DCPsych thesis

An exploration of how integrative therapists working with clients presenting with complex trauma use EMDR as part of their practice: a grounded theory study

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An Exploration of How Integrative Therapists Working with Clients Presenting with Complex Trauma Use EMDR as Part of Their Practice: A Grounded Theory Study

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Abstract

Eye Movement Desensitisation and Reprocessing (EMDR) is widely used for treating complex trauma. Although there is a large evidence base around the efficacy of EMDR, there is little practice-based research into how EMDR therapists work with clients. EMDR therapists come from a range of professional backgrounds and basic EMDR training provides limited guidance on how to integrate it into a therapist's existing practice. This research therefore aimed to explore how Counselling Psychologists and Psychotherapists, who define their practice as 'integrative', use EMDR as part of their practice when working with clients presenting with complex trauma.

Two rounds of semi-structured interviews were conducted with nine integratively orientated EMDR therapists who work with clients presenting with complex trauma. Constructivist grounded theory was used to explore how these therapists work with their clients. A theory was constructed from the data, demonstrating the unique and individual nature of the way each therapist works with different clients, but with significant commonalities. Five main categories resulted: 'Relational Stance', 'Working with Developmental History', 'Parts Work', 'Structure and Process' and Right-Brain Processes'. The interactions and relationships between the categories demonstrate the fluid, dynamic, co-created and highly individual nature of this way of working and led to the development of the core category 'Integration – Uniqueness with Commonalities'.

EMDR is a relatively new therapy and the ways in which it is researched, trained and practiced continue to evolve. This research has relevance for clinicians working with complex trauma who want to use EMDR as part of their practice. The resulting theory has been developed to support clinicians to work at an appropriate level of complexity when using EMDR with clients presenting with complex trauma as part of an integrative practice. It could also serve to inform training, practice and further research, particularly given the diverse clinical backgrounds of EMDR therapists.

Chapter 1: Introduction

1.1 Overview of Chapter

In this chapter I will describe Eye Movement Desensitisation and Reprocessing (EMDR), its origins, current challenges in the field and how the research question evolved from my clinical practice. In addition, I will demonstrate how I have become immersed in the world of EMDR in a variety of ways, some of which have been unexpected. I will describe how my chosen methodology, constructivist grounded theory, embraces the subjectivity of the researcher. Being an insider researcher has implications on the research process and outcomes. It is important for the reader to understand the extent of my immersion in the field of EMDR, and I explore and reflect on the impact and implications of my subjectivity throughout this work. My chosen methodology has also shaped the format of this dissertation and I have explained this below to allow the reader to understand the rationale for the presentation of my research.

1.2 An Introduction to EMDR

The developer of EMDR, Francine Shapiro, discovered the role of eye movement in used in EMDR by chance. She had been walking in a park when she observed that some disturbing thoughts she had been experiencing were disappearing and becoming less upsetting without her making any conscious effort. She realised that whilst experiencing the disturbing thoughts her eyes were moving 'rapidly back and forth in an upward diagonal'. When she tried this process again consciously, holding a disturbing thought whilst moving her eyes in this way, she found that again the thoughts either vanished or 'lost their charge' (Shapiro, 2001).

Shapiro then proceeded to investigate further using other people who she instructed to hold a disturbing thought in their mind whilst rapidly moving their eyes back and forth. She discovered that most people found it very difficult to maintain the speed and duration of eye movement required and so 'led' their eye movements with her finger

to a comparable speed that she had been using on herself. Over the subsequent six months, Shapiro worked with around 70 people and developed a standard procedure for the speed and direction of the eye movements, the methods by which the sessions were opened and closed and the different aspects of and feelings of the memories involved. These standardised procedures consistently succeeded in reducing anxiety levels (Shapiro, 2001).

1.3 The Challenges of EMDR and what is missing from the field

I have been fascinated by the concept and theory behind EMDR therapy since the first year of my Professional Doctorate in Counselling Psychology and Psychotherapy (DCPsych) training, when I chose to write an assignment on 'how research informs practice', on EMDR. However, I was unable to train in EMDR until I had my UK Council for Psychotherapy (UKCP) registration which I was awarded in the fifth year of my training. By this time, I had been practising clinically as a trainee for almost three years.

To undergo training in EMDR a clinical background in mental health is required. This must be evidenced by professional accreditation (The Health and Care Professionals Council (HCPC) for Psychologists and UKCP for Psychotherapists among others). This means that the training and clinical backgrounds of EMDR trainees varies enormously and EMDR therapists can come from backgrounds as diverse as social work and occupational health.

The clinical component of my Counselling Psychology and Psychotherapy training was integrative and relational. Evidence of working in this way had to be demonstrated in order to pass the clinical dissertation and viva and achieve UKCP registration; a requirement of my DCPsych training. Having completed the three parts of the basic EMDR training, I was initially struck by how awkward and formulaic it felt. This was in stark contrast to my established integrative way of working. There were 'magical' moments of healing, but also a great deal of 'misses' which I felt sure were due to my awkwardness in delivering this type of therapy. The training left me with the understanding that there is a right and a wrong way to 'do' EMDR and 'it wouldn't work if you didn't do it the right way'.

The first time I used EMDR with a client I felt I was 'shaming' them by trying to get the 'right' negative cognition. This experience was with a client I had been working with for some months and felt entirely incongruous with our previous work. I persevered with EMDR in terms of practice and supervision, but my experience of using EMDR alongside my existing practice felt as though I was adding on a 'technique' rather than expanding and evolving my integrative practice. This challenge was reinforced at the Process Approval Panel (PAP) I attended to present my research proposal. One of my panellists was extremely sceptical about the possibility that EMDR could be integrated. This did not impact the outcome of my PAP as my question is "How do integrative therapists 'use' EMDR" as opposed to 'how do therapists 'integrate' EMDR". This left me feeling deflated because my personal reasons for exploring this were to understand how experienced integrative therapists use EMDR, and as I learned from my PAP, I was implicitly hoping that they may have developed the ability to integrate this 'technique' of EMDR in a way I was unable to do and in a way which my PAP panellist was unable to imagine. However, it felt important to try to understand how experienced integrative practitioners use EMDR as part of their practice. I felt that this understanding could provide an important contribution to the field of Counselling Psychology by developing a theory around this to inform and support Counselling Psychologists who have an integrative practice as they develop their practice to include EMDR. This feels important as the basic training for EMDR is largely technique driven and therefore difficult to align with an integrative practice. In addition, EMDR is an effective and widely used treatment which many Counselling Psychologists and Psychotherapists would benefit from being able to incorporate into their practice.

1.4 The Development of my Involvement in the Field

I have become deeply passionate about the scope of EMDR, and my involvement in this field has expanded in ways I could not have imagined when I started this research. This journey really began once I had sent out my 'call for participants' (which I will examine fully in the 'methodology' chapter). I received an extremely enthusiastic response from the EMDR community and subsequently had several interactions with each of the respondents, particularly with those who became my participants in this

endeavour. These interactions, both in terms of general communication and data collection, began to broaden my understanding of the field and led me to become a participant in an advanced EMDR training programme, 'Attachment Informed EMDR' (AI-EMDR). I was drawn to this training as it supported the integration of EMDR into my practice and identified EMDR as integrative, with an attachment focus. The trainer took a real interest in this piece of research and we began to discuss potential collaborative work including possible future research, writing and my involvement in training workshops. However, it was at the beginning of the pandemic that our collaboration really evolved.

The shift to online working bought about by the pandemic, meant that the training provider I had been collaborating with suddenly had to take all training workshops online. We therefore worked together to develop an online training process. As well as managing the technical side of the training workshops, I have become more involved in developing the organisation. We are currently working together to evolve the training workshops to include different offerings such as EMDR for addiction and EMDR for couples. Through my developing clinical practice, this piece of research and being involved in this training organisation, I have been inspired to help to develop the field in the form of a training and development community which promotes the supervision, clinical referral, career development, training and peer support network of clinicians working in this way.

1.5 Bilateral Base

Alongside this involvement with EMDR training and professional development and my own research and clinical practice, I had also become involved in developing technology for EMDR therapists. This began after completing the second stage of my basic EMDR training and beginning to use EMDR more frequently. I found administering manual visual bilateral stimulation (moving my hand backwards and forwards across the client's field of vision) was tiring and that my shoulder made an unfortunate sound which was a little distracting for both me and my clients! I investigated alternative means of administering bilateral stimulation (BLS) which were available in the form of electronic 'lightbars' (a plastic tube with a moving LED light for

the client to follow with their eyes), handheld ‘buzzers’ which administer a short vibration in alternate hands, or headphones which deliver a tone in alternate ears. I discovered that there were only three providers of such equipment in the world and all the equipment seemed extremely expensive and the technology somewhat outdated. I also discovered from my experience of EMDR as a client that this equipment could be unreliable.

I wondered if I could make a better version and if so whether this could be done at a purchase cost that would make it accessible to many more therapists than the existing options. Ethically this was important to me as EMDR is widely used within the NHS and in charities and non-profit organisations and I feel that equipment that can help provide the best possible experience for therapist and client should be accessible to these organisations. So, I put together a small team (now known as ‘Bilateral Base’) of product designers and software engineers to find out.

The onset of the pandemic at the beginning of 2020 and the move to online working posed additional challenges to therapists using EMDR, in terms of providing the necessary BLS. None of the methods described above are easily delivered online, so my team at Bilateral Base quickly diversified and developed an online video-consulting platform, with integrated visual, audio and tactile means of delivering BLS all controlled remotely by the therapist. We launched our online platform as a ‘beta’ so therapists would have access to the tools as soon as possible. Launching a beta product free of charge to support therapists during the pandemic meant we quickly built a user base and I interacted frequently with therapists all over the world. We built what felt like a ‘community’ of users and worked with this community to steadily build and evolve our online platform, based on their suggestions and feedback.

Bilateral Base now has several thousand users worldwide and we are on the cusp of launching our hardware for in-person use (lightbar and tactile ‘pods’), which we resumed the development of once the online platform had been completed. As well as speaking to therapists all over the world, I have been approached by the Ministry of Defence, various NHS trusts and several ‘not for profit’ organisations, which has given me a good insight into the way EMDR is used within these organisations. It has broadened my horizons in the field and solidified my wish to improve the experience

of both online and in-person EMDR for therapists and clients alike. I have had contact with several senior training providers, and I am currently talking to a member of the 'Council of Scholars' (a group of 50 the world's leading EMDR researchers and clinicians, bought together to 'assess, guide and direct the future of EMDR therapy') about incorporating a data collection tool for research purposes into the Bilateral Base online platform.

1.6 Possible Implications of my Immersion in the Field

As I have described, this research and my involvement in the field have had a considerable impact on each other. From the early days of my DCPsych training, it became clear that both my clinical practice and my understanding of theory and research came naturally from an 'inside-out' position. I have conducted this piece of research from the point of view of an 'insider'. My immersion in this field has become deeper and more complex throughout the research process so an overview of this journey here seems helpful, to elucidate the subjective lens through which this research developed. I discuss both the ethical implications of my immersion in the field and the resulting need for a robust methodology that honours researcher subjectivity, in the methodology chapter.

The felt sense of my research experience has been rather different to the description as set out above. It has been a multi-dimensional whirlwind of an experience with different parts overlapping and integrating, but at the same time, rather like the experience of being in the sea; I've felt as if I've been riding huge, exhilarating waves which then crash down catching me in the undertow. It has been a dizzying and hugely exhilarating experience, but also utterly overwhelming at times and on more than one occasion I have wished a lifeboat would come along and rescue me! I wanted to convey this felt experience here as it had a direct impact on this piece of research in that it is my excitement and passion for this way of working that has propelled me forwards, but at the same time I am aware that the potential for implicit bias is huge. This research was the start of a journey in this field which now includes clinical practice, training, technology and a drive to help develop this way of working for the benefit of therapists and clients alike. All of these areas overlap and interweave and

have contributed to my ‘inside-out’ and ‘outside in’ learning experience. I have been mindful throughout the research process of the need for reflexivity which is vital when using a methodology which embraces the subjective experience of the researcher. I have detailed the ways in which this was carried out in the following chapter.

1.7 Explaining the Presentation of this Research Project

In this study I have used constructivist grounded theory methodology (CGT). I describe this in detail in the methodology chapter. However, CGT methodology significantly impacts the way in which the research is presented and this may deviate from that of other methodologies. It therefore felt important to be explicit about this at this stage, so it is clear to the reader both in terms of what to expect and in terms of why this research project is presented in this way.

In the original version of grounded theory (Glaser & Strauss, 1967), the literature should be ignored until after data analysis to ensure that the categories are not influenced by existing theories. There has been much debate about this over the years as the absence of a literature review prior to data collection presents significant challenges. Firstly, an absence of awareness of existing literature may lead researchers to make decisions regarding the direction of the research which are inadequately informed. Secondly, there is a conflict with most institutional requirements as students are usually required to present a good understanding of their chosen field in order to justify their research aims, research question and choice of methodology.

CGT recognises the need for an initial literature review and in doing so acknowledges that researchers invariably bring knowledge and pre-conceptions to their research. However, Charmaz (2014) also recognises Glazer and Strauss’ (1967) concern about the influences of early-stage literature examination and advocates that researchers should take steps to avoid being overtly influenced by this. The approach I have adopted, is to undertake an initial literature review prior to data collection to establish whether similar pieces of research have been undertaken. This was to inform my research aims and question and provide the researcher’s rationale. However, I have

also made a concerted effort not to be disproportionately influenced by these, thereby addressing Glazer and Strauss' (1967) concern. I addressed this by adopting a reflexive stance and being 'critically aware' of the research choices and decisions I made and the reasons behind them (Charmaz, 2014 and Dunne, 2011). I recorded these reflections by writing memos, a process I continued throughout the research process. The second literature review is included and interwoven in the discussion chapter and serves to contextualise my grounded theory, by examining the literature relating to the grounded theory constructed through the data collection and analysis.

Chapter 2: Initial Literature Review

2.1 Overview of Chapter

In this chapter, I present the literature to contextualise this area of study. As Dunne and Gamze (2020) advise, I have focussed on introducing the area of study in question and the existing approaches to research in this area. I have been careful to keep this initial literature review broad and to avoid in-depth discussion. This will come in the second literature review within the discussion chapter, after the presentation of my findings and will examine the literature directly related to my findings, thereby "earning"; their way into the discussion (Charmaz, 2014).

I begin by explaining the rationale for the approach to this initial literature review in more depth. I then briefly consider the development of EMDR and the conditions it has historically been used to treat followed by an explanation of the background and clinical implications of complex trauma. I follow this with an examination of the literature relating to EMDR as a stand-alone treatment for complex trauma, which in turn, leads to an evaluation of the available literature that explores the use of EMDR as part of an integrative therapeutic approach for the treatment of complex trauma.

The literature led me to consider the perspective from which the associated research had been conducted. There is limited available literature on EMDR for the treatment of complex trauma. The gaps in this point to perspective as well as content. For this reason, I examine the literature which compares empirical research in this field to research from a clinician's perspective, with the practicing therapist in mind, and conclude by considering key concepts that emerge from the literature. I conclude this initial literature review by giving an overview of the history of integration in psychology and psychotherapy and a review of the literature relating to complex trauma and integrative therapy.

