained in both EMI and Eye Movement Desensitization and Reprocessing (EMDR) and in her experience, she was having better results with EMI. Danie believed the differences in the eye movements was one reason for the variation in results. Danie told Genevieve that EMDR is based on rapid eye movement (REM) and EMI is based on smooth pursuit eye movements (SPEM) and that SPEM seemed to be gentler, less intense, and achieved a more complete result for the client.

Genevieve and her colleagues went back to their clinic and further researched the eye movement therapies. At that time, eye movement therapies were gaining more attention but neither therapy had much research behind it. After presenting this to their supervisors and receiving support, a group of clinicians decided to put on a conference and bring Danie Beaulieu to do the first training in EMI in Saskatchewan. The training took place in Saskatoon in 2012. Genevieve experienced the personal benefits of EMI during this training as part of the training is having EMI performed on each clinician.

Although Genevieve was initially skeptical of EMI and the claimed benefit it would bring, she gained her confidence in EMI through reading, listening and watching at the training. Once she gained this confidence, she tried EMI in her practice. It took one session of EMI with a client for her to fully believe in its utility, as there were immediate and dramatic positive results.

When she first began using EMI, she started with clients that she had been working with using Self-Regulation Therapy and what she found was that the trauma was cleared up very quickly with EMI. Genevieve discussed one client who was involved with the mental health clinic for some time and had seen a number of different clinicians off and on over many years. This client was often discussed amongst the team about what else they could try with her as they had felt they had exhausted all possibilities, but she did not want to end therapy. The client had numerous persistent symptoms, both presenting to addictions and mental health. Genevieve decided to use EMI with her to address some trauma that had occurred earlier in her life. After she had completed four sessions of EMI her trauma was reportedly cleared up. Her symptoms, she reported, were completely resolved. At this point this client ended therapy on her

own as she did not feel like she needed to come any longer, reporting that she was fine. For Genevieve, this outcome for this client “blew me away”.

There are many different presenting problems Genevieve has used EMI with. Clients will present with addictions, anxiety, OCD, anger, relationship difficulties, specific phobias and depression. Genevieve states she may use EMI on a variety of diagnoses in the DSM V as long as there is an etiology of trauma. Genevieve states she has found that trauma can affect people in their relationships and how they cope with anger. She states people who have trauma in their past may misread their partner’s reactions and can find themselves easily triggered, which leads them to react in really intense manners. Genevieve has found that this reaction may be connected to a highly emotional event in their life as a trauma that has lived on. Genevieve believes that at times clients with anger issues can have an underlying trauma to their anger outbursts. She describes the clients having a “sense response” and this “sense response” is their behaviour during an angry outburst.

If there is an etiology of trauma, and the client agrees, Genevieve will start to discuss EMI with the client. She recognizes that when clients come in for counselling, an eye movement therapy is not usually what they have in mind. Genevieve explains the three approaches of CBT, Self-Regulation Therapy and EMI. She tells clients that Self-Regulation Therapy is the gentlest approach, but it takes a long time and that EMI is the most rapid and effective but is more intense. She will also tell them that CBT is a possibility, but it tends to train clients to numb out, rather than heal in her opinion. She lets clients know from her experience that EMI provides the most complete outcomes.

She asks the client which one they are more drawn to and they will usually ask more about EMI.

To further explain EMI, Genevieve will ask the client to try and solve a complex math equation and tells them they do not have to solve it but to just try. She will then ask them if they noticed where their gaze went in order to visualize the numbers. She then asks clients to try and hear their mother's voice and to notice where their eyes looked. Genevieve explains how the eyes help us access different information and that in these two examples the eyes help to visualize and recall sounds. She tells them the eyes help us to record information as well as access information and this usually captures the client's attention to how the eyes are connected to memory. Genevieve then further explains:

I'll tell them that as we work with these traumatic memories the eyes movements help the brain bring fourth information that we're needing to touch on as well it will help your eyes move in new patterns to help the brain integrate that information with other sectors. Brain health as we understand it by interpersonal neurobiology touted by people like Daniel Siegel we understand brain health as regarded by a term integration. Integration has to do with the steady flow of information and energy within the sectors of the brain and between the sectors of the brain, and as we do eye movements it helps us establish that integration and re-establish that integration between the different parts of the brain.

Genevieve may further explain to her clients how trauma is recorded in the timeless part of our brain and this is why flashbacks happen and feel like they are happening in the present moment. Through the eye movements as integration happens, the brain is able to

provide more of a linear sense of time to the memory which leads it to become more historical and feel like it has faded away.

If the client is interested in EMI, she will send the client home with an information sheet that she has developed. Genevieve will give the Impact Academy's website to the client to do some research on their own. Prior to starting EMI there are a few things Genevieve assesses for. One of them is to ensure the client has resources both internal and external. She wants the client to have an external resource like a family member or friend that's a good support for them. If they do not have a good support person, she ensures that the client is aware of how to access professional support if needed. The internal resources are any coping skills the client has and uses, such as a breathing strategy, grounding, self-talk, visualization, progressive muscle relaxation or tapping. Genevieve does not define what these skills must be but wants the client to have some skill or resource that they have experience using. Genevieve also assesses the level of shame the client is experiencing, in regard to their trauma. This is based on Brené Brown's work on shame. Brené Brown (2006) is a social worker who has researched shame, vulnerability, courage and empathy. Genevieve states that this work has led her to understand that shame can be very isolating and draws people away from relationships. For EMI to be successful the client needs to be able to acknowledge what is coming up and put some language to it. Shame can interfere with what people will disclose, which limits the impact of EMI. If there is a lot of shame Genevieve will work on reducing the shame before starting EMI. Once Genevieve gets a sense that the person is comfortable and understands what they are agreeing to, has enough resources, and has enough freedom from shame, she will start EMI.

Genevieve has used EMI with an estimated 100 clients and out of all these clients she has only had one that could not complete EMI. However, the rest of them have had successful outcomes when assessed two weeks after completing EMI. This one client, who had initially discontinued EMI, returned to EMI treatment after several months and was able to complete the EMI sessions, attaining a positive outcome. Genevieve states she has noticed incredible changes in clients during an EMI session. She has observed clients who have been brought to tears of relief. She has witnessed clients move through intense memories, which were constantly plaguing them, to a place where they are settled and able to think of the memory without being overwhelmed by it. Genevieve finds it very touching to be able to witness the changes in a client during an EMI session. She describes witnessing a client going from being plagued by their traumatic memories to the client having tears of relief because the traumatic memory has faded away. Clients will report that they can now feel joy or happiness when they have not felt those emotions for many, many years, or in one case, had no memory of feeling happiness, but after EMI they could feel joy. Clients have been so overjoyed with their results they have wanted to give Genevieve a hug because they feel such relief.

At times, the change in clients is not as dramatic but there is still positive movement. In these cases, clients will feel some relief but not completely resolved of their traumatic memory. Clients will get a sense that this is working and are anxious to have another EMI session. Clients who have this experience do not want to have to wait the two weeks that are required in between EMI sessions. At times, the improvements in clients is not as dramatic and Genevieve states; one reason for this is that EMI is a neuro therapy. In Genevieve's experience with EMI being a neuro therapy, the brain may

change in a way that feels very natural to a client. The client feels like they are just acting like themselves and the client does not feel as aware of the changes.

Genevieve uses a variety of assessment strategies to help her assess whether EMI is effective with a client. PCOMS is a standard measure she uses with most clients. The outcome measurement scores make it very obvious when a client has made significant improvements. At times she will use the PTSD scale that was developed by Danie Beaulieu. This scale measures a variety of symptoms related to trauma and the client rates them on a 10-point scale. During the EMI session, Genevieve will use scaling questions with the client with 1 being not intense to 10 be very intense. She will have clients use the scale to measure the intensity of memories and how much they are bothering the client. She states she will have a client rate the vividness of a visual memory, the amount of anxiety they feel in their body and other kinesthetic reactions like smell, taste, auditory, body sensations or a thought. Genevieve finds it helpful to have some assessment of how the memories are affecting the client. This is because as memories fade away, it is helpful to have a record of what they were experiencing prior to EMI. Genevieve states all of this assessment information is based on the client's subjective self-report.

Genevieve discussed that the one client, who at first did not have a successful outcome, had to stop EMI for a few months because he could not tolerate the reactions he was having in session. Genevieve states the client was aware that this was a possibility but still felt unprepared for it. This client did worse for a few months after the initial EMI session. Once he could go back and complete EMI, he was able to

successfully complete EMI with significant improvement. One of his most notable improvements was being able to be more present in the moment.

The most complex case Genevieve has used EMI with, was a client who was struggling with her marriage. During couple's counselling what was discovered was she was living in a "highly activated" state and she attributed this state to experiences in her childhood. She barely had any memories of her childhood but when she tried to think about it, it caused a great deal of distress for her. Genevieve used EMI with this client and what was revealed was she experienced significant trauma from her caregiver for many years. After completing EMI, this client was able to report joy, an understanding of where her anger came from, and was now able to tune into other's feelings.

Genevieve reports "her neurology was changing in such a way that she's now able to feel for others." This client experience was an example of a challenge of using EMI as at times "clients will have memories they have dissociated completely from and as we do EMI these memories are uncovered that they weren't aware of anymore."

Genevieve states she has had successful outcomes with all her clients she has used EMI. This includes the client she had to stop with as she was able to use EMI with this client several months later. She states on average she will use EMI for 2-3 sessions. EMI has been successful with some challenging clients, clients who have been in counselling for a number of years and clients with persistent mental health issues. Genevieve states she finds EMI to be incredibly effective for clients whose symptoms have a root in trauma. Genevieve finds the clients who only need one session of EMI are usually impacted only by a single traumatic event or the trauma occurred in their adult life with no history of childhood trauma. Clients who have more complex trauma

stemming from years of childhood abuse require more EMI sessions. In either case, for the most part once they have completed EMI they are finished with counselling. Clients are now able to problem solve, tolerate distress and manage challenges in relationships or work. Being able to manage these situations is dependent on the coping skills the client had before EMI. If the client did not have effective coping skills before EMI than after EMI, they are much more able to learn these skills. Genevieve believes that clients are able to use their skills or learn the skills because their nervous system is not in such a hyper vigilant state anymore. Genevieve states they are restored to their “former selves.”

As Genevieve discussed research and PCOMS she was conflicted in believing the research on the dodo bird verdict in that no particular therapeutic intervention is better than another. As she believes EMI to be superior therapeutic intervention to any other she has used. She believes in the common factors of counselling and that these common factors are what we should be focusing on in counselling. Genevieve states she would like there to be more research on EMI but the studies that have been done and the outcomes she has seen are enough evidence for her. She finds research on techniques such as CBT is biased. This is due to the clinicians in these studies having small caseloads and lots of supervision to ensure fidelity and good outcomes. This is unlike her experience in a community mental health clinic with a large case load, trying to get people through quickly, and not a lot of supervision.

Genevieve has gained some personal insights as she uses EMI. From her experience in using EMI, Genevieve has a much better appreciation for the brain and the techniques she can use to really help her clients.

It's made me um want to be more thoughtful about what I can learn and what I can do that can help bring change in clients lives because EMI [is a] particular approach and it [has a] specific protocol that we as practitioners follow. Which is different than some other approaches that will kind of more blame the client if they don't change whereas EMI kind of caused me to recognize that I really have a responsibility as a practitioner to learn the most that I can to be able to benefit my clients it's caused me to recognize I have a, I have a great responsibility.

Genevieve states EMI is an incredibly effective therapeutic technique that gives her hope for her clients. She states she actually looks forward to working with someone with post-traumatic stress because she has this exceptionally good tool and she looks forward to seeing how his/her life can change.

4.4.1 Reflection and analysis. In looking at Genevieve's story through the three-dimensional lens what stood out was the space the story occurred in. The context of Genevieve's story was in the different types of therapies she has used to treat trauma. Her story began as she described her experience in using CBT then moving to Self-Regulation Therapy which led her to EMI. Genevieve's decision to be trained in EMI and to continue to use it was based on the dissatisfaction she had with using CBT. She had started using Self-Regulation therapy which was a somatic approach but was open to the possibilities of neuro therapies.

It was evident that EMI has changed her practice. She has had about 100 successful outcomes with clients including clients with very persistent mental health issues. She has had successful outcomes with clients who have been in counselling for a long time and they were able to end services. Genevieve has found in using EMI she has

been able to help her clients heal and not just learn to cope. She also knows she was helping clients because of the dramatic changes she has witnessed, or self-reports clients have given. She has found EMI to be an incredibly effective treatment that has positive outcomes that happen quickly.

Genevieve's interaction in both the personal and social also stood out. It was her interaction with scholars that influenced her thinking in her mental health practice. Being open to neuro therapies was a possibility that came from work of Daniel Siegel as well as Norman Doidge. Her overall practice has been influenced by Barry Duncan and Scott Miller in terms of a way to approach therapy. In this story, what influenced her work with EMI was the outcomes she was attaining with clients supported through her use of PCOMS. Genevieve also relied on the client's self-report to help her assess the effectiveness of EMI. The personal interaction was also evident in Genevieve's story. When looking inwards, Genevieve described many feelings she has experienced due to using EMI with clients. The client outcomes have evoked feelings of hope, confidence, happiness and at times disbelief of the outcomes. Genevieve has gained personal insights as well from using EMI. She believed she has a responsibility as a clinician to help her clients and that the responsibility did not lie solely with the client. Genevieve also has an appreciation for the brain in how the brain can heal. The reason Genevieve has so much experience in using EMI was because of her belief that EMI is as an effective intervention.

In reflecting on "what is the significance" of Genevieve's story, it is that she believed EMI was: effective, brief and helped the client heal. Genevieve has taken a lot of training in trauma and has a great deal of experience in treating trauma. What stood

out in Genevieve's story was the commitment and responsibility she has to her clients to provide an effective therapeutic intervention. She continued to use EMI because of the positive outcomes she has experienced with clients. Her experience in treating trauma has provided her with the knowledge of what has and has not been effective in treating clients with trauma related symptoms. She has been able to compare her past experience in treating trauma related symptoms with her current use of EMI to treat clients with trauma related symptoms. This past and current experience demonstrated her commitment to finding effective treatments for her clients and her decision to use EMI was based on her experience.

4.5 Themes

The next step of this narrative inquiry was to explore and identify the common themes amongst the four stories to provide discussion of the findings. The four stories answered the main research question of: *What are the experiences of clinicians as they use Eye Movement Integration Therapy (EMI) in their clinical practice?* The thematic analysis was used to draw out common themes from the stories to answer the following five sub questions:

- How do clinicians decide to use EMI in their clinical practice?
- What do clinicians view as evidence for the use of EMI?
- How do clinicians present EMI to their clients?
- How do clinicians decide EMI is effective with clients?
- What are the reasons clinicians continue to use EMI?

There were six main themes that emerged from the four participants' stories. The six themes that emerged were: *dissatisfaction with talk therapy for clients with trauma*

related symptoms, clinicians' feelings, the importance of what the client wants, client outcomes, client self-report and clinician observation, and trauma memories are stored in the body. These themes continued to follow the three-dimensional space of interaction, continuity and space (Clandinin & Connelly, 2000). Within each theme there was a connection made to the literature in order to use the validation strategy of triangulation as previously discussed (Creswell, 2013).

4.5.1 Dissatisfaction with talk therapy for clients with trauma related symptoms. The four participants discussed two key factors in their decision to use EMI in their practice. The two key factors were either not having any prior training in trauma and/or dissatisfaction with the outcomes with talk therapy. The participants that had training specifically for trauma were dissatisfied with the results they were attaining with clients. The other participants discussed not having any training specifically for treating trauma. In our discussions, three participants felt that many of their clients had a traumatic event in their past and found it necessary to have a therapeutic intervention that was effective. One of the top reasons Cook et al. (2009) found that clinicians learn new therapeutic approaches was based on the clinicians' existing needs, values and experiences. The participants in this study were looking for a different therapeutic intervention due to their experience of a lack of positive outcomes, needing a trauma specific training and the value of wanting something better for their clients.

All of the participants discussed using CBT to treat trauma whether or not they had specific CBT training for trauma. Findings from several studies have indicated that clinicians surveyed reported using CBT to treat clients with trauma related symptoms (Pignotti & Thyer, 2009; Sprang et al., 2008). Three of the participants stated that they

were not getting the results with CBT that they found were helpful to clients. One participant identified CBT was helpful when it was used but found EMI to be more effective. Bradley et al.'s (2005) meta-analysis found that clients who had received CBT to treat their trauma related symptoms continued to be symptomatic after 6 months of treatment and two thirds had relapsed with their symptoms. Laura discussed her experience:

It didn't feel like it was adequate because it was CBT based, right? Because yeah you change your thoughts and your feelings. You know change your thoughts, your feelings will change and then your behaviors will change but at the same time it didn't help with the intrusive memories. [The] reliving yeah so it felt inadequate like the resources, well what I was doing felt like it wasn't enough.

Genevieve described her experience as:

Where the work of CBT with exposure is incredibly slow and the person suffers for a very long period in my experience ... I found that is really hard work and the client generally had to work incredibly hard and continue to work incredibly hard to just to manage and cope [but] never healed [from their trauma symptoms].