2.2 Rationale for this approach to the literature review

In a dialogue discussion around the challenges of the role of the literature review in a grounded theory study, Dunne and Gamze (2020) describe the initial literature review as offering a “broad contextualisation of the study”, while at the same time appreciating the position and concern of Glaser and Strauss (1967) that examining the literature in detail early on, could unduly influence the data, analysis and resulting theory.

As discussed in the previous chapter, this initial literature review therefore serves a different purpose to a more conventional literature review. The literature presented and examined represents the available evidence at the point in time that it was conducted i.e., prior to data collection and analysis. I wanted to let this literature review "lie fallow" (Charmaz, 2014, p.166) until the later stages of the research in order to honour the data over the literature during the research process in keeping with the methodological position.

The second part of the review of the literature is included in the discussion chapter and was conducted following the analysis and the development of the Grounded Theory (GT). It therefore contains literature that is directly relevant to the developed theory and in some cases more recent than the literature that was available when the review of the literature contained in this chapter was examined.

2.3 Search Strategy

The search for this initial literature review was conducted using EBSCO to search the electronic databases: Psychology and Behavioural Sciences Collection (PBSC), PsychINFO and PsychARTICLES. My initial searches were conducted using the keywords from my research question in order to access the literature necessary to present a broad contextualisation of the study (Dunne and Gamze, 2020). The keywords entered into the ‘Article Title’ search field were: ‘EMDR’. ‘EMDR’ AND ‘Integration’, ‘EMDR’ AND ‘Complex Trauma’, ‘EMDR’ AND ‘Complex PTSD’ ‘Complex Trauma’, Complex PTSD’. I then also searched for ‘Practice Based Evidence’ and ‘Psychotherapy Integration’, ‘Complex Trauma’ AND ‘Integrative

Therapy' and 'Complex PTSD' AND 'Integrative Therapy'. I examined the titles and abstracts of the search results and obtained the full text version of the papers I deemed to be relevant to this research. I obtained further literature by manually searching the reference lists of relevant studies obtained though my literature search.

2.4 Background of EMDR – Historical Development

Shapiro (1989) conducted the first controlled study of EMDR, carried out in 1989, in order to establish its efficacy in the treatment of PTSD. The treatment group showed reduced anxiety levels and a marked increase in the strength of their positive beliefs, while the control group showed increased levels of anxiety (Shapiro, 1989a). Despite the positive results, this study lacked standardised measures and although there was a control group, there was no 'blind' element to the study.

From her research and experience of using EMDR, Shapiro (2001a) developed her model of pathogenesis which she called the 'Adaptive Information Processing' (AIP) model. The main premise of this model is that memories, whether explicit or implicit and which are dysfunctional or insufficiently processed, lead to a wide range of mental disorders and maladaptive responses (Hase et al., 2017). These memories, whether cognitive, affect-based or somatic are the focus of the EMDR protocol which serves to 'desensitise' these memories by reducing their emotional impact and by 'reprocessing' them into adaptive memory networks (Solomon & Shapiro, 2008).

Since Shapiro's (1989) study, a number of controlled studies have been published which have demonstrated the effectiveness of EMDR for the treatment PTSD. Indeed, more studies have been carried out into EMDR for the treatment of PTSD than any other standardised treatment (Taylor & Van Etten, 1998). They have resulted in the practice guidelines of the 'International Society for Traumatic Stress Studies', designating EMDR as 'effective treatment for PTSD' (Chemtob et al, 2001). EMDR was also recommended for the treatment of PTSD by the UK Department of Health in 2001 (Shapiro, 2001). Less research has been undertaken examining EMDR as a treatment for 'complex trauma' (Korn, 2009). However, following the inclusion of Complex PTSD in the ICD-11, Bongaerts, et al (2022) conducted a trauma-focussed

treatment outcome study for patients with complex PTSD. This study showed symptoms decreased significantly in both PTSD and Complex PTSD following an intensive eight-day treatment programme. The treatment in this study was however multi-modality and although it included EMDR, the efficacy of EMDR in this context cannot be adequately distinguished from the combined efficacy of EMDR, psycho education, prolonged exposure and physical activity.

In 2018 'The Council of Scholars of the Future of EMDR Therapy Project' was formed in order to define EMDR and to address challenges in four specific areas: research, clinical practice, training and accreditation (Laliotis et al, 2021). The 'What is EMDR' workgroup concluded that EMDR should be divided into three different categories in order for treatment planning and expectations to be better understood. These categories are: 'EMDR Psychotherapy', 'EMDR treatment protocols' and 'EMDR Derived Techniques'. Laliotis et al (2021) suggest that the majority of EMDR Therapists who define themselves as 'psychotherapists' will be working with clients presenting with "complex developmental trauma" (p193). This paper defines EMDR Psychotherapy as "Transformative Change Within the Therapeutic Relationship" (p193). It is suggested that 'EMDR Psychotherapy' is a way of working with clients beyond the presenting symptoms and addresses clients' attachment and developmental deficits. EMDR Psychotherapy takes a relational stance and facilitates processing within a relational experience.

This paper and the workshop it was derived from was written by and formed of nine experts in the field of EMDR and the categories as specified in the previous paragraph were formulated through a combination of academic discussion and analysis of Shapiro's core texts. It does not include practice-based research from clinicians and such research could enable the conclusions of this paper to be enriched, expanded upon and better understood.

2.5 Post Traumatic Stress Disorder

The name 'Post Traumatic Stress Disorder' (PTSD) first appeared in the *Diagnostic and Statistical Manual of Mental Disorders, (3rd ed.*; DSM-3; American Psychiatric

Association [APA] 1980), but the concept of this disorder has a long history, which is often linked to the history of war. The diagnosis first appeared in the DSM-I (APA, 1952) under the name 'Gross Stress Reaction'. However, the diagnosis was omitted in the DSM-II (APA,1968) without any official justification. The most logical explanation was that the disorder was linked to war and combat and the DSM-II was written at a time of peace (Reserved, 2015). No official diagnostic category therefore existed until publication of the DSM-III (APA,1980) in which PTSD was defined as 'A stress disorder that is a final common pathway occurring as a consequence of many different types of stressors, including both combat and civilian stress'. The DSM-III-R (APA, 1987) placed more emphasis on the psychological nature of the stressor as opposed to the stressor being purely comprised of physical components. The definition of the stressor was further modified in the DSM-IV (APA, 1994) to include stresses experienced by others as 'a threat to the physical integrity of self or others' (APA, 1994 p427). The latest revision in the DSM-V (APA, 2013) no longer classifies PTSD as an 'anxiety disorder' but places it under a new category 'Trauma and stressor-related disorders', in which the onset of every disorder has been preceded by exposure to a 'traumatic or otherwise adverse environmental event'. The diagnosis of PTSD covers a wide range of conditions, ranging from patients experiencing a one-time traumatic incident to those who have been exposed to chronic traumatisation over time or repeated assaults sometimes from an early age (Nowill, 2010).

2.6 Complex Trauma

Complex trauma occurs when an individual experiences a traumatic experience repeatedly over a prolonged period of time (Herman, 2011). Examples of situations that commonly cause complex trauma are physical or sexual abuse and combat (JoAn, 2000). Complex trauma resulting from, for example, abuse in childhood, is often accompanied by attachment issues, the combination of which can have significant impact on areas such as psychosocial development, impulse control and the ability to form secure attachments in adulthood (Korn, 2009). Complex trauma may also be accompanied by problems in interpersonal relations, somatization, affect regulation and systems of meaning (Herman, 1992).

The conceptualisation and understanding of PTSD has evolved and in addition to a single traumatic event, the impact of a dysfunctional attachment configuration and developmental history now increasingly forms part of what underpins this diagnosis (Kaptan and Brayne, 2021). This has in some ways been reflected in the evolution of the definitions in the DSM and ICD; 'PTSD with associated features' or 'complex trauma' in DSM-IV-TR (APA, 2000) is characterised by high comorbidity on both DSM-IV Axis I and II. Following research over the last few decades into post-traumatic stress and adaptations, it became increasingly clear that the diagnosis of PTSD as set out by the DSM-IV (APA, 1994), was lacking, particularly with regard to the extremely complex symptoms that often emerge following multiple traumatic events or chronic abuse (Korn, 2009).

Empirical studies as well as neurobiological findings support the distinction between complex trauma and DSM-defined PTSD (van der Kolk et al, 2005). Responding to the high rate of comorbidity between PTSD and other psychiatric disorders (Kessler, 1995) as well as the increasingly apparent limitations of the existing PTSD criteria, the DSM IV PTSD workgroup studied the existing research on trauma and children, female domestic violence victims and concentration camp survivors. In doing so, they identified 27 core symptoms seen across these groups and proposed a new diagnostic category referred to as 'Disorders of Extreme Stress Not Otherwise Specified' (DESNOS) (Resick et al, 1997). This diagnostic construct has also been referred to as 'complex trauma' (Herman, 1992). The DSM 5 has moved PTSD from a 'narrow fear-based anxiety disorder' and now includes a dissociative sub-type which may open the way to an improved approach to complex trauma (Friedman, 2013).

The new International Statistical Classification of Diseases and Related Health Problems (11th ed, ICD-11; World Health Organization, 2019) includes a diagnosis of 'Complex Post traumatic Stress Disorder' (CPTSD) which distinguishes it from the DSM-V. The criteria for CPTSD must include the core symptoms of PTSD (re-experiencing, avoidance and hyperarousal) as well as disturbances of self-organisation (emotional dysregulation, interpersonal difficulties, negative self-concept). Many people have trauma histories which have profoundly affected them, which would not be classified as CPTSD or PTSD but could be referred to as 'complex trauma'. There may be a history of chronic or multiple trauma without symptoms of

CPTSD (re-experiencing, avoidance and hyperarousal as well as disturbances of self-organisation). The term 'Complex Trauma', rather than being symptom focussed for the purposes of diagnosis, instead refers to traumatic events that have been experienced and which are "inter-personal, long-term, repeated and severe" (APA, 2013, p.276). One of the conditions of approval for this research by the Process Approval Panel (PAP), was that I should use the term 'complex trauma' as opposed to 'complex PTSD'. The understanding of the term 'complex trauma' as derived from the results of this research will be explored in the discussion chapter.

2.7 EMDR as a stand-alone treatment for complex trauma

Although the treatment of PTSD with EMDR is well documented (there were over 30 Published RCTs by 2019 (De Jongh et al, 2019), treatment of complex trauma has been less widely researched (Van Balkom et al, 2014). There have however been a few examples of EMDR as a stand-alone treatment being used in comparison studies.

Van der Kolk et al (2007) compared EMDR, fluoxetine and a pill placebo in the treatment of complex trauma and in addition, compared two populations: those with child-onset complex trauma and those with adult-onset complex trauma. In this study EMDR was found to be more effective than both the fluoxetine and the pill placebo. It was also found that significantly more participants with adult-onset complex trauma lost their diagnosis by the end of their treatment compared with only 75% of the participants with child-onset complex trauma. Far less of the child-onset population was completely asymptomatic compared to the adult-onset participants. The authors concluded that the eight sessions of EMDR used in this study were insufficient to resolve imprints and adaptations developed over a significant period of time (Van der Kolk et al. 2007). The differing efficacy between child-onset and adult-onset PTSD may have been due to the type as well as the length of treatment and different approaches to EMDR were not explored or considered in this research.

Muraoka et al (1998) investigated the use of EMDR as a treatment for complex trauma resulting from combat noting that previous studies had yielded mixed results. Their study produced positive outcomes by using 12 sessions of EMDR, longer than in

previous studies. They recommended that in cases of complex trauma, the number of sessions of EMDR should be increased. This research did not take into account whether the trauma was developmentally rooted, only that the trauma was multi-episode. This understanding could have potentially provided a richer understanding of how the recommended increase in the number of sessions could be used to increase efficacy.

Research by Choi & Kim (2004) also reported successful results in treating complex trauma with EMDR. This was a single case study of a multi-traumatised woman who had previously been unsuccessfully treated with both psychotropic medication and supportive therapy. The study showed successful results after six sessions of EMDR but reflected that the good therapeutic relationship that pre-existed between the therapist and patient may have been key to the success of this case. There was no comparison case study to assess the efficacy of the same treatment plan without the existing therapeutic relationship.

The beneficial impact of previous therapeutic intervention and a good therapeutic relationship appears to be supported by research by Leeds & Korn (2002). They argue that lack of affect regulation, which is typical in patients suffering from complex trauma, means that stabilisation of the patient must first be achieved before trauma processing with EMDR can be attempted (Shapiro & Leeds, 2000). Their study resulted in a Resource Development and Instillation (RDI) protocol being developed to stabilise the patient sufficiently in order to address the relevant traumatic memories and attempt to process them with the use of EMDR. The efficacy of this RDI was assessed with both psychometric and behavioural outcome measures from two single patient case studies. A greater number of participants would be beneficial in future research. The authors also suggest that future research could benefit from integrating the EMDR based RDI with elements of resource development from other modalities. Similarly, Luber & Hofmann (2009) found that in a patient with complex trauma, the affect tolerance of the patient can be compromised, and the patient can be unstable if they are not sufficiently stabilised through a good therapeutic relationship prior to commencing EMDR. In these cases, clinical complications can arise and the EMDR process does not work efficiently. Luber & Hofmann (2009) inverted the EMDR Standard protocol to enable these patients to reduce their symptoms and reach a point

where they were stable enough to work with their traumatic memories through EMDR. This approach was found to be particularly helpful when treating patients with psychiatric hospitalisation histories or inpatient settings, but research is needed to further substantiate the initial clinical findings of the proposed inverted protocol (Luber & Hofmann, 2009).

Despite the limited number of randomised controlled studies of any treatment for complex trauma, trauma treatment experts have come to a general consensus that work with survivors of childhood abuse and other forms of chronic traumatisation should be phase-oriented, multimodal and titrated (Korn, 2009). As the understanding of complex trauma and the practice of EMDR has developed over the years, EMDR has not recently been considered as a stand-alone treatment for complex trauma. The understanding of complex trauma as being developmentally rooted has led to EMDR therapists using a more relational, integrative and holistic approach to EMDR to facilitate the developmental repair needed to address the roots of the subsequent trauma presentation (Laliotis et al, 2021 and Plagaro, 2022). As mentioned previously, the implications of the term 'complex trauma' and related research will be considered in the discussion chapter.

2.8 EMDR as an integrative therapy for complex trauma

Shaprio (1995) stated that one of the basic principles of EMDR is that its application should dovetail with other established areas of clinical practice. In the practice guidelines of the 'Society for the Study of Dissociation' for the use of EMDR with clients suffering from dissociative disorders, EMDR is be seen as an integrated method (Young et al, 1995). Shaprio (2002) believes that it is the integration of EMDR across psychological disciplines that makes it best suited to meet the needs of both clients and clinicians. Shapiro co-wrote the chapter 'Integration and EMDR' with John Norcross in his 'Handbook of Psychotherapy Integration' (Norcross & Goldfried, 2005). In this chapter Shapiro uses the metaphor of a prism to describe how EMDR is comprised of a spectrum of therapeutic modalities, each being a vital contributor to the entire therapeutic process, rather like the way the range of colours in a prism all contribute to the resulting white light. The chapter considers integration from a

theoretical rather than a practical perspective and looks at different theories of integration. These will be examined in the discussion chapter in the context of the findings.

Marich's book (2012) 'EMDR Made Simple: 4 Approaches to using EMDR with every client' suggests using EMDR in four different ways, with four 'faces': Face 2 is 'Flexible EMDR' in which EMDR is integrated with other approaches/theories. She asserts that the relationship should be primary and that the technique and theory ought to be viewed as secondary considerations. She offers clinical examples of the application of EMDR with this approach, including examples of working with complex trauma. (Marich & Marich-Merkin, 2012). Hase and Brisch (2022) also argue that the specific reference to the core element of EMDR, the therapeutic relationship, is what is missing from EMDR and the development of EMDR from a protocol to a psychotherapeutic approach. and that it should be understood to be a core element of EMDR therapy.

Dworkin (2003) suggests that at the theoretical level, EMDR represents an integrative model of psychotherapy and that greater use of this model can be achieved by integrating additional therapeutic elements such as empathy, the intersubjective and transference and countertransference. Korn (2009) brings together an integration of EMDR related interventions for the treatment of dissociative disorders in complex trauma. The aim being to expand the therapeutic scope of EMDR and present interventions that can be useful in facilitating the therapeutic process in patients with complex trauma. However, she asserts that there is still a "desperate need for research aimed at clarifying the optimal treatment strategies for individuals with complex trauma" (Korn, 2009, p274). The 'What is EMDR' workgroup of the Council of Scholars of the Future of EMDR defined EMDR as "an integrative, client-centered approach that treats problems of daily living based on disturbing life experiences that continue to have a negative impact on a person throughout the lifespan…" (Laliotis et al, 2021, p187). This description is general as opposed to being in the context of a specific presentation. However, in their definition of 'EMDR Psychotherapy, the What is EMDR' workgroup expand on the definition of EMDR to include reference to treating the client holistically including relational and behavioural domains and specifically refers to the use of EMDR Psychotherapy for the treatment of attachment-based issues and developmental trauma. As discussed earlier in this chapter, these

definitions were based on academic discussion by clinical experts as opposed to research, as there is scope for broadening the understanding of how EMDR is used with clients presenting with complex trauma.

There are relatively few qualitative studies into EMDR compared to the number of quantitative studies available. Marich (2009) used case review and semi-structured phenomenological interview to illustrate how EMDR was used in the continuing care process of a cross-addicted female patient. The participant reported 18 months of sobriety following this treatment as opposed to a maximum of four months sobriety following her previous 12 courses of treatment using traditional approaches. This analysis revealed six 'critical themes' about her treatment and recovery and offers a much richer and in-depth insight and analysis into the success of her treatment than the reported length of sobriety following treatment. This study could benefit from follow up research to compare the critical themes identified to themes identified with other patients and to both enrich and distil the themes through the discovery of commonalities. Further quantitative research to understand the efficacy of working with these six critical themes with multiple participants would further confirm the validity of this qualitative study.

Walter et al (2004) took a different qualitative approach and examined how three therapists integrated EMDR into their client work. This study focused on the way in which each therapist integrated EMDR into their own theoretical orientation (humanistic, psychodynamic and cognitive-behavioural). They found that all the therapists deviated from the standard EMDR protocol and their decisions about which parts of the protocol to deviate from were driven primarily by their theoretical orientation. This study can be seen as an interesting starting point from which to examine EMDR as part of an integrated therapeutic model. However, Walter et al (2004) focused entirely on methods of integration from the perspective of the particular modality of the practitioner. Each participant answered questions based on their use of EMDR integrated with their own particular therapeutic modality. Although some examples of different disorders were cited, these were varied and the emphasis was very much on the method of integration across different modalities rather that the effectiveness of EMDR as part of an integrative therapy to treat any particular condition or disorder.

Shapiro et al (2002) examined individual case studies of patients with complex trauma from a range of traumatic settings and suggested that EMDR could and should be integrated into the therapeutic process. Lillienfeld et al (2013) expand on this by stating that clinicians should adapt their clinical approaches to both build on each patient's capacities and to meet the individual needs of specific patients.

Research by Walker et al (2016) considered the benefits of combining EMDR with Cognitive Analytic Therapy (CAT). They suggested that by combining these two therapeutic approaches, a more effective therapy for certain patients may be achieved and the strengths of each modality were able to compensate for the weaknesses of the other, particularly when treating patients with complex interpersonal trauma. Although this research only considers integrating EMDR with one other specific therapeutic model, the authors, although acknowledging the challenging nature of combining therapeutic models, conclude that the merging of therapies in a systemic way is both exciting and has the potential for significant benefit.

Several other papers have considered the 'integration' of EMDR with another modality. The term 'integration' has various definitions and there are different theories behind the concept of 'integration'. In a book containing illustrative clinical vignettes, Arad, H. (2018) considered how EMDR and relational psychoanalysis can be integrated in order to use EMDR in a modified and more embodied way. Lobenstine and Courtney (2013) used a single-case study for an efficacy study into the treatment of co-morbid post-traumatic stress disorder and major depressive disorder, using EMDR integrated with ego-state therapy. Wade and Wade (2001) explored the use of EMDR combined with ego-state therapy, clinical hypnosis and EMDR and Miller (2015) explored clinician's experiences of working with clients with complex post-traumatic stress disorder when integrating EMDR with transpersonal psychotherapy. These studies will be examined more fully in the discussion chapter but have been mentioned here in order to illustrate the variety of existing research involving 'combining' or 'integrating' EMDR with another modality.

Shapiro and Brown (2019) consider the scope and development of what they term "an innovative and integrative trauma treatment" (p139). They speculate that in their

experience, EMDR therapists either stick religiously to the standard protocol or have a more flexible stance and integrate EMDR with other modalities. This paper discusses the integration of EMDR with various other modalities, including psychodynamic treatment, mindfulness and ego-state therapy and demonstrates a variety of integrative possibilities involving EMDR. However, this paper does not consider the question of 'how' EMDR is integrated with different modalities and only considers the integration of EMDR with another single modality.

Ford and Courtois (2020) consider more specifically the elements of what is required to use EMDR with clients with complex trauma histories. They recommend an approach that is relationally based and sequenced, and which focuses on relational impairments and self-regulatory identity, based on evidence that presentations of complex trauma, including attachment and developmentally based trauma, require adaptations of standard trauma treatments such as prolonged exposure, cognitive processing therapy, EMDR and narrative exposure therapy. Their recommendations were general to the presentation of complex trauma and while the recommendations are designed to be utilised by EMDR therapists, they are not specific to EMDR.

2.9 Empirical research versus daily clinical practice

The majority of research into EMDR is quantitative and studies have been criticised for small sample sizes, methodological inconsistencies and an inadequate number of treatment sessions for patients with CPTSD (Rouanzoin & Perkins, 2001). Norcross and Wampold (2011) suggested that Randomised Controlled Trials (RCTs) are likely to be based on single modality treatment orientations, but in reality, the efficacy of clinical practice is more likely to be due to common factors across orientations such as the therapeutic relationship. Clinicians have however, been criticised for not relying solely on empirically supported treatments, but it can also be argued that clinical outcome research fails to keep up with the demands of daily clinical practice (Seligman, 1995). However, other therapists (e.g. Sikes and Sikes, 2003) have been using their clinical expertise and experience to use EMDR with a wider range of disorders than those supported by empirical trials and their findings have been reported in peer reviewed journals (Nowill, 2010). Laliotis (2022) experimented with

how her therapeutic presence could impact the therapeutic process whilst following the evidence based (as detailed above) EMDR standard procedural steps. She found that working relationally with EMDR enabled her client to describe her experience in greater detail, experience new emotions about her experiences and develop the capacity to be in a relationship of secure attachment. This is a case study which relies on the experiences of a single client and it therefore limited. However, the importance of the therapeutic relationship is examined more fully in the second part of the review of the literature within the discussion chapter. These studies demonstrate the benefits of using practice-based evidence (PBE) as opposed to the traditional evidence-based practice (EBP) model. Hogan and Heart (2003) support this view by questioning how anything new will ever be tried if only interventions with an approved evidence base can be applied.

Complex trauma has very little controlled intervention research and the empirically evaluated research that does exist often indicates variable success. It seems that for the therapist, the most important guidance to treatment choice, whether it be part of an integrative therapeutic model or a stand-alone treatment, is patient feedback (Seligman, 1995). In their individual case studies, which examine the treatment of complex trauma with EMDR, Korn and Leeds (2002) encourage researchers to undertake further studies in clinical settings which may contribute to an understanding of the needs of clinicians working in the field.

The question of efficacy in the research environment versus effectiveness in the real world can be considered in this context by looking at Evidence Based Practice (EBP) and the difficulties it holds when considering research into areas such as complex trauma. The use of randomised control trials (RCTs) can be criticised for failing to predict outcomes for the individual patient from data that has been summarised at group level (Margison, 2000). EBP research and ‘real’ clinical situations are very different and Roth and Fongay et al (2004) state that “generalising from one to the other is questionable”.

EBP generally insists on a rigid form of ‘measurement’ and assumes research without measurement to be invalid (Mitchell, 2003). Research into EMDR for the treatment of complex trauma may be better served with ‘Practice Based Evidence’ (PBE) involving

the gathering of data from routine clinical practice (Margison 2000), so that research is practice led, as opposed to practice being research led (Heart and Hogan, 2003). Margison (2000) argued that preferably, both EBP and PBE are required for psychotherapy but the EBP could be conducted based on evidence gathered from PBE. PBE would allow EMDR to be integrated into clinical settings by practising therapists and research could be conducted in accordance with the expertise of the individual therapist and integrated into their particular therapeutic model (Nowill, 2010). Richards and Barkham (2021) found that RCTs alone are unlikely to provide a broad enough evidence base for psychological therapies in general. They suggested that practice-based evidence is complementary to evidence-based practice and can enrich research findings by considering areas such as the content of sessions and focus on the experience of the therapist. This paper focussed on spiritually integrated approached to psychological therapies but presents a solid base for future research with different presentations and modalities. Hennik (2021) examined the benefit of understanding therapist and client as co-researchers in the research paradigm, enabling their mutual communication and context to be examined as well as the impact of the collaboration. This research was based on three single client case studies which present the need for further research in this area with a greater number of participants. Marich et al (2020) reviewed 12 qualitative studies involving EMDR published in peer reviewed journals and concluded that when used in conjunction with robust methodologies, qualitative research can reveal important data beyond efficacy alone. This data shows more about the impact of EMDR, the reasons for using it and the way in which it is used by clinicians in the field. In a narrative literature review of practice-based research practice in Counselling Psychology, Henton (2012) examined the tension and at times “incompatibility” (p 12) between empirically based RCTs and the real-world clinical practice and found practice-based research to be both important and relevant to the profession of Counselling Psychology.

2.10 Background of Integration – Historical development

Until the mid-twentieth century it was more usual for therapists to adhere to a single therapeutic modality. However, a ‘one-size fits all’ approach posed certain challenges and therapists began to train in a variety of different approaches and began referring

to themselves as ‘integrative’ rather than ‘purist’ (Lapworth & Sills, 2010). The integrative moment began to develop from different perspectives. Therapists identified the need to expand their skill sets, in order to have a more adaptable response to the needs of individual clients and to expand their practice to embrace the impact of the therapist as a person, their experiences and values (Norcross & Goldfried, 2005).

In Norcross & Goldfried (2005) estimated that there were around 400 different types of therapy and the majority of practitioners now refer to themselves as ‘integrative’ (Lapworth and Sills, 2010). However, this is not reflected in the training these therapists have received. Certainly, in the UK, most therapists are not trained in an integrative approach, so what does ‘integration’ really mean here? There is no universally agreed definition of ‘integration’ in a therapeutic context, although (Hollanders, 1999) defined it as a new theory being developed by combining various theoretical ideas and argued that it was the dogmatic mentality, that can arise from a theoretically purist practice, that technical integration was challenging.

Most therapists would describe themselves as ‘integrative’ (Lapworth & Sills, 2010), so the concept of integration seems to be ‘know’ and ‘not known’ at the same time. It appears from the literature, that ‘integration’ is a term often used to describe any way of working other than a purist modality and that the number of therapists working in a purist way to a clearly defined modality are limited. Of course, even within single modality descriptors like ‘transpersonal’ there are many elements of different modalities and although a transpersonal therapist might describe themselves as such, this may not mean that they do not practice within an integrative framework. Different theories of integration are considered in the context of my results within the discussion chapter.

2.11 Complex trauma and Integrative Psychotherapy

When examining the literature relating to complex trauma and integrative psychotherapy, it is interesting to note the lack of research that involves ‘integrative psychotherapy’ as a single modality in its own right as opposed to integration meaning the use of two or more modalities concurrently or what could be seen as a

single modality therapy e.g. EMDR, CBT or Play Therapy, being described as an integrative therapy. The concept of integration is explored more fully in the discussion chapter.

Meskunas (2022) examined the efficacy of integrative group therapy as a treatment for complex trauma in comparison with a control group with the same presentation. The test group we treated 'integratively' with a combination of 'process-orientated therapy;' and 'trauma-informed yoga' with an emphasis on polyvagal theory (Porges, 2011) and neurobiology (Siegal 2012). The treatment also involved psychoeducation, the opportunity for 'trauma processing' and group meditation. After eight weeks the test group showed reductions in both complex stress symptoms and sleep disturbance. This study involved a small sample size, and the authors recognise that the results may have been impacted by unexpected circumstances during the process.

Topham and VanFleet (2011) examine the use of 'Filial Therapy' (FT) in the treatment of complex trauma in maltreated and neglected children. Attention is paid here to the theoretically integrative nature of FT which is described as an integration of family therapy and play therapy. The authors recognise the complexity of this client group and the intertwined nature of attachment and developmental trauma with the presenting violence of abuse they have experienced. The integrative nature of FT is explored including the possibilities of integrating it with other modalities such as play therapy, group therapy and cognitive-behaviour intervention. The application if the integrative nature of FT and its particular application to this particular client group and presentation is explored in detail. This exploration provides a useful basis for further exploration of the application of well researched therapies and how they can be applied to different client groups and presentations. The recommendations in this book are drawn from the clinical experience of the authors, but it provides a strong basis for future quantitative and qualitive research with different integrative therapies, presentations and client groups.

Olson-Morrison (2017) completed a case-study of a single adult client presenting with complex trauma. The case-study describes the detailed application of play therapy throughout the phases of trauma treatment with specific reference to

complex trauma. Integrative Play Therapy (ITP) is described as play therapy integrated with other areas, such as drama therapy, sand play and doll play into the therapeutic process and is said to allow therapeutic flexibility depending on the client's presentation and developmental and therapeutic needs. The paper emphasises the need for therapy for complex trauma to be developmentally relevant, due to the developmentally rooted nature of complex trauma. This case study details the phased trauma treatment of a single patient with IPT and demonstrated the application and the application of its integrative scope with one patient. This case study would form an interesting basis for understanding the commonalities in the application of IPT with multiple patients in further research.