These experiences with CBT were supported by van der Kolk (2014) as he purported CBT was not an effective treatment for PTSD. Ogden and Fisher (2015) suggested that what has happened is the implicit memory cannot be put into language and when only talk therapy is used, this leads to ineffective client outcomes. van der Kolk (2014) stated that CBT does not address the memories that were stored in the implicit memory and relied only on the memories that have a verbal story attached to them. Duros and

Crowley (2014) also argued that talk therapy alone was ineffective in treating trauma related symptoms.

4.5.2 Clinician's feelings. One of the common themes amongst the participants was the way in which the participants discussed their feelings in relation to EMI. Many times, throughout the stories the participants brought up their feelings about EMI, about using EMI for the first time and the feelings EMI gave them for their clients and their practice. There was a range of feelings that came up for each participant, however, in every story each participant reflected on their feelings about using EMI.

When discussing using EMI for the first time, the participants all had stories about how they felt. In each story participants described feeling nervous and/or skeptical about using EMI with their clients. When describing feeling nervous, the fear came from doing something wrong or harming their client in some way. Laura described "I was scared oh my gosh I was so scared, the first lady that I did it with I said to her, I said okay, I want you to phone me tomorrow and do a check-in with me." When the client did not call to check-in Laura's reaction was "this went south, I really did something horrible to this woman...something bad has happened." Lisa described her feelings of EMI for the first time as:

I was kind of nervous to use it at the start actually... [I questioned] what if something goes wrong, and you don't know how to fix it. When you first start using it you know like there's always the question like what if I'm not doing it right?

Dunne and Farrell (2011) found in their investigation into the experiences of clinicians integrating EMDR into clinical practice similar descriptions of fear and that the fear was

related to retraumatizing the client. Margo discussed “I wasn’t sure if I’d actually be using it on anybody when I first finished with it [EMI training] because it was like I don’t know if I can, I didn’t feel comfortable doing it.” This is consistent with the findings from Dunne and Farrell’s (2011) study as they suggested one challenge of integrating EMDR was the fear and anxiety clinicians can experience.

Besides feeling nervous and scared, participants also shared feeling skeptical prior to the first-time using EMI. Genevieve’s feeling in regard to using EMI the first time was “the question again was do I believe?... Believe that this is for real because it seemed it is just so different than what I had seen.” Lisa described at first being “a little bit sceptical cause it can work really quickly.” Dunne and Farrell (2011) also found from their participants a sense of skepticism about EMDR. This skepticism was resolved when one participant was able to use EMDR and observe the results of EMDR (Dunne & Farrell, 2011). These feelings described by the participants were linked to the sense of responsibility they felt towards the client. The participants were skeptical of whether the results Danie Beaulieu was purporting were actually achievable with their use of EMI. This skepticism may also have arisen due to the risk participants were taking attempting a technique with minimal evidence to support its use.

Each participant expressed their feelings about using EMI in their practice. When asked to discuss their experience in using EMI, participants described overwhelmingly positive feelings. In Margo’s story she reported “I love it, I believe in it so much”. Laura described her experience with using EMI as, “I absolutely love it.” Genevieve reported being “very happy I have it as part of my toolbox.” Lisa described her feelings about using EMI as “if I didn’t think it was beneficial, I probably wouldn’t

use it.” According to Barry Duncan (2010) one of the indicators for a successful outcome in therapy is the clinician’s and client’s belief in a therapeutic technique. The feelings described were indicative of the clinician’s belief in EMI. Cook et al. (2009) found that one of the main reasons clinicians decided to use a new therapy and continued to use it, was the enjoyment in conducting the therapy. This was consistent with the feelings the participants described which indicated enjoyment. Each clinician used positive feelings to describe their experience using EMI.

The participants also had many different feelings to describe the outcomes they were achieving with clients when they used EMI. Being “shocked” and “surprised” by the outcomes were the two most common feelings identified. Genevieve stated, “I’m actually um shocked at how effective it is, its um it’s kind of surreal.” Lisa discussed:

I was really surprised you know that, cause you obviously have to have some sort of like a belief in it to use it in your practice, but yeah I was just really surprised that just how effective, you know, it’s been.

The feelings that were evoked for the participants after seeing the results of EMI appeared to be one of the reasons the participants continue to use EMI. Cook et al. (2009) concluded that increasing a therapist’s self-confidence was a motivator for a clinician to use a new therapeutic technique and continued use was based on a therapist feeling successful. The feelings described by the participants suggested that they each had an increase in confidence related to using the approach.

In looking to the future, participants indicated feelings to describe their continued use of EMI. All the participants described feeling a sense of hope for their clients when treating them for trauma. The participants felt this hope was due to feeling they actually

had a therapeutic technique that was effective. In the common factors approach to counselling one of the greatest indicators of change is providing the client with hope (Duncan, 2010). In this context, hope came from a sense of competency the clinicians felt in using EMI and treating trauma. As Genevieve said, “I look forward to working with someone working with post-traumatic stress because I know I have a tool ... an exceptionally good tool.” Margo has a similar reflection “its [EMI] just given me hope and it helped me to be very effective.” In this study these feelings of hope came from the outcomes that the participants had witnessed with their clients.

4.5.3 The importance of what the client wants. The theme of the importance of what the client wants was apparent in all the stories of the participants when using EMI. All four participants, when telling their stories, discussed the focus being on the client. When deciding to use EMI in their practice, the participants discussed the main determinant was what the client wanted from therapy. In the common factors approach to counselling, client involvement and client input were key components to therapy (Barth et al., 2012). As Margo noted, it depended on when the client brought up the trauma in their regular counselling sessions, “it also depends on when they’re finally talking about the abuse, how emotional they are.” Laura discussed really ensuring the client understands EMI and really trying to use language that is client friendly as well as having the client repeat back what is being said to ensure understanding. All the participants discussed letting the clients decide for themselves whether or not they wanted to try EMI. As Barth et al. (2012) discussed, clinicians want therapeutic interventions that offer flexibility in terms of engaging clients when they are ready. According to Barth et al. (2012), engagement of the client is paramount in the common

factors approach. Barth et al. (2012) used the term fidelity to discuss staying “true to the client’s goals in the treatment process” (p. 113) and this was evidenced by all four participants’ descriptions of their interactions with clients. Each participant described engaging their clients in this manner in various ways. Engagement of the clients was deemed a main category in Strand et al.’s (2013) examination of common elements in evidence-based treatment manuals for trauma. Participants wanted clients to decide for themselves that they wanted to try EMI.

The other factor in keeping the focus on the client was using EMI with clients who were presenting with symptoms related to a trauma but did not require the client to have a diagnosis of PTSD. Wampold (2015) argued that in the treatment planning phase the therapist must look beyond theory and the client’s diagnosis. Wampold (2015) maintained that the therapeutic intervention selected must be an appropriate match for the client. EMI was not restricted to clients who only had a diagnosis of PTSD and this provided the opportunity for therapists to select this intervention when it was deemed appropriate. It allowed the client to be able to identify a past trauma that may be impacting their current symptom presentation. Clients were allowed to make their own appraisals of whether they believed the past trauma could have an impact on their current functioning. All the participants took this approach with the clients they use EMI with, as they all discussed using EMI with a variety of diagnoses.

The participants also discussed that not all clients were candidates for EMI. Margo discussed she does not use EMI on clients who are on medications. This would exclude some clients from EMI as one of the treatment recommendations from the APA (2017) was the use of pharmacology. Lisa discussed not being able to use EMI with

clients who are actively suicidal which excludes many clients she works with. Lisa also stated clients need to be “emotionally stable and have good coping skills.” Lisa described this as a challenge of EMI in that not all clients are “appropriate or just not being a good candidate.” The participants also gave stories of clients needing to have emotional regulation skills to cope with the EMI treatment. Margo reported having to stop EMI with a client “because of it [EMI] was so overwhelming for her some of those emotions.” Genevieve described her experience with one client:

one [client] wasn't able to tolerate the treatment and stopped in the middle of a really traumatic episode and he didn't do well for a time but eventually was able to continue the treatment and we were successful but initially it wasn't helpful for him.

This example demonstrates the risk of EMI for clients. Clients may have to experience intense emotional reactions that they may not be able to tolerate or cope with. In this case the client returned for EMI and was able to have resolution to his symptoms. However, for other clients the risk would be they would not return for future treatments or counselling.

The participants also assessed where the client was at in terms of being able to do EMI. Genevieve discussed shame and wanting to ensure the client was comfortable:

If I sense that there's a lot of shame, then I will spend more time seeking to build some rapport and connection with the person first, um, and working on some of that shame helping them tune into my acceptance of them as a person.