Paivio and Pascual-Leone (2023) have produced a detailed guide to working with complex trauma with the integration of Emotion-Focussed Therapy (EFT) into clinicians' individual practice. This book chapter presents a detailed understanding of how EFT can be integrated into the practice of clinicians from different backgrounds. It discusses how EFT can be integrated both in terms of theory and of clinical practice. It presents the practical application of this approach in a way that allows clinicians to either integrate it into their existing practice or to apply the way of working as a complete package. This guide is research based and the format of the application of this approach and its scope for integration in the treatment of complex trauma could usefully be applied to other therapeutic approaches.

2.12 Conclusion

There is evidence that EMDR can be effective in the treatment of simpler cases of PTSD (De Jongh et al, 2019). However, the integration of EMDR for more complex cases has been less widely studied (Nowill, 2010). Knipe & Korn (2009) conclude in their review of EMDR for the treatment of complex trauma by asserting the need for further research in order to ascertain treatment strategies for patients with a diagnosis of complex trauma. Future research into the treatment of complex trauma needs to include patients currently excluded from empirical studies due to the complex post-traumatic adaptations associated with complex trauma (Van der Kolk and Courtois, 2005). The need for studies with minimal exclusion criteria is also emphasised by van

Balkom et al (2014) who point out that suicidal behaviour, dissociation or substance abuse are characteristic of the complex trauma population and yet often such exclude patients from trials.

Further research needs to compare a variety of therapeutic modalities and different combinations and sequences of modalities and interventions (van Balkom et al, 2014). Korn and Leeds (2002) also invite the prospect of further research into integrating EMDR with other approaches and Walker et al (2016) find developing an integrative approach with EMDR to be a potentially exciting way to deliver significant benefits. Several studies have combined or integrated EMDR with one other modality, but there is a need for further research into EMDR as part of an integrated therapeutic approach for the treatment of complex trauma. There is also a need for clinician based PBE research rather than empirical studies (Henton (2012), Richards and Barkham (2021).

In recent years there has been a development in the understanding of EMDR from a purely protocol driven intervention to a psychotherapy modality in in own right with the capacity to be used both integratively and relationally (Laliotis et al, 2021, Plagaro, (2022), Hase and Brisch (2022), Shapiro and Brown (2019), Laliotis (2022), Courtois and Ford (2019). This understanding parallels the development of the understanding and conceptualisation of complex trauma as being developmentally rooted and this understanding (Kaptan and Brayne, 2021) has informed the root of EMDR as a psychotherapy. However, this understanding is, at this stage primarily rooted in the understanding of academics and clinicians and research is needed to establish how EMDR is being used and developed by clinicians in their work with patients with complex trauma.

2.13 Research Aims and Research Question

Following my review of the literature, this research aims to explore how Counselling Psychologists and Psychotherapists, who define their practice as ‘integrative’, use EMDR as part of their practice when working with clients presenting with complex trauma.

The analysis of data obtained from the experiences of practising integrative relational therapists will be used to construct a theory behind how EMDR is used in conjunction with an integrative practice when working with complex trauma. A theory is pivotally important because the process of constructing an explanatory theory will uncover a process inherent to the subject matter in question, thereby generating a robust theory which is grounded in the data (Charmaz, 2014). These research aims have led to the following research question:

How is Eye Movement Desensitisation and Reprocessing therapy used by integrative therapists when working with clients presenting with complex trauma?

There is also an implied sub-question here which is:

Is it possible for EMDR be integrated into a therapists' practice?

Chapter 3: Methodology

3.1 Overview of Chapter

In this chapter I give an overview of the epistemological bases for qualitative research and I present my epistemological stance and ontological position. I then describe the rationale for my qualitative approach to the research and my chosen qualitative methodology.

3.2 Epistemological Position

There are broadly three types of competing philosophies when it comes to the construction of knowledge in qualitative research: positivist (realist), phenomenological and interpretivist (social constructionist). A positivist position is based on the assumption that reality is objective and exists independently of human understanding or perception (Bager-Charleston and McBeath, 2020). A phenomenological position relates to the experiences of the individual participants and is concerned with the quality of the experience itself rather than the understanding of the participant's reality (Willig, 2013). An interpretivist stance assumes that there is no objective reality, and that reality is constructed through the interpersonal creation of meaning and understanding (Willig, 2014, Bager-Charleston and McBeath, 2020).

My philosophical stance, from the perspective of a clinician, developed during the first few years of my training. It feels important to describe this here as it has influenced both my epistemological position and my choice of research methodology.
My philosophical stance is predominantly from an inside-out position and is based around humanity, connection and relationality. I believe subjectivity to be central to the construction of knowledge as opposed to a more positivist objectivity.

My position therefore is that meaning is made by individuals. Meaning is not a given, it is constructed by individuals and can be impacted by factors such as environment

and culture (van Deurzenet al., 2006) and individuals make individual and subjective meaning out of their experiences and circumstances which may differ greatly from what can be externally observed (objectivity). Meaning is constructed and not viewed as a 'truth' to be discovered and this position is encapsulated by a constructivist as opposed to an objectivist epistemology (Crotty, 1998). Knowledge and meaning are developed within a social context between individuals and their environment.

There has been much debate around the terms 'constructivism' and 'constructionism' and these terms are often used (incorrectly) interchangeably (Young and Collin, 2004). These terms can be distinguished by understanding the perspectives from which they are used (Charmaz, 2014). Constructionism is a theoretical perspective concerning the construction of social realities from both an individual and interpersonal perspective. Constructivism is a social sciences perspective which assumes that individuals construct the realities they participate in (Charmaz, 2014). Constructivism can therefore be distinguished by its focus on the process of individual engagement in the construction of knowledge as opposed to constructionism by which meaning is constructed through culturally dependant social processes and action (Young and Collin, 2004).

Through this understanding and informed by my clinical philosophy, I developed a constructivist research epistemology, as an interpretive understanding of an individual's meaning is emphasised by constructivism. Reality is positioned as subjective and subject to the experience and perception of the individual. A constructivist approach involves acknowledging and embracing the researcher's subjectivity and considers the impact and influence of the researcher an inevitability (Charmaz 2014). Indeed, the intersubjective relationship between researcher and participants is paramount in a constructivist epistemology as the meaning is co-constructed (Pidgeon and Henwood, 1997). I concur with Charmaz' view that "we are part of the world we study, the data we collect and the analysis we produce" (Charmaz 2014, p17). I have therefore been careful to choose a methodology which fully embraces the subjectivity of the researcher; 'subjectivity is inseparable from social existence' (Charmaz, 2014, p.14), meaning that within a constructivist methodological framework, both researcher and participant may be changed as a result of the

interactions between them. The research is therefore positioned as neither a neutral observer nor value-free expert (Charmaz, 2014; Ponterotto, 2005).

3.3 Ontological position

Ontology can be understood as the study of 'being' (Crotty, 1998) and of questioning whether reality is seen from a single of multiple perspectives (Denzin & Lincoln, 2005). My ontological position is one of relativism because I believe that multiple subjective realities exist, each influenced by context, as opposed to a single objective reality (Guba and Lincoln, 1989). From a relativist perspective, 'reality' cannot be distinguished from an individual's subjective experience of reality. This means that there are as many realities as there are individual people and from a research perspective, a relativist ontology seeks to understand the subjective experience of individuals' reality and the multiple truths that exist withing a group of people (Levers, 2013). This ontological position informs my epistemological stance, as constructivism is characterised by holding an ontological position of relativism in terms of the existence of multiple realities and the construction of data arising from multiple subjective realities (Charmaz, 2014). Ontological relativism is also aligned to my philosophy as a clinician based around understanding the subjective experience of my client.

Taking the ontological position of relativism means that data analysis reflects the researcher's subjective experience of the data (Willig, 2013) which is an appropriate position for the current research considering my relationship to the field as discussed in the introduction chapter and my position as an inside researcher as discussed in section 3.6 of this chapter. The position of relativism and the awareness of multiple realities required reflexivity, with regards to both my subjective assumptions and interpretations of the data and on the meaning and subjective realities and experiences of my participants, to maintain the accuracy of my participants meanings and interpretations.

3.4 Rationale for a Qualitative Approach

My rationale for a qualitative approach to this research was to consider what was most appropriate in answering my proposed research question (Willig, 2014). Quantitative research methods have been traditionally used in the field of psychology and have been viewed historically as being the most valid. However, more recently this view has been criticised for its lack of purpose and meaning (Guba & Lincoln, 1994). In order to explore how individual therapists use EMDR when working with complex trauma, I needed to be able to capture their individual actions and experiences. Therefore, a qualitative research methodology seemed more appropriate. In addition, the aim of this research is to provide a theory behind this way of working, and a detailed framework to inform the training and practice of Counselling Psychologists and Psychotherapists working in this way. A qualitive research methodology was more suited to this aim.

3.5 Grounded Theory and the Current Research

Holding my epistemological stance and ontological position in mind and having made the decision that my research aim is more suited to qualitative research, I turned my attention to deciding which qualitative research methodology would best suit my research question. I wanted to examine my participants' actions and experiences, so an experiential methodological approach seemed appropriate. I returned to my research aims when considering which methodology to use, in particular the aim to develop an explanatory framework from my results for use within training and clinical practice.

The nature of my research question points towards the development of a theory and I was interested in generating a theory from the actions and experiences of a number of clinicians. A theory is developed from analysis of data, with data collection and analysis continuing simultaneously until no further categories can be identified from the data (Willig, 2013). I was therefore drawn to Grounded Theory as a methodology because it would involve the generation of a new theory which is grounded in the data (Glaser & Strauss, 1967). Charmaz (2014) observed that other qualitative

methodologies “rarely if ever lead to a new theory construction” (P9). I have chosen to use the most recent version of Grounded Theory, ‘Constructivist Grounded Theory’ (CGT) (Charmaz, 2014) as it sits well with both my own epistemological stance, the aim of my research and my position as a researcher-practitioner. Grounded theory is suited to ‘how’ questions with the research in question directed towards action and processes (Willig, 2013). However, grounded theory methodology has evolved and there are three distinct versions, which I needed to consider in line with my epistemological stance and ontological position.

I wanted to develop a theory behind the way my participants practice, and in doing so, examine their actions and experiences rather than the words used to describe them. For this reason, I discounted narrative enquiry. Had my research aims been more focussed towards understanding my participants’ lived experience of working with EMDR with complex trauma, I may have used interpretive phenomenological analysis (IPA). However, I wanted to explore my participants’ experiences of working with a specific client group in a particular way and through doing so, develop a theory for use in practice. I considered research in the form of a case study because case studies are also concerned with theory generation (Willig, 2013). However, access to patient data and the ethical implications of conducting a detailed case study into a therapist working with complex trauma were considered to be too complex with too great a risk of compromising anonymity.

Thematic Analysis (TA) and Reflexive Thematic Analysis (RTA) would have been potentially suitable methodologies as they can be used to recognise and organise themes in qualitative data (Willig, 2013). RTA in particular would have been appropriate in some ways for the current research as it views the researcher’s subjectivity as not only an unavoidable part of, but actually as integral to the research process (Braun and Clarke, 2021). However, TA and RTA are most suited to research questions relating to understanding people’s conceptualisation of different phenonium (Willig, 2013) and I was more interested in the ‘so what?’ component of the research, particularly the opportunity to offer practice-based recommendations, through the developed understanding of participant’s actions rather than their understanding of a phenomena. Little existing research documents the experiences of therapists that can be used to inform and support the development of theory related to working

integratively with EMDR. Given that the research question posed has not directly been studied before, I wanted to use a methodology which would enable me to develop an explanatory framework for practice, which could then be usefully referred to by other therapists.

One of the originators of GT, Barney Glaser spoke about abilities GT researchers would need to possess, without which they would struggle with the methodology. These were: "the ability to conceptualise data, tolerate confusion and tolerate regression" (Glaser, 2010). I reflected on this and was reminded of my Clinical Integrative Training, in which one of the greatest skills I learned was to tolerate confusion and ambiguity, moving away from my natural pull towards safety and certainty. I was further encouraged towards GT by Birks and Mills (2015) who pointed out that GT is a very 'active' methodology and better suited to researchers who like to 'write rather than read'. In my introduction I wrote about the tendency of my approach to be from an 'inside out' position, so although choosing a GT approach felt somewhat daunting, I felt that it suited my personality.

3.5.1 Brief History of grounded Theory

In 1967, Barney Glaser and Anselm Strauss sought to develop a methodology in which a theory could be developed that was 'grounded' in the data rather than moving from theory to data and thus relying on pre-existing theories (Willig, 2013). In 'The Discovery of Grounded Theory' Glaser and Strauss (1967) emphasise that a new theory should 'emerge' from the data and be developed by the researcher in contrast to a quantitative research process which tests a pre-conceived hypothesis. This latter approach suggests that the researcher's role is to uncover something that is already present within the data and does not involve the subjective role of the researcher and the researcher's influence on the findings and analysis. The lack of recognition of the researcher's subjectivity, suggests a more positivist stance and felt at odds with my constructivist epistemology and philosophical values of relationality and intersubjectivity.

Since this first version, grounded theory has evolved into two further main iterations; the more structured version of Strauss & Corbin (1990) in which Mills et al., (2006)

called ‘evolved’ GT and Charmaz’s (2014) ‘Constructivist Grounded Theory’. Evolved GT includes greater recognition of the role of the researcher in the development of a theory, with it being to approach the construction of the data systematically and maintain an objective view (Strauss and Corbin,1998). The researcher and the method are not seen as separate and researcher subjectivity should be avoided: “the technical tail is beginning to wag the theoretical dog” (Melia, 1996: 376). This version is highly structured and has been criticised for its rigidity because the method needs to able to respond to the data by being flexible, therefore the procedure for Evolved GT may get in the way of the development of the theory (Willig, 2013).

From an epistemological perspective there are two versions of grounded theory: objectivist grounded theory and constructivist grounded theory. Objectivist grounded theory is rooted in a positivist theoretical perspective and assumes that objective data exists, and it is the researcher’s role to find it. Glaser and Strauss (1967) describe this as the grounded theory emerging from the data. The researcher in objectivist grounded theory is required to remain separate from the participants and their realities and attempts to conceptualise patterns of behaviour. Constructivist grounded theory adopted first by Strauss and Corbin (1990) and then by Charmaz (2006) who explicitly described her methodology as such, in which data is co-constructed by the researcher and their interactions with the participants and the data and attempts to interpret the participants understanding of their experiences. Constructivist grounded theorists also engage in a reflexive process to identify their preconceptions and subjective interpretations of the data and the resulting grounded theory.

3.5.2 Constructivist Grounded Theory

In 2006 Charmaz published a social-constructivist version of grounded theory. Charmaz (2006) holds a different philosophical position, one of constructivism, which believes in multiple possible interpretations of reality. Constructivist grounded theory (CGT) emphasises the importance of the researcher’s subjectivity and instead of referencing a theory ‘emerging’ from the data, refers to a theory being ‘constructed’ by the researcher as a result of interacting with the data. It sees the data and the resulting theory being constructed from what already exists as opposed to being ‘discovered’. CGT takes a more reflexive stance which recognises the impact of the interactions

between researcher and participants. This sits comfortably with my epistemological, ontological and philosophical viewpoints. CGT has many procedural and methodological similarities to both classical and evolved GT including simultaneous data collection and analysis and the application of theoretical sampling. I will describe this in more detail in the following sections. It is the philosophical position that differs.