The participants strived to ensure there was a therapeutic alliance and that the client was comfortable with what was proposed. Since Laura was not the primary therapist her first

goal was, “I step in and develop a therapeutic alliance.” Clinicians often chose therapeutic techniques that emphasized the therapeutic relationship (Nelson et al., 2006). Duncan (2010) emphasized the most important factor in a counselling relationship was the therapeutic relationship. A second category in Strand et al.’s (2013) study was ensuring a therapeutic alliance when working with individuals being treated for trauma. All four participants wanted clients to make the decision to do EMI on their own and wanted to ensure the clients were comfortable trying it. Lisa stated when bringing EMI up to a client, she explored if, “they’re interested in it and then if they are, talk further about it at other sessions. If they aren’t, I just kind of leave it, I don’t push it or anything”. Connirae Andreas (personal communication August 30, 2018), one of the original creators of EMI stated that EMI is supposed to be collaborative with the client. She noted that during EMI clinicians needed to be obtaining ongoing feedback from the client in order to make any adaptations that clients wish (C. Andreas, personal communication August 30, 2018).

When focusing on what the client wants, the participants also identified respecting a client’s skepticism of EMI. Some clients have told Margo “oh you’re [wanting] to play with my mind ... you’re not going to do that with me.” Margo stated this was why she does not usually discuss EMI initially as she wants the client to first have confidence in her as a clinician. Genevieve noted that “when people are coming in for counselling ... they don’t have eye movements in mind.” Being aware of this skepticism helps to ensure Genevieve provides as much information as possible about EMI for the client to make an informed decision. Lisa also states at first, she was hesitant about using EMI because “what if I try it on these people and then they’re like

this is ridiculous it's not working, it's not helping necessarily.” This was also a finding in Dunne and Farrell (2011) when identifying the difficulties in integrating EMDR into clinical practice as clients are often not expecting to be approached about EMDR when they come for counselling services. The participants recognized that clients would have a level of skepticism about EMI given that an eye movement therapy was most likely not what the client thought they would be approached with. Also, since the underlying mechanism of change for EMI cannot be explained it could leave a client feeling skeptical about an eye movement therapy

4.5.4 Client self-report and clinician observation. Throughout the stories, the client's self-report was the main factor determining EMI's effectiveness. This is consistent with Ionita and Fitzpatrick's (2014) study of 1668 Canadian psychologists that client self-report was the main mechanism to determine a therapeutic intervention's effectiveness. These self-reports from clients of diminished symptoms were the main motivations for participants to continue using EMI. This was evident in all of the participants' stories. There were various ways in which the participants solicited client self-report such as utilizing the subjective units of distress, subjective feed-back of their symptoms and through questionnaires. Research into the common factors approach to counselling suggested that continually eliciting client feedback is very important to the success of counselling (Barth et al., 2012). Prior to conducting EMI, all the participants described finding out how the client's life was being affected. Sparks, Kisler, Adams, and Blumen (2011) reported that eliciting ongoing client feedback is extremely important in decision making in therapy and this feedback should be the guide in the

selection of the next steps in therapy. Margo uses a questionnaire that she developed that she uses to go over the client's symptoms before and after EMI.

[I] take a baseline. I have a lot of questions that I ask them ahead of time... I'm pretty thorough over what I ask of them as far as you know, the intensity of their picture, the intensity whether or not there's sleeplessness all that sort of stuff... and then when get together after that we start talking about that and revisiting everything they've told me on the questionnaire... and seeing what the intensities are ... and if they, and if they're still having some of the initial things they came in to see me about you know... it's a matter of the anecdotal sort of things.

Laura uses the pre and post PTSD symptoms checklist that was developed by Danie Beaulieu (2003). This is a client's self-report rating of their symptoms on a 10-point scale. Laura also listens to the client give their self-report of what they have noticed as change.

So, their subjective reports of how they are feeling of how they are coping in their lives and how they are managing in their day-to-day lives with ah in the absence of the symptoms that they were trying to cope with before... If there's been improvements... the client's subjective reports ... just having that feedback about the success of it... when I look at the symptoms checklist pre and post I know that they've achieved benefit from it ... clients refer to it's as almost miraculous... its improvement based on their reports not mine ... It's what they believe and I think that's the most important thing.

Genevieve uses the ORS as one tool to assess improvement in clients. During the session, Genevieve relies on the client self-report to assess whether EMI is improving the

distress of the traumatic memory. Genevieve does this by asking clients to rate their distress on a 10-point scale where 10 is very distressed and 0 is not distressed. She uses this scale for clients to measure the level of distress in whatever modality the client experiences the traumatic memory, for example, thought, physical sensation, smell or visually. Genevieve stated:

PCOMS provides evidence ... if I use the PTSD symptom checklist that Danie provided us in the training that provides evidence, the scaling questions provide evidence, as well as the client's oral report. I guess all of these are as evidence based on the, the client's oral report ... now not just oral report but the client's self-report, but I would also say from my observations, incredibly obvious that the client is changing.

PCOMS is considered an evidence-based outcome measurement tool that has been researched with RCTs (Duncan & Reese, 2015). Lisa relied mainly on the client's self-report on whether EMI has been effective. She noted, "I'll do two follow-up appointments to see if they [clients] notice any changes or any positive changes [and] if their mood has improved or if they are feeling better about things or if there's been a change."

All of the participants' main reason for their use of EMI was based on the client's self-report on the reduction of their symptoms. It has been found that clinicians use a therapeutic intervention and continue to do so if they feel there is effectiveness in their use of the technique and that the effectiveness was validated by the client (Cook et al., 2009). All participants reported that the client's self-report was the main source of evidence they valued the most. However, as Meyers (2002) indicated a client's self-

report of change is not always accurate given that clients tend to rate their current level of distress with their way they are currently feeling. When the participants heard a client describe the improvements in their lives this was the evidence they needed to establish that EMI was an effective intervention. As Lilienfeld et al.'s (2014) argued this could be seen as confirmation bias in that the clinician is looking for evidence to support their hypothesis. Relying on client self-report continues to be the practice of many clinicians as suggested by Ionita and Fitzpatrick's (2014) study. Ionita and Fitzpatrick (2014) argued clinicians need to use a combination of observation, self-report and an outcome measurement scale to inform treatment effectiveness. This combination was evident in one participant's story. While the observations of clinicians and client self-report should not be devalued, confirmation bias is important to consider, and additional evidence should be attained using objective measurement tools.

Relying on client self-report is a common practice among mental health clinicians to assess for change (Ionita & Fitzpatrick, 2014). Assessing for change, is one of the many clinical decisions clinicians make and what has been found is clinicians do not rely on empirical evidence to guide decisions (Anastas, 2014; Thyer & Pignotti, 2011). Even though there is empirical evidence suggesting that there are a host of biases with relying on the client self-report, clinicians in direct practice prefer to rely on the reports of clients and their clinical observation (Ionita & Fitzpatrick, 2014). Many clinicians believe in the importance of client's values and the importance of what the client values as change in their life (Thyer & Pignotti, 2011). It has been argued that clinicians are more concerned about an intervention's effectiveness on an individual and researchers are more interested about the overall effect of an intervention (Dunne &

Farrell, 2011). This may be one reason client self-report is often relied on. This also is in congruence with a social constructivist point of view as this point of view believes there is no one true reality; therefore, clinicians may construct along with each client to define what change is for that client (O'Connor, 2015). As presented in all the narratives the four participants relied on the client's self-report of their symptoms and functioning and found this to be the best evidence to assess for change and effectiveness.

4.5.5 Client outcomes reported by clients and observed by clinicians. All four participants described many stories of client outcomes after using EMI. In the four participants' stories they each reported, for the majority of the clients they have used EMI with, EMI has been effective in alleviating the client's presenting symptoms. Laura stated, "everyone that I've done [EMI] with has achieved therapeutic change." In Beaulieu's (2003) own report the results were similar. Beaulieu (2003) found in her research that, the twenty-six participants that participated in this study, they had an 83% reduction in their trauma related symptoms when assessed two-three weeks after EMI. In their small study with twelve adolescent participants, Struwig and van Breda (2012) also found significant differences between the pre and post-test measuring trauma related symptoms after one session of EMI. There were many stories told from the participants of examples of the outcomes with their clients. There were examples of a decrease in symptoms with clients who had been involved in counselling for many years. These clients were dealing with multiple presenting problems such as anxiety, gambling, OCD and after being treated with EMI the clients were able to end therapy due to a reduction in their reported symptoms. Laura described a client who after EMI felt so good, stopped taking her anti-depressant medication and is now an advocate for EMI.

Specifically, there were two sub-themes that were pinpointed which were immediate, long lasting and effective and comprehensive outcomes.

4.5.5.1 Immediate, long lasting and effective. EMI was described by all of the participants as being a therapeutic technique that brings changes to clients in very few sessions. Three participants identified the majority of their clients, after one session of EMI, reporting a reduction in their reported symptoms. One participant described having clients report a reduction in symptoms on average after two to three sessions of EMI. The results attained by the participants were similar to previous findings, as significant improvement in symptoms had been found after one session of EMI (Beaulieu, 2003; Struwig & van Breda, 2012; van Breda & van der Spuy, 2018). Further, Beaulieu's (2003) second research report found the 26 participants had an 83% reduction in their trauma symptoms after receiving one to six sessions of EMI.