In addition to CGT being suitable for the research aims and aligned with my clinical philosophy and epistemological perspective, it felt important that my chosen methodology suited me from a personal perspective as I would be 'living with it' for several years! This feels particularly important with CGT as the researcher "drives the research" (Dunne & Gamze, 2020 p3).

3.6 Insider Research

As I described in the introduction chapter, I am immersed in my area of study. I therefore wanted to explore the implication of being an 'insider researcher'. Although both classical (Glaser and Strauss, 1967), and evolved GT (Strauss and Corbin, 1998) call for objectivity in the researcher, the 'personhood' of the researcher has an influence on all qualitative methods to a greater or lesser extent (Dweyer and Buckle, 2009). From a constructivist perspective, it could be argued that there is no researcher neutrality in qualitative research (Rose (1985). Acceptance of this allows an awareness of researcher subjectivity to develop which can then be used and considered reflexively within the research process.

As well as researcher subjectivity, consideration needs to be given as to whether the researcher is a 'member' of the researched population and the extent to which this membership is known or disclosed to the research participants. Three distinct categories of membership were developed by Adler and Adler (1987): 1) 'peripheral research members' which are those not participating in the core activity of group members, 2) 'active member researchers' who take part in activities but without the goals and values of members and 3) 'complete member researchers' who are either already full members of the group or become so during the research process. In this research, my member role falls into the latter category. As described in the

introduction, it was my own clinical experience with EMDR which led me to this research area and my clinical practice with EMDR also developed during the research process leading to me becoming a 'full member' during the course of the research process.

There are many implications of being a 'full member' insider researcher. This status may enhance the understanding of the researcher, but the heightened subjectivity may also be seen as overly influencing the collection and analysis of the data. As a trainee Counselling Psychologist and Psychotherapist, the experience of understanding the intersubjective space was familiar to me and the reflexive practice necessary to work with subjectivity is part of my everyday clinical work. This practice and the role of researcher subjectivity were also part of my consideration when selecting an appropriate research methodology.

I experienced being an insider researcher as helpful in terms of feeling it elicited a sense of trust and openness from participants. I was mindful of not making assumptions about knowledge, and to explore fully each participant's experience. I feel that my eagerness to fully understand their actions and experience enhanced my curiosity rather than being detrimental to it. Adler and Adler (1994) describe full member research as being the "ultimate dual role" (p73). Holding dual and even multiple relational roles was a significant part of the research process and I explore the challenges of this in the following section on ethical considerations.

3.7 Ethical Considerations

This study was granted ethical permission by Metanoia and Middlesex University Research Ethics Committee (see appendix 4). I used the British Psychological Society's (2018) Code of Ethics and Conduct and the Code of Human Research Ethics (BPS, 2018) to guide me in consideration of ethical issues. I was primarily concerned with protecting the identity of my participants and their clients if, for example, case examples were used in the data. However, I also wanted my participants to be clear about the process, intended use of data and their rights within this process. Each participant was sent a Participant Information Sheet (See Appendix 1) prior to their

interview along with a consent form (See Appendix 3) for them to give their informed consent for the interviews to be recorded, transcribed and analysed and the results published.

At the beginning of each interview, I spoke to each participant about confidentiality and protection of identity and suggested using pseudonym for clinical examples and minimising the use of identifiable details. However, I wanted to balance what I hoped was reassurance in terms of identity protection with my participants being able to talk freely, so I also assured them that if any names or identifiable features were inadvertently given, that I would exclude these from all documentation.

The management of dual and sometimes multiple relationships has been an ethical and practical consideration throughout this research process. As described in the introduction chapter, I am a stakeholder in EMDR in several different ways. I made it explicit to my participants prior to interview that I am a research-practitioner and use EMDR in my clinical practice. As described above, this gave me 'membership' to this group. I felt this was helpful in the data collection process as participants appeared to be open and non-withholding. As well as the explicit assurance, I gave them in terms of confidentiality, I felt the knowledge that I am a clinician gave them additional reassurance in that I am used to working within strict confidences. I felt this allowed my participants a certain freedom to deliver their experiences, knowing that I would maintain the confidentiality of their clients.

I had not founded Bilateral Base at this time, but subsequently I have formed new and different relationships with participants, both through Bilateral Base and through the training organisation for whom I work. I have participants in training workshops in which clients of mine have also been participants and colleagues I have met through Bilateral Base have become interested in my research and vice versa. The world of EMDR is a relatively small one and the management of dual relationships an everyday requirement. I manage these relationships congruently, addressing any challenges explicitly and collaboratively. With each new 'relationship' with the same individual there is an implicit and where necessary an explicit re-negotiation for a different kind of relationship.

3.8 Recruitment Criteria

To meet the aim of my project, 'to explore how integrative therapists use EMDR as part of their practice when working with complex trauma', I identified the following specific selection criteria for participants:

- To be either HCPC registered Counselling Psychologists or fully UKCP accredited Psychotherapists.
- To be fully accredited EMDR practitioners or consultants.
- To identify themselves as having an integrative therapeutic practice
- To identify themselves as having a 'relational' practice.
- To be working with EMDR with clients presenting with complex trauma

The above criteria ensured an appropriate amount of clinical experience in terms of both primary clinical training and EMDR. This is because Counselling Psychologists and Psychotherapists are unable to commence the basic EMDR training until they have been awarded full UKCP accreditation or HCPC registration.

The basic EMDR training takes place in three separate stages and a minimum of two months is required between each stage. Once the basic training has been completed, EMDR therapists are required to have received supervision from an accredited EMDR Consultant for a minimum of 25 clients. The accreditation process to achieve EMDR 'Practitioner' status also cannot be commenced for a minimum of two years post UKCP accreditation or HCPC registration. This means that the majority of EMDR Practitioners are experienced clinicians with at least two years' experience practising EMDR in addition to their primary psychology or psychotherapy training.

Participants were required to consider themselves to be 'integrative' therapists and to have a 'relational practice'. I chose not to include definitions of these terms thereby leaving it open to self-selection by participants. This felt important because it left the phenomena of integration and the concept of relationality open to exploration in the research process. This decision felt 'in line' with Charmaz's position that a constructivist approach to grounded theory is optimal because, "Data does not provide a window on reality. Rather the 'discovered' reality arises from the interactive process and its temporal, cultural and structural contexts" (Charmaz, 2014, p.524). There is

also an underlying assumption in CGT that the data is produced through interactions between researcher and participants. For this reason, Charmaz (2014) refers to 'participants' as 'co-producer' or 'co-researcher' and I will hereafter refer to 'participants' as 'co-researchers'.

In addition to the above, participants are required to work with EMDR with clients presenting with 'complex trauma'. I also chose not to include a definition of complex trauma. This was because, as discussed in the initial literature review, there are a variety of definitions both explicitly and implicitly within the literature. In addition, I felt that the ways in which my participants understood the concept of complex trauma, much like their understanding of the concepts of integration and relationality, would add richness to the data.

3.9 Recruitment Strategy

I approached the EMDR Association UK and Ireland to advertise my 'call for participants' to their membership. They asked me to submit a research proposal which they quickly accepted and asked me to submit my call for participants for review. My phone rang as my call for participants landed in my inbox from the association and over the next few days, I received over 40 responses! This was not what I had anticipated as I had heard accounts of long and arduous recruitment processes from several colleagues, so as well as being delighted, I made a note in my reflexive journal to hold this in mind when conducting the interviews and reflect on the seeming eagerness of therapists to share their experiences.

In accordance with the full version of Grounded Theory, I had intended to apply theoretical sampling. This involves collecting initial data and analysing it before returning to the field to collect further data; because of this I did not need to recruit all participants prior to data collection. I decided to conduct an initial evaluation of each respondent in the order in which I had received their response. I felt as long as the co-researchers met my recruitment criteria this was the fairest method of selection.

Several respondents did not meet the selection criteria because they, did not meet the requirement for being a fully accredited EMDR practitioner. Others were unable to complete interviews in the time frame I had available. Out of the 40 respondents, 12

did not meet the criteria for recruitment and five were unable to participant in interviews in the allocated time frame. I accepted the remaining 23 respondents and contacted them to explain the methodological process of theoretical sampling i.e. I would continue to collect and analyse data until the point of theoretical sufficiency, meaning that this process would continue until no new categories could be identified in the data. It would therefore be impossible to confirm the recruitment of all the co-researchers prior to beginning data collection as the number of participants involved would be determined by when 'theoretical sufficiency' was achieved (Willig 2013). The implications of this strategy are that the broader the methods of sampling employed, the larger the pool of co-researchers needed to achieve theoretical sufficiency.

3.9.1 Reflections on recruitment strategy

The table below shows the information collected for my sample. I wondered afterwards whether I could have come up with a better strategy in terms of greater diversity and on reflection I could have considered demographics in my recruitment strategy to get a broader sample base. The gender ratio was 50:50, but I didn't consider asking about race or sexual orientation. The final co-researcher group had more Psychotherapists than Counselling Psychologists, which I was concerned about initially, but on reflection, appears to be approximately proportionate to the ratios of these professions in the field in general.

Co-researcher Pseudonym	**Gender**	**Professional Qualifications**	**NHS or Private practice**	**Initial Training Modality**
Janet	Female	Psychotherapist	Private Practice	Humanistic/ CBT/ Integrative
Collette	Female	Psychotherapist	Private Practice	Integrative/ Transpersonal
Jacob	Male	Psychotherapist	Private	Integrative/

			Practice	Transpersonal
Liz	Female	Psychotherapist	Private Practice	Integrative/ Transpersonal
Tristan	Male	Psychologist	Private Practice	Counselling Psychology
Bill	Male	Psychotherapist	Private Practice	Humanistic/ CBT/ Gestalt
Melanie	Female	Psychotherapist	Private Practice	Integrative/ Transpersonal
Steven	Male	Psychologist	Private Practice	Counselling Psychology/ Transpersonal Psychology
Olivia	Female	Psychologist	Private Practice	Integrative/ Transpersonal

Table 1: Participant Characteristics

3.10 Interviewing and Self-Disclosure

My co-researchers were interviewed independently using semi-structured interviews. The interviews were recorded and transcribed for the purposes of analysis. I interviewed most of my co-researchers in-person, for the first round of interviews, although two were conducted using a video-conferencing platform due to distance and time constraints. The second round of interviews were all conducted via video conference as they were much shorter, and this method allowed them to be conducted within a short space of time. I did not feel that the quality of the data or the openness of the participants was impacted by the use of video conferencing. However, the introductory stages of the two first round interviews conducted remotely had to be

managed more explicitly as the usual introductory elements of an in-person interview though the processes of arrival and introductions etc were not available. I did not experience any challenges in this regard with the second round of interviews as my research relationship with the co-researchers was already established.

The interview involved broad, open questions to allow each co-researcher to convey their subjective experiences of treating clients presenting with complex trauma using EMDR in a way that was non-directive and without being 'led'. Charmaz (2014) recommends GT interviews should take the form of a 'guided conversation' rather than an interview and this was my experience.

I began each interview by asking the question 'can you describe how you work with EMDR with clients presenting with complex trauma?'. After asking the initial question, I then prompted for additional information, clarification or examples where it felt this might be useful. I used memos after each interview to record possible themes emerging as well as reflexive observations around the process including implicit processes such as the relational way the participants engaged in the interview process.

3.11 Recording and Transcribing

I was diagnosed with dyslexia when I was 15 and the formulation of written work is challenging and time-consuming for me. For this reason, I elected to have my interviews transcribed by a transcription service. I am aware that many researchers elect to transcribe their own data in order to begin the process of immersing themselves in it, which seemed particularly important when using CGT, given the simultaneous process of data collection and analysis in Charmaz's (2014) version of Grounded Theory Analysis. Therefore, after each interview I listened back to the recording straight away and made notes which initially recorded my thinking and ideas about areas of emphasis and formed the basis for emerging themes.

3.12 Data Analysis

The CGT process of conducting simultaneous data collection and analysis is systematic and explicit strategies were followed during this process (Charmaz and Greenberg, 2020). This involved 'Coding', 'Memo-writing', 'Theoretical Sampling and Sufficiency', 'Constant Comparative Analysis', and 'Integration of the Theoretical Framework'. Following these guidelines is recommended by Charmaz (2014) in order to identify categories and to understand the relationships between them (Willig, 2013) in order to construct a theory which is grounded in the data (Charmaz, 2014). There is a degree of flexibility in the process outlined below to ensure that the research process is not stymied by adherence to overly rigid methodological procedures (Pidgeon, 1996). In the sections below, I have demonstrated how these GT procedures were applied to the data.

3.12.1 Generating Theory – Using NVivo 12 Coding Software

I decided to use coding software called 'NVivo' as attempting to organise the CGT coding process manually felt completely overwhelming. After uploading each transcribed interview to NVivo, the software enabled me to select a portion of the text and save it under each code. I experienced a feeling of 'trust' in the organisation and process of the software and this allowed me to focus on the task of coding and to code with 'speed and spontaneity' Charmaz (2014) p48. I initially used line-by-line coding which involved studying the data line-by-line to begin to conceptualise my ideas. I coded in this way using 'gerunds'; categorising each line with a short name that encapsulates the 'action' in that section of text (Charmaz, 2014).

3.12.2 Initial Coding and Using Gerunds

I uploaded each transcript to NVivo and embarked upon initial (line-by-line) coding adhering closely to the data and using gerunds to see the actions in each line rather than applying any pre-existing ideas that I had developed during the course of data

collection. Glaser (1978) advises that the use of gerunds for initial coding helps the researcher stay close to the data by 'preserving actions'. Coding in this way allowed me to consider the data in a different way and comparing these fragments of data enabled me to ask analytic questions about participants' actions and experiences (Charmez & Thornberg, 2020). The process of moving back and forth between data collection and analysis allowed me to check on the pertinence of my developing ideas around emerging themes and to answer questions that had arisen during the coding process. These questions and ideas were recorded in the form of 'memos' (See Appendix 5 for example).

3.12.3 Focused Coding and Constant Comparative Analysis

The initial coding process was extremely intensive, but after completing the process of initial coding (line by line) for my first three interviews, my initial codes began to coalesce, and focussed codes and various themes began to emerge (Charmaz and Thornberg, 2020). I kept track of these by engaging in rigorous memo writing to track and organise my thinking and begin to introduce tentative focussed codes into NVivo. The process of 'focused coding' allowed me to sort and separate the data and apply initial coding. As I went through this coding process, I wrote memos to help develop and explore my ideas about the codes and organise them into analytical categories. Memos were also used to direct and focus further data collection depending on the coding of the data already collected (Charmaz 2014). These were figural in helping me achieve this (See Appendix 5). Additional data was collected in light of categories which emerged from the first data collection and analysis. I then refined and expanded the major categories with additional selective data using theoretical sampling in light of the more recent data (Willig 2013). This process was then repeated and constant comparative analysis used throughout. Constant comparative analysis is a process by which differences within a category and sub-categories can emerge (Willig, 2013). This can be achieved by focusing on the differences within a category as well as the common features that form a category. This process allows the full intricacies and complexities of the data to be explored and recognised. The objective in carrying out this process is to form links between the categories and to integrate them in such a way that all variations both between and within categories are captured (Willig 2013).

I then repeated this process until the categories and sub-categories I had developed captured the vast majority of the available relevant data and no additional categories could be identified from new data; the point at which theoretical saturation was achieved. At this point, I was then able to examine the categories, sub-categories and relationships between the categories and sub-categories and explore theoretical formulations that had emerged from the data analysis (Willig 2013). I have illustrated this process in Appendix 8 which shows how sections of the initial interviews were assigned to initial codes, focussed codes, sub-categories and categories.

The ninth interview I coded produced no new focused codes or sub-categories and at this stage I had a sense of five 'main' categories. However, the relationship between two of my main categories felt harder to understand than the other three categories, which I felt had reached 'theoretical sufficiency' through constant comparative analysis. I felt that because of this and the implicit nature of the phenomenon I was considering, I needed to return to my co-researchers to understand more fully the layers and depth of the data to ensure the robustness of the research and the theory I was generating. This felt particularly important as the concepts with which I was grappling had been developed from multiple data sources and my own subjective response.

In CGT the influence of the researcher's subjectivity is emphasised and co-constructing the data along with interactions with the co-researchers is expected (Charmaz, 2014, Dunne & Gamze, 2020). This also formed part of working ethically as a researcher; collaborating with my co-researchers in order to verify my subjectivity and reflexivity in the construction of this theory. I therefore returned to my co-researchers to better understand the relationships between the categories, for greater understanding in the categorisation and to find out what was at the core of this theory. I decided to be completely congruent with my participants. The concept of the core category, with which I was struggling, had an emergent feel for me, so the understanding and depth I was seeking needed to have a similar emergent quality. I shared with them what was emergent and that the purpose of the second round of interviews was to both verify and to deepen my understanding

3.12.4 Theoretical Sampling and Theoretical Sufficiency

Returning to my co-researchers for a second round of interviews was both rewarding and clarifying and emphasised to me the co-created nature of this process. I had been struggling with the concept of 'integration' in the context of this research since the interaction with my PAP panellist I described in the initial literature review. Reflecting on this at the time led to my understanding that my unconscious bias had been directing me away from the possibility that EMDR could be integrated, which is why I had felt so 'stuck' with the data analysis and had returned to my co-researchers for help.

All but one, who was away on holiday, quickly responded to my request for a follow up interview and seemed motivated to continue to engage in the process. Strauss and Corbin (1998) suggest that researchers follow their "gut sense" (p 150). Mine seemed to have been stymied in the context of the core category due to my unconscious bias around a theory with integration at the heart of it. Returning to my co-researchers felt clarifying and at the same time provided a sense of rigour as they all responded with the same conclusion, albeit in very different ways. This data enabled me to understand the relationship between the five main categories and through doing so, to form the basis of the core category of this grounded theory.

3.12.5 Memo Writing

Recording my thought process using detailed memos from the outset allowed me to record my reflective journey and helped me to organise my ideas around the emerging codes, sub-categories and categories. They helped facilitate 'constant comparative analysis' and were a lifeline to me in terms of being able to 'hold on' to thoughts, ideas and reflections which often felt like they would dissolve away like dreams if I hadn't pinned them down with a memo. Memo writing was key in the evolving nature of the categories and sub-categories and served as a key reminder of the analytical insights I had at various stages. They also helped to ensure a sense of quality in the study (Charmaz and Greenberg, 2020) (see Appendix 5).

3.12.6 Theoretical integration

The use of diagrams to conceptualise and understand my evolving theory were key and led to questions around the relationships between categories and the formulation of the core category. This led to returning to my co-researchers in order to help me understand the relationships between the categories. Having received input from my co-researchers, I then considered this in the context of the other main categories and the relationships between them. Integration was at the core of my theory, but it felt like it needed some clarification in the context of this GT as it is not a term with a universally accepted meaning, as discussed in the following chapter. Broadly speaking, the 'integration' in this GT is integration of the five main categories and their sub-categories. However, I wanted to capture and demonstrate the unique nature of every intersubjective therapeutic meeting that had been so apparent throughout the data. Simply depicting integration as the integration between the other main categories felt reductionist and as though the essence of what I and my-co-researchers had collaborated on had not been adequately encapsulated. On the basis of this I evolved the core category to 'Integration – Uniqueness with Commonalities', which I felt captures what is at the heart of this GT.

3.12.7 Trustworthiness and Quality

I have made references in the above sections to where quality was maintained under various aspects of this research methodology. I will now set out the mechanisms I used to maintain quality and trustworthiness in this research. Although quality and trustworthiness are crucial in qualitative research, there is no universally accepted criteria (Corbin & Strauss 2015). I therefore elected to follow the set of evaluation criteria set out by Charmaz (2016). Charmaz (2016) advocates the use of four main criteria for CGT studies: credibility, originality, resonance and usefulness. Treharne and Riggs (2014) ask for the additional criteria of reflexivity (discussed under 'credibility') and transparency which are significant components of CGT methodology. I have added this to my evaluation criteria and I describe them below.

3.12.7.1 Credibility

The issue of credibility is applicable to two different components of this research; 1) the treatment of the data and analysis and 2), the beliefs and behaviours of the researcher. With regard to the data and analysis, I have demonstrated credibility by making systematic, constant comparisons throughout the data collection and analysis process. This iterative process began with initial coding; comparing codes to new data and also codes to other codes, continuing throughout the process of focussed coding. Comparisons are made between sub-categories and categories and both are checked against both new and existing data until theoretical sufficiency was reached. As mentioned previously, once theoretical sufficiency had been reached, I returned to my co-researchers after a period of reflection on the emerging categories and core category, for the process of theoretical sampling. This involved validating my understanding of the data with my co-researchers and gathering further data to expand and enrich my categories. The iterative processes employed though-out the CGT data collection and analysis built the levels of trustworthiness that Williams and Morrow (2009) argue is essential in counselling psychology research. Once the main categories and core categories have been developed, they are then compared to existing literature. As mentioned previously, this takes place after theory development as due to the nature of CGT, the researcher does not know prior to this where the research process will take them (Charmaz & Greenberg, 2020).

From a researcher's perspective, 'credibility' means taking on what Charmaz (2017) refers to as 'methodological self-consciousness'. This means a high level of reflexivity throughout the process, not just in terms of methodological decisions, but also around the person of the researcher and their views, opinions and values, both conscious and unconscious. I described in the introduction, the extent of my immersion in the field and the challenges, as well as the benefits, of being an 'insider-researcher'. I have explored this subjectivity throughout the research process. This reflexivity was particularly important during the process of data collection and analysis and I used reflexive memo making throughout the process to understand and reflect on my subjectivity (See Appendix 5).

3.12.7.2 Originality

Originality refers to either the offering of new insights or provision of a new understanding of an established question (Charmez and Greenberg, 2020). The generation of a new theory from inductive data analysis, derived from the experiences of the participants and the subjective analysis of the researcher in accordance with CGT methodology facilitates this requirement. The following discussion around the developed theory and existing literature gives context to the developed theory. In this research, the theory constructed from the analysis of the data, pointed to a new understanding of the common components involved in working with EMDR and complex trauma. The core category of 'integration – uniqueness with commonalities' also offered a new perspective, on the concept of integration, in the context of the results.

3.12.7.3 Resonance

In CGT, resonance means that data gathering strategies need to evolve to more effectively understand participants' experiences. This took two forms in this research. Firstly, as I described earlier, the iterative process of simultaneous data collection and analysis allows the researcher's early ideas to inform subsequent data collection (Charmaz & Greenberg, 2020). This allowed me to enrich the data in subsequent interviews. For example, early on, I recognised a sense of collaboration when participants spoke about the therapeutic relationship. This idea was recorded in memos following early data collection and analysis and was explored in more depth in subsequent interviews to enrich and expand upon the findings.

3.12.7.4 Usefulness

As the research component of a professional doctorate, usefulness in the form of contribution to practice and future research was a key consideration from the start. This will be discussed fully in the discussion chapter and recommendations for practice informed by the results, will be made.

3.12.7.5 Transparency

Throughout the process I kept a detailed audit trail in the form of memos to document the analytic process and my reflexive journey. Alongside this I used both research and peer supervision to reflect on the analytic process and my personal reflexivity throughout. As described above, I also used respondent triangulation in the form of a second round of interviews to validate and enrich my analysis.

3.14 Summary

This chapter has described the methodological components I employed in this GT study and the strategies I used to ensure rigour and quality. I have evidenced the methodological journey and my reflexivity is demonstrated throughout and supported by the associated appendices.

Chapter 4: Findings

4.1 Overview of Chapter

In this chapter, I first describe the challenges I encountered in presenting my findings and the rationale for the approach I have used. I then briefly re-visit what is involved in the construction of a Grounded Theory (GT) in the context of my approach to this chapter. I then present detailed explorations of the five main categories developed, in turn, including their sub-categories. The sub-categories relating to each category are shown in a table and a diagrammatic representation is included for each of the main five categories. These diagrams represent the fluid nature of these findings, both within the sub-categories and between them within each category. I finish by presenting the development of the single core category.

4.2 Challenges in presenting the findings

Presenting the analysis of my data was challenging due to the non-linear nature of grounded theory. In grounded theory, methodology, sampling, data collection, and data analysis are conducted simultaneously (Charmaz, 2014, Glaser & Strauss, 1967). The decision-making process for the adaptation of constructivist Grounded Theory for this research, was very much interwoven with the process of data analysis. For this reason, there is a necessary amount of overlap and cross-referencing between the chapters in order to present a full and rounded picture of this process, the analysis of the data produced and the resulting grounded theory.

4.3 Rationale for presentation of the findings

In grounded theory it is usual to present the core category first in the Analysis chapter. However, I have chosen to present my categories in a way that represents the organic way in which they were constructed because understanding the construction of the sub-categories, main categories and the relationships between them, feels crucial in

understanding the development of the core category. This method of presentation also mirrors the preceding methodological chapter which describes the process of the data analysis and the construction of the categories I feel that this will give the reader a better understanding of how and why the sub-categories, categories and finally the core category were constructed in order to form the basis for this grounded theory. In accordance will recommendations by Dunne and Gamze (2020), I will not explore the theoretical context of my findings in this chapter, this will be explored in the following 'Discussion' chapter.

4.3 Construction of the Grounded Theory

As mentioned previously, I chose grounded theory as the most appropriate methodology for this research because the development of a theory was necessary to provide a comprehensive response to my research question. In the following sub-section, I present an outline of the process of the grounded theory analysis and the development of a theory behind how integrative practitioners use EMDR as part of their practice.

4.3.1 Category construction and relationships

In the construction of the GT it is vital to understand, not just how the individual categories are constructed, but how each conceptual category relates to the others (Urquhart, 2013). The core category was constructed though analysis of the relationships between the categories., I explored the initial relationships resulting from my own analysis of the data and theoretical sampling by returning to my co-researchers for a second round of interviews, deepen and enrich my understanding of the relationships between categories. This data is presented in this chapter along with quotations to demonstrate both how it enriched and clarified relationships between the main categories and enabled the construction of the core category. The relationships between the categories is examined in section 4.7 'Core Category'. However, during the process of examining the individual categories and sub-categories, the relationships and integration between the categories will begin to emerge.

4.4 Overview of the findings

The core category generated through the analysis was termed ‘‘Integration – Uniqueness with Commonalities’ to indicate what was at the core of how my co-researchers worked with EMDR and complex trauma. This was derived from the development of the five main categories and the relationships between them. The five main categories were identified as; ‘Relational Stance’, ‘Working with Developmental History’, ‘Parts Work’, ‘Structure and Process’ and ‘Right-Brain Processes’. These categories are comprised of sub-categories and developed from focussed codes, which are outlined in the following sections. An illustration of the analytic process which includes focus codes, sub-categories and main categories is in Appendix 8.

4.5 Main Category 1 – Relational Stance

4.5.1 Introduction

The central importance of a relational way of working began to emerge from the very first interview, as a major component in how integrative therapists work with EMDR with complex trauma. This category conceptualises the importance of taking a relational stance when working in this way and is divided into three sub-categories, which are examined below to demonstrate how the category ‘Relational Stance’ was constructed.

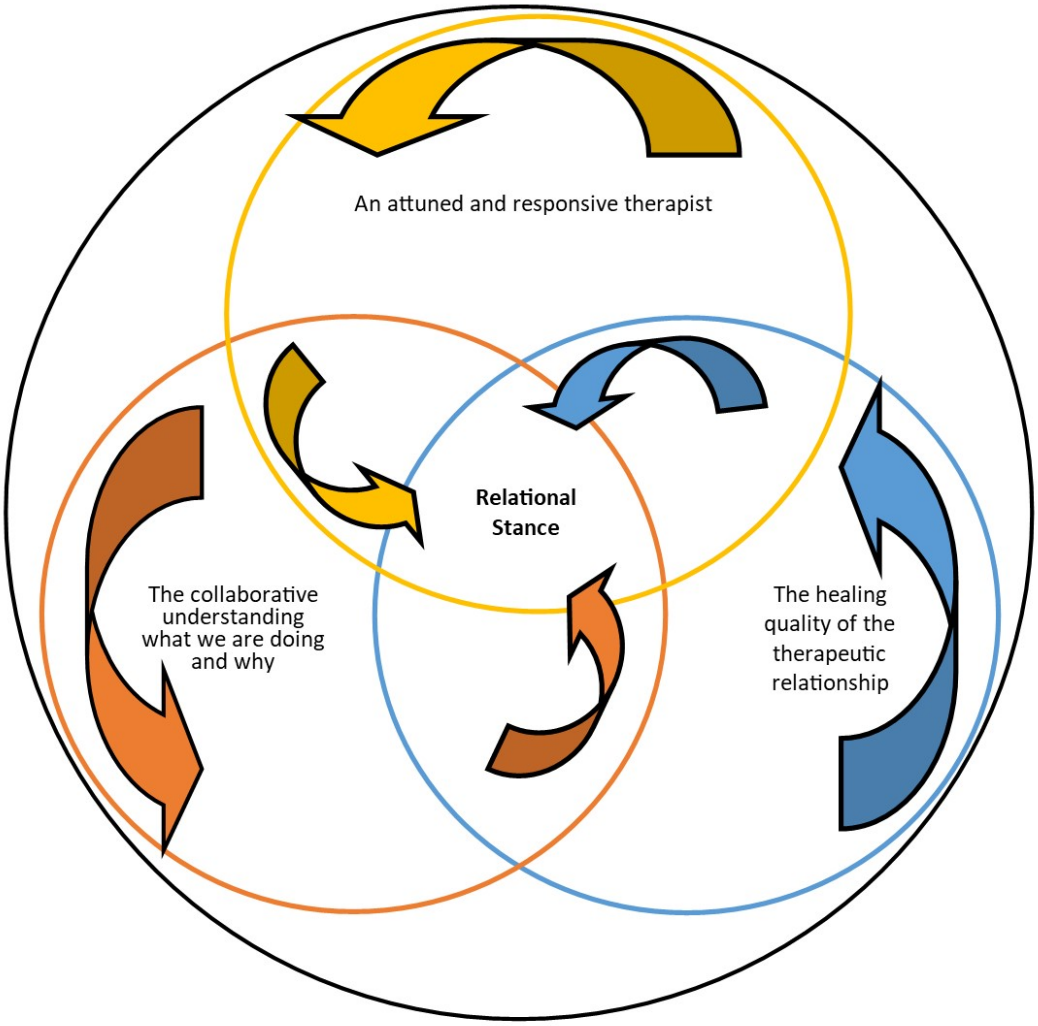

Figure 1: Diagrammatic Representation of 'Relational Stance'

Category	**Sub-Categories**
Relational Stance	An attuned and responsive therapist
	The collaborative understanding what we are doing and why
	The healing quality of the therapeutic relationship

Table 2: Relational Stance – Sub-Categories

4.5.2 An Attuned and Responsive Therapist

The importance of an attuned and responsive therapist was apparent throughout the interviews. A dynamic immediacy between therapist and client was described and a sense of congruence in the therapists' response, borne out of their attunement, and resulting responsiveness. Below I illustrate how this sub-category was constructed, using quotes from a range of co-researchers. This range of quotes demonstrates the uniqueness of each therapists' understanding and how, through our collaboration as co-researchers, this category was constructed. I feel this is important to illustrate as it demonstrates the depth and richness in the responses as well as the variance.