The participants discussed having follow-up appointments to assess for client change at various intervals such as one week, two weeks, one month and two months. Beaulieu (2003) recommends clients be seen 10 to 14 days between EMI sessions. The number of total sessions for each client was dependent on several factors. These factors include the initial assessment appointment with the client, how many sessions were needed to ensure the client had the appropriate coping skills, the EMI session(s) and then follow-up appointment(s). In some instances, clients were able to be discharged from therapy in as little as four sessions. This would meet the criteria for brief therapy as in Saskatchewan up to ten session of SFBT was considered brief in Mireau and Inch's (2009) study. Lisa described "when I use it [EMI], it definitely cuts down on like how long I see someone." Genevieve used EMI because "it brings incredible results in a

short period of time.” Laura discussed, “using this tool has been able to effect change so profoundly and quickly.” Margo’s experience with her clients has been “for some people it [EMI] can take one or two but for most it’s just taking one session.” Overall the participants discussed EMI being an intervention that reduced trauma symptoms in few sessions.

4.5.5.2 Comprehensive outcomes. The participants discussed the outcomes they have witnessed with their clients as being comprehensive. What stands out for all of the participants was that after EMI sessions clients reported a decrease in symptoms compared to what they were experiencing prior to EMI. More specifically, the participants in this study discussed that clients who have had EMI reported complete resolve of their trauma related symptoms. Participants brought up that clients reported, or others noticed that their symptoms caused little to no distress.

Participants described a more comprehensive outcome by the observation that when clients worked on one specific trauma that EMI also helped a client recover from other traumatic memories. This is consistent with Beaulieu’s (2003) reported experience with EMI, as clients go through EMI, other traumatic memories may come up and once there are no more traumatic memories identified the clinician knows EMI is completed. Beaulieu (personal communication July 7, 2018) described during EMI, memories are accessed and bring forth this information in the sensory networks, for example in the form of physical reactions, visual images, emotions or cognitions. She stated this is very different than what is experienced in talk therapy. For example, a client in talk therapy can control what information is discussed. Beaulieu (personal communication July 7, 2018) provided an example of what she meant by this; if a client does not want to cry in

session the client will switch topics in order to avoid this reaction. In contrast, with EMI, Beaulieu (personal communication July 7, 2018) stated that the client does not control what information is accessed and does not control what reactions will or will not happen. This then allows for any traumatic memory that was causing the distress for the client to be identified and treated. Clients may see this as risk to having EMI and this is something clients need to be made aware to ensure there is informed consent (Beaulieu, 2003). Laura reported that this effect led to a client of hers discontinuing EMI. Laura discussed:

she wasn't able to complete [EMI] because she was in extreme denial about the source of the trauma. The source of the trauma was childhood abuse however she was not prepared to, she was in denial of that. [She] was trying to reason that it was her employment. I think that's why she became so angry in EMI, saying you're just repeating the same thing over, over and over again because she didn't want to go there [childhood abuse].

van der Kolk (2002) suggested that in talk therapy when clients constructed their narrative of the trauma memory, they talked about the essence of what occurred which most times leaves out the important aspects which are stored in the implicit memory. Due to trauma memories being stored in the implicit memory, clients are not always able to consciously recall traumatic memories (van der Kolk, 2014). EMI activates the limbic system, and this allows the trauma memories from the implicit memory to surface (Beaulieu, 2003). Interestingly, van der Kolk (2014) uses EMDR to treat PTSD and what he has found is "once people started to integrate their traumatic memories, they

spontaneously continued to improve” (p. 256). This is interesting as van der Kolk described similar outcomes as EMI but with a different eye movement therapy.

Margo described her experience with clients when using EMI:

as we are doing the movements ... they'll say oh this has come up for me, meaning another trauma so sometimes EMI takes care of everything... they're accessing other pictures of other things that have gone on ... EMI is almost like an umbrella over so many different areas, not just the areas for the trauma that they're dealing with but also some of the other areas.

Margo went on to discuss an example of this with one client:

What ended up happening as she was doing the eye movements, she said, “I can no longer see the picture of my son.” What was happening with him um starting to um see the husband, the ex-husband. What ended up happening is that after, when we finished working with the son, [I] gave her a week, the memories as far as the ex-husband also disappeared.

Genevieve described EMI as allowing her clients to “heal” from their trauma memories.

Genevieve discussed clients “have been restored you know to their... to their former self.” Once they have completed EMI, clients were then able to use their coping skills or then had the ability to learn the needed coping skills. Lisa stated clients “come to like an emotional acceptance sort of, of the event” and that this acceptance allowed the client to “you know, maybe the sadness or the trauma like stays but those are, like you know, the healthier emotions that you can cope with.” Beaulieu (2003) predicted clients, after EMI, may come to an acceptance of their traumatic memory and this acceptance causes their emotions to be less distressing. This acceptance means the client may still have

emotions in regard to the trauma, like sadness, but they are no longer distressed by the memory (Beaulieu, 2003). Lisa also described EMI as it “targets different parts of the brain that EMI gets “right to it” in terms of the problem.” Laura has noticed that clients will have “epiphanies” during EMI sessions which has allowed clients to move forward with new information in order to process the trauma.

The other common factor in all of the participants stories was, for the clients who had EMI, that after EMI was completed, clients were finished with therapy and from their accounts had, for the most part, not returned for services. All the participants discussed this being compelling evidence for them of the effectiveness of EMI and a reason for their continued use of the intervention. Some participants gave examples of clients who had been in counselling for many years or had persistent chronic mental health symptoms that had been able to terminate from counselling. What participants have described as notable was that clients were the ones who were saying they no longer required services. Genevieve described her experience:

I would say often, often they’re pretty much done with therapy. There might just be a couple things to discuss but often when the post-traumatic stress symptoms that were interfering with them within their life, once that is resolved, their problem-solving ability and their tolerance for distress and their difficulties tolerating challenges in relationships or challenges at work or those things start to change for them because they now have so many more resources in them to be able to um make use of.

In Laura's context of using EMI with clients who have a different primary clinician, she has found that consistently she will do one session of EMI, and after one follow-up session clients are able to be discharged from therapy.

4.5.6 Trauma memories are stored in the body. In the stories, all the participants discussed the physiological component in trauma related symptoms. The participants discussed many symptoms that clients reported as being kinesthetic when discussing the impact of trauma memories. Participants also discussed the different areas of the brain that were involved in the storage and retrieval of trauma memories. The participants discussed linking memories and physiology when explaining symptoms to a client, in what the participants witnessed during an EMI session and the description of the changes reported by clients.

When the participants discussed how they explained EMI to clients, the common approach was discussing how trauma memories are stored in the different areas of the brain and body. When participants introduced EMI to clients, all used an approach that discussed a mind-body connection. EMI has been referred to as a neurotherapy, which would necessitate an explanation of trauma related symptoms that incorporated the connection between the brain and physical symptoms experienced (Beaulieu, 2003). Dunne and Farrell (2011) reported similar findings from the participants in their study that when describing EMDR they most often would give a description of how EMDR "facilitates communication between the limbic system and frontal lobe" (p. 182). Margo discussed "how trauma and a lot of other issues they're facing at the time has to do with one part of the brain that just stores emotions, stores pictures." Margo's description is

aligned with van der Kolk's (2014) description of traumatic memories being stored in the limbic system. When explaining EMI with clients Genevieve discussed:

I'll tell them that as we work with these traumatic memories the eyes movements help the brain bring forth information that we're needing to touch on as well it will help your eyes move in new patterns to help the brain integrate that information with other sectors.

In Genevieve's description she acknowledged the role of the eyes in accessing and integrating trauma memories. Participants tried to explain to clients the reasons they were experiencing the symptoms and what the brain's role was in storing memories.

There were a number of examples of symptoms clients described to the participants that were related to physiological responses. Lisa described the experience of one client, "the dentist kind of like retriggered the physical trauma that the person had experienced, so that's kind of where we figured out all the anxiety was coming from." Genevieve stated clients reported living with a "chronic level of anxiety or either disassociating or moving into fight and flight." Participants described all the clients being treated for trauma experiencing physical symptoms of anxiety. van der Kolk (2014) suggested that trauma lives on in the body, meaning that traumatized individuals continue to have a physical reaction as if they are currently being traumatized even if the traumatic event occurred many years ago.

In reexperiencing the trauma, participants noted that clients described a number of different symptoms. Participants discussed clients would report visual images of the trauma always in their mind, physical ailments they experienced during the trauma, and emotional reactions. Any thoughts or emotions they had during the trauma can occur in

the present moment which can leave clients responding in a manner they do not understand the reason for. Genevieve described clients' "nervous system living in a hypervigilant state."

The participants discussed a number of reactions clients have during an EMI session. Participants witnessed clients having the same physical reactions during the EMI session that they most likely had during the traumatic event. For example, clients would experience nausea and other somatic complaints. This was consistent with the qualitative findings from two EMI studies in that participants noted that clients in EMI sessions had strong somatic reactions such as nausea (Struwig & van Breda, 2012; van der Spuy & van Breda, 2018). It was also observed clients may have more of an emotional response like the panic they felt during the trauma. Struwig and van Breda (2012) also found that in an EMI session their participants reported clients had strong emotional reactions that were most likely similar to their emotional reactions at the time of the trauma. Margo described what she has witnessed during an EMI session:

all sorts of emotions are accessed at that time so yes those do come up sometimes it is the physical stuff, sometimes as I said you know they're accessing other pictures of other things that have gone on ... basically any sort of emotion or any sort of physical ailments they had before.

Laura's experience during EMI was that clients will "have the physical sensations that they were experiencing at the time [of the trauma] they reexperience those."

When the participants discussed the outcomes for clients after EMI all participants discussed a "settling" of clients or witnessing, in their opinion, a change in their physiology. For example, Margo described the outcomes for client as "it's almost

like their whole body starts to quiet down.” Laura described it as, “I’ve seen how quickly people can really receive, um relief from their symptoms ... so wanting to be able to offer something a little bit more to be able to release some of the symptoms.” Genevieve stated she has witnessed “somebody who’s rattling with anxiety and panic attacks go from that to being calm and settled in your office and be able to talk about things they couldn’t talk about before.” Lisa described what she witnesses as, “it moves it from this fearful like intense sort of triggering sort of thing to more of an acceptance and it’s, you’re able to think more like rationally and logically about it as opposed to that intense fear.” This was consistent with what Struwig and van Breda (2012) found in their study where participants reported on the TSCC (Briere, 1996) a significant decrease in the physical anxiety symptoms after one EMI session. One participant in this study reported feeling an unexplainable “lightness and relief” (Struwig & van Breda, 2012). This settling of the limbic system was speculated by Beaulieu (personal communication July 7, 2018) as being responsible for the long-term effect of EMI, in that it allows people to be no longer having a physical reaction to their memories. These are some examples of what the participants have observed with successful outcomes with clients after EMI. These examples of changes in physiology suggested clients can experience relief from their physiological symptoms after EMI.

4.6 Summary

This chapter gave an in-depth description of four clinicians from Saskatchewan who use EMI in their clinical practice. Each story was analyzed using the three-dimensional space and was written in chronological order. I provided my reflection and analysis after each story to discuss what I deemed as the significant aspects of each story

in the three-dimensional space. In the reflection and analysis, I also discussed what I thought was the significance and meaning of each story. Next the common themes were discussed and a connection to the literature was made to ensure the findings triangulated. The next chapter discusses implications for practice, future research recommendations and the limitations to this study.

Chapter 5: Discussion

In this narrative inquiry, the participants' praise for EMI shone through in each story. Although each story was unique there were common themes that spanned across the four stories. Each participant spoke of EMI in a very passionate manner which made it difficult at times to not get caught up in the success stories. Through these stories there were many examples of successful client outcomes, however, it was also evident that EMI is not used with all clients. These four participants have found EMI to be an exceptionally good intervention with the clients who are good candidates for EMI.

For this narrative inquiry I was the sole researcher, I completed the interviews, the transcription, analyzing the data and writing the findings. After I completed the interviews and when reflecting on the interviews, I had the impression that the four stories of the participants were very similar. Once I transcribed all of the interviews, I started to become aware of the nuances of each story. As I began analyzing and submersing myself in each story through the three-dimensional lens it became apparent the distinctiveness of each story. It was during this analysis stage that it was very clear each participants story had a very distinct meaning that was unique from the other participants. My reflection and analysis highlighted the meaning and significance of each story to highlight the uniqueness. Although each participant's story was distinctive there are common themes found that bridged the stories together.

5.1 Significance

These narratives highlight the experience of clinicians who use EMI in their clinical practice with clients with trauma related symptoms. Since this was a small qualitative study it does not allow for generalizability however it does provide an in-

depth description of the reasons clinicians use or have used EMI in clinical practice. This study begins to address the gap in literature by providing narratives of clinicians' experiences other than that of Danie Beaulieu.

The significance of this study was to provide some additional research on the experience of using EMI as well as the decision-making process of clinicians who use EMI. There are currently only two published studies on EMI. The other research were two reports by Danie Beaulieu. Adding to this limited literature may provide clinicians with a detailed understanding of the reasons clinicians are using EMI in their practice. It also identified some preliminary challenges of using EMI in clinical practice. This research contributes to what Danie Beaulieu subjectively purports but also suggests that clinicians in current practice can also achieve positive results.

5.2 Limitations

There are several limitations to this study that need to be considered. First is the recruitment strategy, interviewing only participants who were certified in EMI may have contributed to a biased representation of the benefits of using EMI. This is because recruitment for this study came from a provincial list of clinicians who use EMI. Recruiting from this list, skewed the sample right from the beginning as if they did not support the use of EMI they would likely not be on this list. As Lisa stated, "if I didn't think it was beneficial I probably wouldn't use it." The limited number of clinicians who were invited to participate in this study may have lent itself to recruit clinicians who were only attaining successful results. The list of EMI clinicians in Saskatchewan was approximately twenty. Recruiting from a larger number and from a broader range of clinicians may have resulted in obtaining a more balanced representation of using EMI.

The next limitation was the overrepresentation of the positive aspects of EMI. The purpose of the study was to gain an understanding of the experiences of clinicians who use EMI in their clinical practice. It was not my intention to only report on the positive experiences, however, as the findings suggest this was the experiences of these four participants. At the beginning of this research I did not anticipate hearing such successful outcomes. There were some challenges identified throughout the stories and themes however, these were not as well represented as the positive outcomes. The focus on the positive outcomes may be due to relying mainly on client self-report. This may have limited the findings due to the biases of client expectation and the novelty effect. How EMI was presented to clients may have impacted these two effects on change. The findings suggested that the participants provided a very hopeful outcome with EMI when presenting it to clients and this may have impacted how the clients perceived change. Another factor contributing to the client's expectation for change was having clients search on the internet about EMI as this could influence what they expected from EMI. It is also difficult to discern whether clients not returning for service was a positive outcome due to EMI or do to natural attrition from services. Due to these limitations the findings need to be read and appraised with these limitations in mind.

Amongst the narratives, there were discrepancies in how clinicians were using EMI. For example, one clinician identified not using EMI with clients who are on medication while another clinician identified using EMI with clients who are stabilized on medications. Another notable discrepancy was the difference in the time period the clinician completed their post measurement as there were reports of measurement at 1 week, 2 weeks, 1 month and 2 months. In one participant's situation she was not the

primary therapist so the previous therapy may also have an impact on the change. This suggests these four clinicians were not using EMI in the same manner and so there was not fidelity across the intervention. Three out of the four clinicians identified using an eclectic approach as their theoretical orientation and this may have affected how they integrated EMI into their clinical practice (Dunne & Farrell, 2011). This limitation highlights that there may be a need for more clear protocols for EMI and supervision for clinicians. These discrepancies also leave open the question *how do we know EMI was the reason for change?*

Another limitation of this study was due to it being a qualitative inquiry, the findings are not able to be generalized. The findings are limited to the experience of four participants. Also, this study was also limited to participants in Saskatchewan. My own biases of EMI were a limitation, given that I use EMI in my current clinical practice. As discussed at the beginning of this research, my story resonated with many of the participants stories and perhaps the findings may be questioned as researcher allegiance. I tried to mitigate my biases through reflexive journaling by being aware of my own assumptions and opinions of EMI. I also mitigated my biases by immersing myself in each story individually and journaling the decisions I made in terms of coding. In the end, my story was similar to the participants but being aware of this during the research allowed me to be cognizant of it when making decisions throughout the research. I also did not disclose my personal experience with EMI until the end of the interviews and only when asked by participants. Creswell (2013) stated that a good qualitative study offers a holistic account of the topic researched and takes into account multiple perspectives. I

believe this research offered an understanding of the complexities of clinical decision making and the use of EMI that took into account perspectives other than my own.