Jacob described this attunement and responsiveness as a 'dance' and emphasised the very personal nature of this interaction:

> *In effect we're sitting down, being with, attending to a client's experience… It is an intuitive, individual, very, very personal and intimate dance of one human being with another*

The need to work in a way that is more active than passive was seen as important. Collette emphasised the necessity of an active therapeutic role when working with emotions related to hyperarousal, which is obviously common when working with clients presenting with complex trauma.

> *You know that old therapeutic idea of helping people to just sit with things? That's great for the adaptive emotions; Anger turns to sadness and sadness into acceptance or whatever. But the hypo-arousal related emotions, the shame, despair, hopelessness, aloneness, self-disgust, they don't transform. And if people sit with them, they just go down and then they dissociate. And you think they feel better. They don't feel better at all, they've just dissociated.*

'The stance of along sidedness and self-compassion' is a focussed code which was eventually merged into the sub-category 'An attuned and responsive therapist' (see appendix) but the stance of self-compassion was evident throughout the interviews,

implicitly as well as explicitly. Liz gave an example of how taking a stance of self-compassion changed her client's experience of her presentation:

> *That was a very important thing in helping her deal with the ADHD issues because it seemed to get through her experience of being wrong and naughty all the time and making it okay. She was still lovable.*

Melanie described the importance to some clients of being able to experience compassion towards their younger selves, or perhaps to the younger parts of themselves, to understand their experiences in a different way.

> *I think the self-compassion is really important… when they were five and they tell themselves that they should have been able to stop this guy abusing them. Then you can say just look at the little girl that you were, just look at her. What do you see? Now some clients hate their little child. And then you need maybe to bring somebody else in, but clients often they then say, "Well, she was very little. She was really small, and it's very sad that it happened to her," and then the compassion comes in.*

When Tristan described a client of his to me, it was his description of the process of using EMDR with this client that demonstrated to me how attuned and responsive he was to this client. At every moment he seemed to be with his client as a holding presence, moving the processing on when needed, but also just being with and allowing the processing to flow, very much like the 'dance' described earlier by Jacob.

> *I know that I don't need to do anything at this point. I need to just say, okay I know that's very painful, stay with that, go with that, tuck your legs, hold the buzzers, whatever it is, go with that, stay with that. Stay with that, stay with that, stay with that. I'm with you here, it's just like, I'm with you, I'm with you in this. I'm with you. I'm with you. Hold on, hold on, keep going, we'll get there. And then it starts to move on, and it starts to ease up, and I go, okay it's getting a bit easier. Good, notice that. Notice that, notice that, notice how it's getting a bit easier. I am with you in this, it's getting easier. Now what happened? Now*

where are we? What's going on now? Go with that, go with that. Now we're levelling out, okay. Now it's desensitizing,

The above quote seems to hold self-soothing, 'alongsideness' and attempts at co-regulation. Bill spoke about how the relationship both supports and informs the attunement of the therapist to the client "And that then is just down to that client therapist relationship to know what's the best for you right now. What would help you right now?". Bill delivered these questions in a very gentle and compassionate way, as if trying to soothe an early developmental part. Working with child ego states with be discussed fully later on under '4.4 Parts Work', but consideration of it is relevant here in understanding the sub-category 'an attuned and responsive therapist'. Olivia described the need to be attuned to a regressed client to allow the therapist to appropriately respond "because when you're talking to people who've regressed to two or three years old, what do you do with the two or three-year-old but hold their hand and give them a hug".

An important aspect of a therapist being attuned to their client and responding appropriately is the use of psychoeducation. This was a focus code which was merged into this sub-category during the process of constant comparative analysis (See appendix 6). Olivia described how she had experienced educating clients as 'empowering' them:

Yeah, so that's what I was saying a moment ago that I think it's really important to educate the client. I think it's empowering for them to be educated, and obviously it depends who they are and what they need.

Olivia went on to talk about responding to clients with psychoeducation around concepts, to understand their internal processes. She gave an example of how she used psychoeducation around the concept of 'boundary image' as a response to clients who are in danger of being 'flooded', should their 'barriers' collapse:

Because I find boundaries is a really helpful concept in this model, because people either have walls up) or they'll suddenly go, and they've got nothing, and they're just absorbing everybody else's feelings and feels overwhelmed and

over responsible. Again, educating clients with a concept of what's your boundary image? How are you going to protect your essence and not let everybody's stuff come into you.

4.5.3 The Collaborative Understanding of What we Are Doing and Why

There was a real sense among my co-researchers of a collaborative, co-creative endeavour with their clients, and a real feeling of mutual respect and equality within that endeavour. Both parties bringing their own understanding and experiences, but meeting each other as equal, respectful adult humans.

I think people deserve a human relationship; it's a very human, equal adult relationship – Collette

One co-researcher identified a ‘we-ness’ intrinsic to the alliance, “it's important to me it feels like an us.” (Janet). The work was often described as relational collaborative endeavour, “the relationship feels collaborative, while I'm doing EMDR. It's not me doing it to them, it's us doing it together” (Liz). Olivia described the “essential nature of the therapeutic relationship” to this way of working and how she sees herself and her client as a ‘partnership’ in the endeavour. The sense of collaboration and equalness was apparent throughout the data:

I think at the moment it's our ability as a collaborative team to regulate her affect - Melanie

Jacob described how this collaborative understanding of what therapist and client are doing and why it is so necessary in work with complex trauma, but also how EMDR is ideally placed to offer this collaborative understanding due to the targeted nature of the therapy.

If you hit a target broadside, you're just going to activate a whole lot of networks, and the client is going to go away just activated and dissociating, maybe going away and self-harming again, because there's a lot of self-harm involved, of

course. But with EMDR, there's the brilliance of EMDR. It gives us the tool. It gives us the focus in understanding what we're doing and why. Where we are, what is it we're doing, where we're doing it, when we're doing it, and why we're doing it, and how we're doing it. That's the absolute brilliance of EMDR, of attachment-focused EMDR. Is this making sense?

Collette spoke about the explicit nature of her collaborative relationship with her clients involving an open and honest dialogue about the direction and efficacy of the therapy.

The reason I'm doing this, is I don't ever want you to think, I'm not quite sure if therapy is helping. I always want you to know exactly how therapy is helping. Instead of the therapy being this process where you sign up for it, and you're not quite sure whether it's helping or not, but it probably is, but you can't really talk about it because you don't want to upset your therapist. I quite regularly say, "How are we doing? Is this what you wanted? Is this meeting your needs? How is this going? How is this working for you?

Her clarity and genuine invitation for feedback from her clients, felt very much embedded in her therapeutic process, as a part of that process, a therapeutic intervention as well to help her to understand her client's experience:

So that's meta processing, make the implicit explicit. But then make the explicit relational. What's it like to do that with me
In one on one, I'll do the same. It's a balance, you can't do it in an anxious way, "Tell me I'm doing okay". It has to be a genuine desire to know, how is this working for you? What was that like for you? Because if it's not a collaboration, it doesn't work as well.

The use of implicit understanding is discussed fully under later on, but it is clear from this data that the collaborative understanding of what we are doing and why is an implicit as well as an explicit process. Elements from the previous sub-category 'An attuned and responsive therapist' are also interwoven here. The therapist is attuned to her client's need for understanding and insight, much of which may be implicit. The

therapist then responds, in that this implicit understanding and this is communicated to the client in the form of explicit feedback.

4.5.4 The healing quality of the therapeutic relationship

The codes and themes around the therapeutic relationship began to emerge from the beginning of the first interview. What I have tried to demonstrate below is the richness and depth of this sub-category, illustrating this with a variety of quotes from across my co-researchers first round of interviews. The importance of the therapeutic relationship was unequivocal across the data:

> *The relationship with the client is incredibly central to it – Jacob*

> *For me it's a relational process, it has to be a relational process. I can't hide behind it. I'm with them, watching them very closely. That's very important – Janet*

> *There has to be a relational experience between the client and the therapist. – Steven*

Co-researchers described their understanding that the therapeutic relationship is healing in itself, as well as the relationship acting as a container to allow to work to take place:

> *And it's in the containing frame of the therapeutic relationship. So ultimately it is the relationship that heals, and all of the evidence points in that direction. No matter what technique you use, if the relationship isn't there, it won't work. It's not just the technique that you apply.. – Jacob*

> *I think any therapy, it's always largely about the relationship. – Steven*

As mentioned previously, my co-researchers all also identified themselves as ‘integrative therapists’ which was part of the recruitment criteria. However, no two co-researchers had the same background or training, and many had experienced a

variety of different trainings in various modalities. As the categories developed through this analysis will show, there are key commonalities in how these therapists work and the relationship is seen as key, whatever the therapy/modality and emerged strongly throughout the data.

> *Any kind of psychotherapy training, whether it's psychoanalytic through the person-centred pseudo-Gestalt psychosynthesis, doesn't matter. The basis is the relationship. – Liz*

> *It is clear to me that unless you have a therapeutic relationship, whether you come from person-centred or from Gestalt or from transpersonal, you're not really getting the kind of results that you want to get. - Tristan*

The relationship was understood, not simply as a vital component of the therapeutic endeavour, but as an evolving and developing construct. The importance not only of establishing a therapeutic relationship early on, but also of the limitations of the relationship at that early stage and the need for this to be strengthened and developed for the work to take place:

> *And one of the milestones is the therapeutic relationship at the beginning. So, as you do the history-taking, you already establish a therapeutic relationship….. Then you have the preparation phase, and the way you conduct a preparation phase, it enhances the therapeutic relationship. – Tristan*

> *The therapeutic relationship is central. I believe that without the attunement and involvement and interest and curiosity of inquiry, that you're never going to get alongside a client and the client's material – Janet*

The importance of the strength and depth of the therapeutic relationship was understood by my co-researchers to be particularly pertinent in work with clients presenting with complex trauma, which is obviously the focus of this research. It was broadly understood across co-researchers that work with this client group would not be possible without an established therapeutic relationship

I couldn't do EMDR work with this client who's been multiply sexually abused by a large number of people, I couldn't do that if there was not a good therapeutic alliance. She's got to trust me enough to sit in a room with a man to go over what happened to her. – Tristan

With those kinds of clients, the relationship is primary because it's all about establishing trust and safety and their capacity to tolerate their own feelings and stay present in the room, show vulnerability. – Steven

4.5.5 Relational Stance – Summary

As stated in the introduction to this section, an emphasis on various aspects of the therapeutic relationship, became clear from the beginning of data collection. Through the process of coding and constant comparative analysis, the three sub-categories discussed above were constructed and these categories were tested against further data by the process of theoretical sampling to ensure that these sub-categories we sufficient to encapsulate data from further interviews. These sub-categories sit closely under the category 'relational stance' which demonstrates the overall relational approach taken by my co-researchers towards their clients, the elements of which were categorised with the sub-categories which in turn were formulated by the focused codes derived from the analysis process (See appendix 8).

4.6 Main Category 2 - Working with Developmental History

4.6.1 Introduction

Developing an understanding of how their clients developed their presenting issues from an attachment and developmental perspective emerged strongly throughout the data. This understanding broadly took the form of understanding clients' attachment experiences, finding and understanding the root cause(s) of a client's dysfunction, understanding a client's core belief system and understanding how clients regulate and soothe themselves. These different aspects of understanding clients' developmental history formed the four focussed codes which are the basis of this category. Through constant comparative analysis, these codes were distilled into two sub-categories: 'Understanding the client's attachment history and the emergence of their core belief system' and 'Working with dysregulation and self-soothing'. The category itself 'Working with developmental history' was constructed from these two sub-categories and was named as such to indicate that the understanding of a client's developmental history is important because of how these therapists' were using and interpreting this information to both develop their case conceptualisation and to inform the direction of the work.

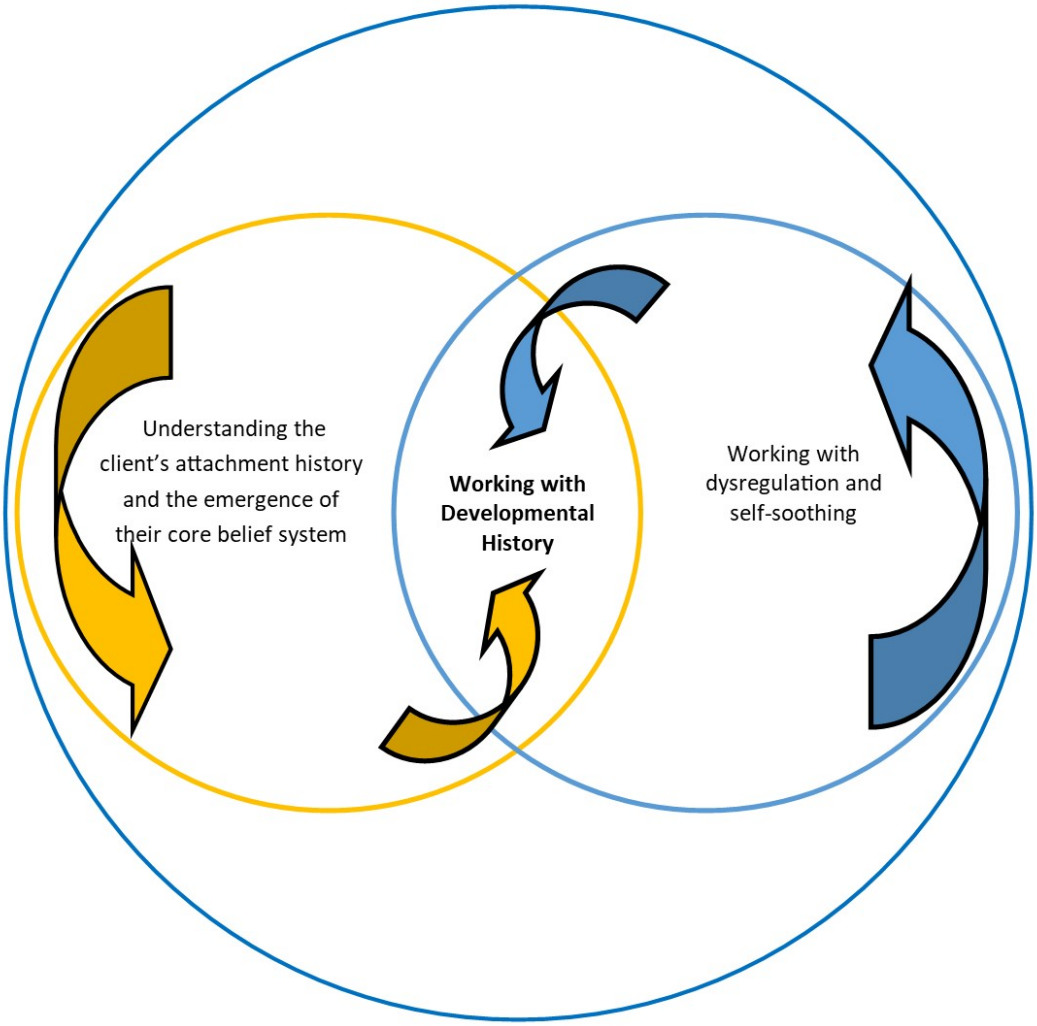

Figure 2: Diagrammatic representation of 'Working with Developmental History'