5.3 Implications for Practice

There are several implications for practice this study identified. At times it is necessary to look beyond empirical research and look for the best available research (Thyer & Pignotti, 2011). There are treatment interventions available like EMI that may provide successful client outcomes that currently lack empirical validation. Lack of empirical validation does not mean that these interventions should be dismissed. Rather clinicians need to be able to critically evaluate what is deemed evidence and the applicability of the intervention for their client (Thyer & Pignotti, 2011). It is also important to note that in Bradley et al.'s (2005) meta-analysis, they did not make generalizations about CBT for the treatment of PTSD. This was due to the RCTs that were reviewed, being unable to control crucial factors such as a client's belief in the therapy and the clinician commitment to the therapy (Bradley et al., 2005). This study has indicated that even though there is minimal empirical evidence for the use of EMI there are many stories of successful outcomes with clients. At this time, these descriptions of client improvement may be part of the best available research but clinicians need to be aware it does not allow for generalizable evidence to make definitive statements (Anastas, 2014). For example, it is most likely to early in the research for generalizations for the use of EMI with first responders on a defined time period. The premise behind social constructive research is that facts were not being sought out but rather to understand the experiences and perspectives of clinicians who use EMI. (O'Connor, 2015).

In practice, consideration of using objective measures to evaluate a treatment's effectiveness as well as factoring in common factors to change is another practice implication. Using objective measurements may be more imperative when using an intervention with minimal empirical evidence. One reason is that clinicians do not recognize a client's deterioration 70% of the time (Hatfield et al., 2010). The findings from this current study suggested that several strategies were used by the participants such as questionnaires and subjective units of distress to try to obtain an objective measurement. However, all of these methods relied on the client's self-report. One clinician did use an outcome measurement along with client self-report for evidence to the effectiveness of EMI which suggested therapy was successful for those specific clients. Even though clinicians have used EMI, it needs to be considered that client outcomes may be related to other factors such as previous therapy, medications, extra-therapeutic factors and/or client perception of change. This is not to dismiss the outcomes that were reported but more that clinicians need to be aware of all the possible factors that could lead to change. Interestingly, one of the identified recommendations from the APA (2017) treatment guidelines was that there were not enough studies reporting on patient-centred outcomes such as quality of life and functional impairment and this is a recommended area for future research.

The next implication for practice is that clinicians need to look beyond current talk therapies when treating clients with a history of trauma. The participants in this study have indicated through their stories that talk therapy does not necessarily help clients with past traumas. Social work interventions usually consist of clients coming in and discussing their problems and problems are worked through via speaking. From the

research in neuroscience it is becoming more apparent that social workers may need to start using therapies that go beyond talk therapy and incorporate the mind and body. Through the participants stories in the current study it was evident that when using EMI, they observed and the client reported, physiological changes that seemed to address the symptoms the clients were reporting.

Clinicians need to be aware of the responsibility that we have to our clients to find effective treatments and also be aware of how biases can affect outcomes. Finding an effective treatment for our clients is the responsibility of clinicians. There are effective treatments such as EMI and it is our responsibility to start evaluating what we believe is evidence for an intervention. We need to be aware of the disadvantages of relying solely on client self-report. We also need to be aware of how our own biases affect our interpretation of treatment outcomes in order to not make generalized claims. From the social constructivist perspective, there are multiple realities to explain a perspective. This then is not to dismiss what these participants were reporting but encouraging clinicians to be aware of how our biases may affect our assessment of treatment interventions. As van der Kolk (2014) stated clinicians in practice is a “hotbed for experimentation” (p. 264) meaning clinicians in practice are ahead of researchers in what is effective. However, critical evaluation of the evidence is necessary (Anastas, 2014).

We cannot always be waiting for research to find the scientific evidence for a therapeutic intervention. We also need to not devalue interventions like EMI just because a dearth of research studies to support it. The findings in this study highlight some of the remarkable results clinicians are getting from using EMI and these findings

add value. This value comes from clinicians in this study from various backgrounds, attaining successful outcomes with clients and with clients with a variety of presenting symptoms. As Thyer and Pignotti (2011) discussed, a critical evaluation of the evidence is needed in order to make decisions. The narratives depicted four participants' experiences in evaluating what they deem as evidence for the effectiveness of EMI. EMI should not be dismissed due to the minimal empirical research but also not generalized based solely on the outcomes with clients.

It was identified that EMI cannot be used with all clients with trauma related symptoms. In all the stories there were examples of clients who were not a good candidate to have EMI, unable to tolerate the intervention, or declined to try EMI. It was also identified, the amount of shame a client experiences may be another reason a client may not be good candidate initially for EMI. Whether cultural differences affected a client declining to try EMI is an area that could be further explored. It is important to understand there are clients who may be excluded or choose to be excluded from the use of EMI. Even though there were descriptions of many successful outcomes there were also clients that EMI could not be used on or who could not tolerate the intervention. It is noteworthy to point out that in the majority of the RCTs that were reviewed for the APA's (2017) treatment guidelines, those RCTs had similar exclusion criteria for clients as reported in this study. Higher dropout rates with CBT-based treatments that focus on exposure may be due to the client feeling too overstimulated from reliving the traumas and not experiencing quick relief from their symptoms (van der Kolk, 2014). This implication is noteworthy as EMI, as well as EBPs, may not be able to be used with all clients with trauma related symptoms.

This research offers potential hope for both clients and clinicians. From my experience in counselling, clinicians do not always get to witness or observe the successful outcomes with clients. The participants' descriptions of what they have witnessed provides practicing clinicians hope that there is a therapeutic technique that can bring about positive change. We need to remember hope is very powerful in terms of client change (Duncan, 2010). There is also hope for clients with trauma related symptoms in that there is a treatment intervention that may help them.

It is important to consider EMI may be an effective intervention in clinical practice. The findings from this study provide examples that EMI is a brief and effective intervention for the clients EMI is appropriate for. Given lengthy waitlists for community mental health clinics EMI may be able to provide a brief and effective therapy. Also, given the enduring impact trauma can have on individuals, EMI may be an intervention that provides these individuals with relief from their symptoms from trauma if these individuals are good candidates. This to me would be the most important implication from this research. For the clients who were able to be treated with EMI, not only were they feeling better, but they were no longer being plagued by their trauma memories.

5.4 Recommendations for Future Research

Given the qualitative findings for the use of EMI, it would be recommended that EMI be studied through empirical research. Empirically validated studies would help to support the qualitative research and this would address the issue that was found in this study of relying mainly on client self-report. There have been empirically supported studies for EMDR and conducting similar studies for EMI is necessary. Given the

number of clinicians who use EMI in Canada and around the world it is time for research to evaluate what is happening in practice. Danie Beaulieu (personal communication July 7, 2018) is supportive of empirical research however, she does not want to lead research projects on EMI. Since Beaulieu is a practitioner and not a researcher this may be one reason EMI has not been more rigorously studied. Also, the questioning of whether eye movements are necessary in EMDR may also limit researcher's interest in EMI. In this study, the participants all commented that they would be supportive of more research but that it was not going to hinder them from continuing to use EMI.

Studies examining the long-term effects of EMI are needed. The current literature on EMI is based on outcomes after being treated with EMI, however there is no research into long-term outcomes. A study examining whether client's improvements are maintained over time are recommended. Another recommendation is given that the findings from this study were overly positive, future research into the challenges of implementing EMI into clinical practice may be beneficial. This could provide some valuable information for the reason's clinicians are not using EMI more often with clients.

5.5 Conclusion

This narrative inquiry sought to answer the research question of *What are the experiences of clinicians as they use Eye Movement Integration Therapy (EMI) in their clinical practice?* The purpose of this study was to add to the research on EMI in order to provide information about the utility of EMI as a therapeutic intervention. This study expanded on the limited research on EMI by providing detailed accounts of how clinicians actually use EMI with clients. The findings from this research provides mental

health clinicians with some knowledge about the utility of the therapeutic intervention of Eye Movement Integration Therapy (EMI). Also, this study highlighted some of the important aspects and challenges of EMI based on the participants' experiences. From their experience, the participants thought using EMI was an effective therapeutic intervention for those clients who were able to have EMI.

As this research was based on a social constructivist point of view, it was my intention to provide practice knowledge to co-construct the reasons clinicians use EMI. This research provided insight into what are important factors to how clinicians decide to use a therapeutic intervention with minimal research. The findings also provided an account of what these clinicians deem as evidence for EMI as a therapeutic intervention that in turn guides their practice decisions. The intention of this research was to expand the discussion of using EMI in clinical practice and to understand the experiences of four clinicians in Saskatchewan that are using EMI. This study indicates there are numerous factors that clinicians need to consider when making clinical decisions in the treatment of trauma and that there is need for more research and consideration given to ensure findings are relevant to clinicians in practice.

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Appendices

Appendix A – University of Regina Ethics Approval



Research Ethics Board Certificate of Approval

PRINCIPAL INVESTIGATOR
Patricia Dekowny

DEPARTMENT
Faculty of Social Work

REB#
2018-095

SUPERVISOR
Dr. Kara Fletcher

TITLE
The Decision to Use Eye Movement Integration Therapy: Exploring Clinician's Experience's through a Narrative Inquiry

APPROVED ON
June 20, 2018

RENEWAL DATE
June 20, 2019

APPROVAL OF
Application for Behavioural Research Ethics Review
Consent Form
Interview Guide
Recruitment Email

Full Board Meeting

Delegated Review

The University of Regina Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol, or related documents.

Any significant changes to your proposed method, procedures or related documents should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

ONGOING REVIEW REQUIREMENTS

In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month of the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for the renewal and closure forms:

<https://www.uregina.ca/research/for-faculty-staff/ethics-compliance/human/ethicsforms.html>



Raven Sinclair, BA, CISW, BSW, MSW, PhD
REB Chair

Please send all correspondence to:

Research Office
University of Regina
Research and Innovation Centre 109
Regina, SK S4S 0A2
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Appendix B – Recruitment Email



Faculty of Social Work

21-June-2018

To whom it may concern;

You are invited to participate in a study about your experience in using Eye Movement Integration Therapy with clients who have trauma related symptoms.

Participation involves one semi-structured interview lasting 60 – 90 minutes. The interview may be in person, via skype or telephone which will be decided upon agreement to participate in the study. Upon completion of the transcripts you will be given the opportunity to review your transcript for accuracy. One follow-up interview may be asked of you lasting up to 30 minutes. You will also be asked to review the initial findings for accuracy.

Any identifying information will be kept confidential. Your participation in this study is voluntary and there is no honorarium provided. This study has been reviewed and received approval through the Research Ethics Board, University of Regina. The information from this study will be used for Patti Dekowny's Master of Social Work thesis.

If you are interested in participating or require additional information please contact Patti Dekowny at houldswp@uregina.ca or (306) 741 0896.

Thank-you for your consideration in participating in this research it is much appreciated.

Sincerely,

Patti Dekowny BA, BSW, RSW

Appendix C – Consent Form



Participant Consent Form

Project Title: The Decision to Use Eye Movement Integration Therapy: Exploring Clinician’s Experience’s through a Narrative Inquiry

Researcher(s): Patricia Dekowny BA, BSW, RSW
Master of Social Work Student
Faculty of Social Work
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houldswp@uregina.ca
306-741-0896

Supervisor: Kara Fletcher BA, MSW, PhD, RSW
Assistant Professor
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Kara.fletcher@uregina.ca
306-664-7380

Purpose(s) and Objective(s) of the Research:

The purpose of this research is to explore clinicians’ experiences in using Eye Movement Integration Therapy (EMI) with clients. The goal is to understand the reasons clinicians are using EMI and what clinicians see as valid evidence to EMI’s perceived effectiveness. The data collected for this research will be used to complete a thesis to meet the requirement for the MSW program.

Procedures:

A semi-structured interview will be conducted either in-person, via skype or telephone based on your preference and location. Interview will be between 60 – 90 minutes. The interview will ask questions about your experience in using EMI in your clinical practice. You are invited to elaborate on any question in order to provide a detailed account of any of your experiences in using EMI. You also may refrain from answering any question. The interview will be audio recorded and transcribed verbatim.

A follow-up interview may be requested and be approximately 30-45 minutes. A follow-up interview will either be via Skype or telephone based on your preference. The follow-up interview will be audio recorded and transcribed verbatim. After the transcripts of the interview are completed, you will be offered the opportunity to review their transcript to ensure accuracy. Once the data is analyzed and the findings are written into your story it will be returned to you to ensure accuracy of your story was captured. Please feel free to ask any questions regarding the procedures and goals of the study or your role. You may also choose to turn the audio recording off at any time.

Funded by: There is no funding for this research

Potential Risks:

Due to the nature of the topic, you may find recounting some of these experiences distressing. If at any time you feel uncomfortable or wish to terminate the interview, please tell the interviewer.

Potential Benefits:

The potential benefit of this research is to provide a better understanding of the reasons clinicians use EMI and the effects of EMI with clients to better understand the perceived clinical worth of the intervention.

Compensation:

There is no compensation for this study.

Confidentiality:

Only the researcher and the researcher's supervisor will have access to identifying data. Each interview will be given a number and your name will not be attached to the recording. The findings will be written using a pseudonym.

- **Storage of Data:**

- The audio recording will be password protected and the transcripts will be password protected. Both will be stored on a password protected computer.
- Informed consent and identifying information will be stored in a locked box in a locked office.
- Once the thesis is completed the data will be transferred to a USB and stored in a locked box in a locked office. The files will be deleted from the computer.
- When the data is no longer required it will be destroyed.

Right to Withdraw:

- Your participation is voluntary and you can answer only those questions that you are comfortable with. You may withdraw from the research project for any reason, at any time without explanation or penalty of any sort.
- Should you wish to withdraw, all data collected from you (audio and transcripts) will be destroyed.
- Your right to withdraw data from the study will apply until **one month following your interview**. After this date, it is possible that some results have been analyzed, written up and/or presented and it may not be possible to withdraw your data.

Follow up:

- The initial findings from this study will be provided to you for your review to ensure accuracy. You will be asked to identify areas that need to be corrected, further developed or removed. To obtain results from the study, please feel free to contact Patricia Dekowny at 306-741 0896 or houldswp@uregina.ca

Questions or Concerns:

- Contact the researcher(s) using the information at the top of page 1;
- This project has been approved on ethical grounds by the UofR Research Ethics Board on (insert date). Any questions regarding your rights as a participant may be addressed to the committee at (306-585-4775 or research.ethics@uregina.ca). Out of town participants may call collect. OR

Consent:

- Option one will be used for the initial consent at the start of the first interview
- Option 3 will be used for subsequent interviews.

Continued or On-going Consent:

- One follow-up interview may be required. At this time, verbal consent will be obtained from you to continue with the study.

Option 1 - SIGNED CONSENT

Your signature below indicates that you have read and understand the description provided; I have had an opportunity to ask questions and my/our questions have been answered. I consent to participate in the research project. A copy of this Consent Form has been given to me for my records.

<i>Name of Participant</i>	<i>Signature</i>	<i>Date</i>
<i>Researcher's Signature</i>	<i>Date</i>	

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Option 3 - ORAL CONSENT

Oral Consent: If on the other hand the consent has been obtained orally, this should be recorded. For example, the Consent Form dated, and signed by the researcher(s) indicating that “I read and explained this Consent Form to the participant before receiving the participant’s consent, and the participant had knowledge of its contents and appeared to understand it.” In addition, consent may be audio or videotaped.

<i>Name of Participant</i>	<i>Researcher's Signature</i>	<i>Date</i>
----------------------------	-------------------------------	-------------

Appendix D – Interview Guide

1. Gather information about participant. Tell me about your professional career?
 - What is your profession? How many years have you worked in this profession? What is your employment history in relation to your profession? What theoretical orientation do you practice from?
2. What has been your experience in using EMI in your clinical practice?
 - How did you hear about EMI?
 - What factors led to your decision to take the EMI training?
 - What is your overall impression of EMI?
 - How long have you been using EMI?
 - How did you decide to use EMI in your practice?
 - Prior to EMI what therapy did you use to treat trauma?
3. What has been your experience in using EMI with clients?
 - What types of identified problems do you use EMI with?
 - How do you present EMI to clients?
 - How often do you use EMI with clients?
 - Approximately how many clients have you used EMI with?
 - How do you decide EMI is an appropriate intervention for a client?
 - On average how many sessions do you use EMI with for one client?
 - What have clients said about their experience of EMI?
 - What factors do you use to determine client is effective/not effective with a client?
4. What are the challenges of using EMI?

5. What does your agency think of you using EMI?
 - Are you supported in using EMI by your supervisor?
6. What do you see as the evidence for the efficacy of EMI?
 - How do you feel about the lack of research on EMI?
7. How has EMI affected you professionally and personally?
 - How has EMI changed your clinical practice?
 - Share how you felt about using EMI at the beginning? And now?
8. Stories of results. Please share within the confines of confidentiality.
 - Is there a story you could share about a successful outcome with a client?
 - Is there a story you could share of an unsuccessful outcome with a client?
9. Is there anything else you would like to share about using EMI?

Appendix B

Client Assessment Questionnaire

Client name: _____

Assessment date: _____ Age: _____

Sex: Male
 Female

Civil status: Single
 Married
 Divorced

Description of trauma or triggering event: _____

Date (or dates) of trauma: _____

Symptom	Symptom intensity in the past two weeks									
	<i>Not at all</i>					<i>Worst imaginable</i>				
	1	2	3	4	5	6	7	8	9	10
Physical symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychological distress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sadness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Avoidance (<i>situations related to the trauma</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nightmares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disturbances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-esteem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual relations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpersonal relations:										
Spouse/partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Session number: _____

Session length: _____

Therapist's signature: _____