Category	**Sub-Categories**
Working with Developmental History	Understanding the client's attachment history and the emergence of their core belief system
	Working with dysregulation and self-soothing

Table 3: Working with Developmental History – Sub-Categories

4.6.2 Understanding the client's attachment history and the emergence of their core belief system

The understanding of both clients' attachment experiences and core belief system emerged throughout the data and are able to sit together within this sub-category due to the data indicating that core belief systems emerge as a result of our attachment experiences. Jacob described his understanding of this:

> *You have complexity and deep attachment trauma burned into the system from a client's early childhood experiences.*

Steven spoke about the importance of understanding the client's developmental history in terms of their early attachment relationships

> *So looking at their childhood patterns, their attachment with parents and any primary caregivers, extended family.*

Several therapists spoke about the ways in which attachment and developmental experiences are key to informing the work:

> *So we have to get into, right down to the bottom of the root system. It's no-good cutting off weeds at the surface. It's no good just damming the river. We've got to find the source experiences or the root experiences. That's why attachment... and a fundamental understanding of the neurobiology of attachment needs to be, in my view, at the heart of all psychotherapy, because 99 out of 100 cases that present themselves are to do with the neurobiology of attachment before the age of 12 - Jacob*

Standard Protocol EMDR (Shapiro, 1989) largely focusses on a client's recent trauma as a presenting issue. Across the data co-researchers described how understanding a client's developmental and attachment history is important and why focusing simply on a recent trauma often does not have the desired impact in terms of reducing the client's distress:

Because you haven't factored in the understanding of attachment and fundamental human experience….. 800 or 900 clients. It's something like 10,000 hours, and I would say that, of those, I would say I would have had... let's say I'm approaching 1,000 clients. And I would honestly say that I've had single-incident simple trauma four or five. The rest are all attachment-involved. Every single one. - Jacob

Developing an understanding of the root of a client's dysfunction, allows the therapist to structure the work with the client in terms of the 'targeting' approach used in EMDR. This overlaps somewhat with another main categories, 'Structure and Process' in terms of the understanding of a client's developmental history, forming the basis of the structure of the work.

Several co-researchers had a psycho-dynamic component to their training and Steven described how this approach informed the use of developmental understanding in working with EMDR

There's a strong emphasis in I guess psychodynamic in a way, which I think EMDR does. The whole aspect of a touchstone event is relating to role of childhood and earlier touchstone events. That kind of orientation is there.

Yeah. I've also done psychodynamic training.,... what happened at various points. I'm looking for relationship deficit that will cause trauma. – Janet

Tristan did not have any psychodynamic influence in his training and spoke about, in his earlier work, focussing on the presenting trauma. However, he then described how working with EMDR has bought about a greater understanding of the importance of a client's developmental history in informing the work.

I'm increasingly aware that the roots of issues go back much further.

He then described a pivotal case in his therapeutic journey, which demonstrated to him the importance of developmental understanding in informing the work:

And I remember I had a turning point in my therapeutic journey with a patient who came into the hospital, he had a severe OCD, he had a major aversion to anything that looked like blood, he was highly anxious and so forth. And he'd been treated conventionally for quite a while and no-one had ever seen the fact that his mother had committed suicide in front of... he walked into the room, and his mother was stabbing herself with a knife repeatedly, died in front of him, bled to death. So, no-one had ever really connected... I mean they'd highlighted this incident, but no-one had ever really dealt with it.

My co-researchers work with a variety of client groups, the common factor being that they all work with complex trauma within these client groups, Janet and Jacob both described how the understanding of a client's developmental history is vital to the work as it impacts whatever the client is presenting with and how complex developmental trauma is usually at the root of these presentations

I work a lot with sexual addiction and I've always been looking at sexual trauma as part of the addiction. But also, attachment problems and the trauma of poor attachment…. No one being there or people being narcissistic and never meeting their needs, or whatever. I'm always looking back at early attachment patterns as well. Where they learnt to break contact. – Janet

Let's look at the neurobiology of this. If you've got a client in distress with OCD or with bipolar or personality disorder, which is a diagnosis I absolutely loathe because it ought to be called 'developmental trauma disorder', most of the diagnoses have their roots in attachment experience and the capacity to self-soothe or not appropriately and functionally and adaptively. – Jacob

This quote feels like it really gets to the heart of what the co-researchers were describing, which is that whatever the diagnosis, it is the root, the developmental cause of the distress that needs to be treated rather than the symptoms.

4.6.3 Working with dysregulation and self-soothing

This sub-category is about understanding the client through their dysregulation and their self-soothing strategies and how the work is informed by the client's ability to regulate and self-soothe. Jacob described how an understanding of a client's ability to regulate informs his work:

> *Most of the diagnoses have their roots in attachment experience and the capacity to self-soothe or not appropriately and functionally and adaptively….and that, in 99 times out of 100, goes back to how they learned affect regulation in their primary attachment experiences.*

Jacob went on to describe the fundamental importance of understanding how clients self-soothe or their inability to self-soothe appropriately:

> *If you really take it back to the fundamentals of human experience, everything, I think literally everything the clients bring to psychotherapy is a consequence or an experience of their inability to sooth themselves appropriately for their current age.*

Steven described how a client's ability to regulate themselves forms an important part of his assessment.

> *Do a thorough history. A few things are going to determine whether I do EMDR. One, their capacity to tolerate their own emotions. For many people, they're affect-phobic. They're avoidant or kind of aversive to their own emotions.*

He also spoke about how information regarding a client's ability to regulate and soothe themselves informs the work in terms of what the client can tolerate. As well as informing the direction of the work.

> *To make sure they're safe. To make sure they can tolerate their own feelings. That, for some, might take a few weeks. For some that could take ... I might work more than a year before I actually do any EMDR.*

If they're outside their window of tolerance, they're going to shut down the process. Whether it's hypo-arousal or hyper-arousal, either way they're just going to shut it down. Defences will kick in. Even as brilliant as EMDR is, it cannot bypass someone's defences. If it does, they could get dysregulated.

Jacob spoke about his understanding of the reason people present to psychotherapy in the first place is because they are unable to regulate and soothe themselves in functional ways

I didn't realise it at the time, in the sense of reparenting, because the reason in my understanding, both neurobiological and felt sense, the reason people present in psychotherapy is because they have dysfunctional ways of affectual soothing. It's as simple as that.

It became clear from the data that understanding a client's ability to regulate themselves when they are hypo-aroused as well as hyper-aroused is important, especially as it may not be as immediately obvious. Steven gave an example of the importance of this understanding in determining why a client may be blocking affect:

Again, that depends. If they're really terrified of the emotion, we need to understand what it is. That's where I said something like blocking beliefs might come in. They might have a belief that feelings are dangerous. They might have a feeling that, if they go there, they'll go crazy.

Collette described the importance of understanding how clients regulate or the reason they are unable to do so:

He is in a worst state than most. Most people I work with have more of an ability to regulate themselves. He decompensates and can't regulate himself, except by switching off and throwing himself into his work. That's how I did it with him…. that was an EMDR session, you can process non-verbal stuff with EMDR, but with him we needed to reach this hypo-aroused child. We needed to reach through just waking him up a little.

4.6.4 Working with Developmental History – Conclusion/Summary

Two very distinct areas relating to clients' developmental history emerged from the data. Getting a real understanding of their attachment and developmental history and the cause of their dysfunction and through these, understanding how their core belief system was developed and understanding how a client learned to soothe themselves. These two areas formed the basis of this category.

4.7 Main Category 3 - 'Parts' Work'

4.7.1 Introduction

The concept of working with 'parts' emerged strongly across the data. I have used inverted commas around the word 'parts' in the title of this category, to indicate that I have used the term 'parts' as a generic expression to describe the commonalities in working in this way.

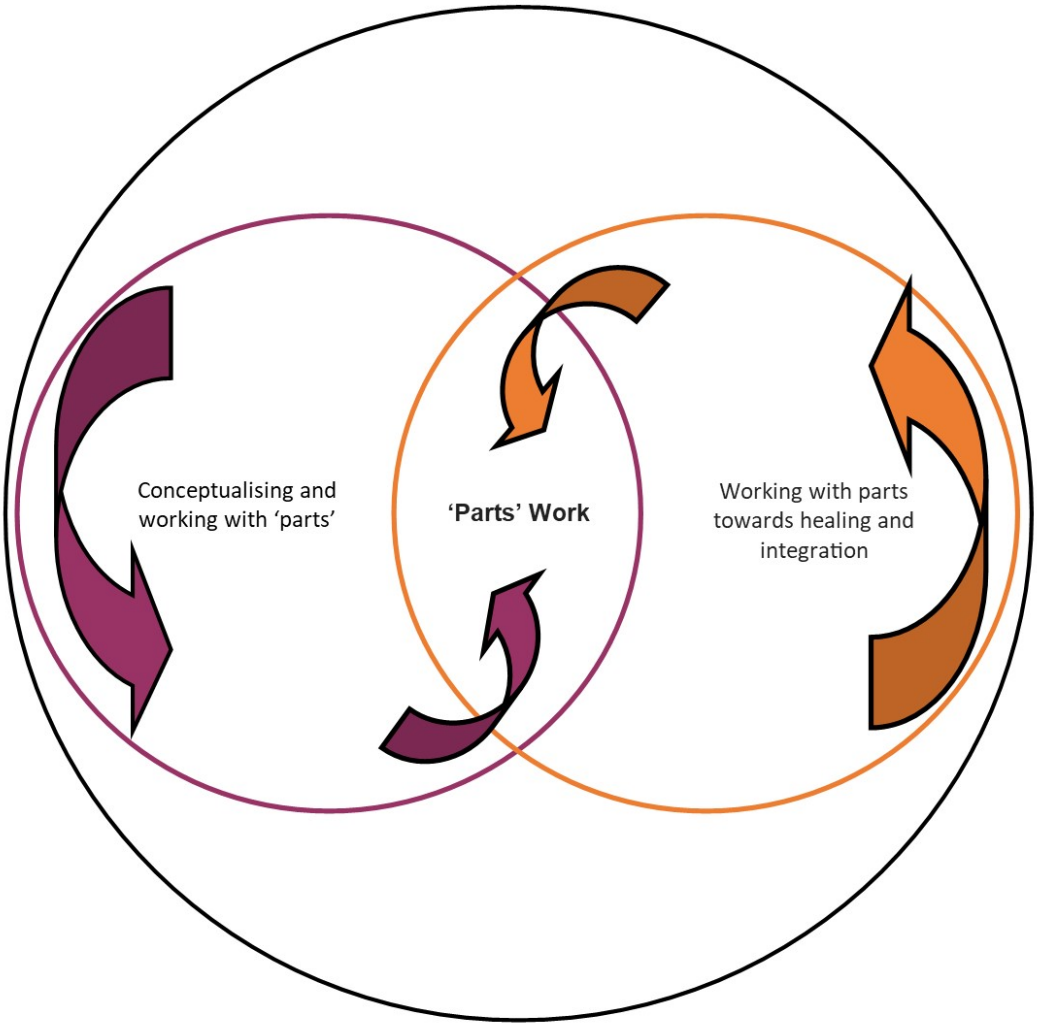

Figure 3: Diagrammatic Representation of 'Parts' Work

Category	**Sub-Categories**
'Parts' Work	Conceptualising and working with 'parts'
	Working with parts towards healing and integration

Table 4: 'Parts' Work- Sub-Categories

4.7.2 Conceptualising and working with ‘parts’

There are several aspects of working in this way that distinguish in some ways how different therapists work in the same way, the most obvious being the language being used to describe it. As mentioned previously, my co-researchers come from a variety of different training backgrounds from a range of modalities. This means that a range of language was used to describe working with different ‘parts’ of the clients including ‘sub-personalities’ and ‘ego-states’. There are also distinctions between the conception of ‘parts’ and way of working with them, depending on the model. However, there was such a degree of unification in the construction and the multiplicity of different ‘parts’ and how they interrelate, that conceptualising them as a broad way of working, by bringing them together as a category, seemed appropriate, whilst at the same time, recognising that there are differences. The commonalities across the data in terms of ‘parts work’ were broadly; the importance of understanding each client in terms of a collection of parts and the identification, examination and understanding of the different parts which form the whole.

Across the data, my co-researchers described how they conceptualised and identified ‘parts’ with their clients. Collette described one of the ways in which she introduced ‘parts’, by asking her client

> *“Can you see the part of you that's behind that feeling?” or “Can you see the part of you that's sad?”*

Janet had a slightly different approach

> *Welcome it in, hello, let's see what you've got to teach us.*

Jacob uses a more psycho-educative approach to introduce parts work:

> *We're not just working with a metaphor of a five-year-old. We're not working with an adult remembering being five, we are working... this is so important to*

acknowledge. We are working with the five-year-old who is still alive and not very well in the client's system.

Melanie described the way she conceptualised 'parts' to access parts of the clients which seemed inaccessible.

I've been getting to the stage where I was routinely using the ego state idea of parts work as a way of talking about and working with split off parts.

Jacob described the process of using parts to understand a client's presentation and for case conceptualisation in order to inform the direction of the work:

So, we work with parts, and when we understand a client's presentation as a part stepping forward and taking over and we work with that part, then it sort of, it gives us a real focus and tool, a kind of structure in which to understand and do case conceptualization so that we're going to target and work with the issues that are indeed right at the root of the client's dysfunction.

Each co-researcher described different ways of working with the different parts of their clients. Liz spoke about the dialogue that she encourages between different parts to elicit a greater understanding of the parts

They do dialog with that part. So, if there is an inner critic, you dialog with the inner critic. Or you can encourage the client to actually be the inner critic and ask them questions. Then you dialog as well, but, and ask the... find out what it's like being a critic or being the pain or being whatever it is that they're struggling with.

She describes then using psychoeducation to develop a collaborative understanding of the impart of the different parts.

Having sub-personalities, that fits in with the ego-state therapy. So, you can do that, and then you can follow that and say, "So, when this happens, that's this

particular sub-personality or ego state that comes to the floor and hijacks everybody else".

Understanding what different parts 'need' is a way of working that emerged strongly from the data. There is a strong developmental feel to this work as the part in question was often described as being a 'young' or 'child' part and understanding who that part needs informs what was developmentally missed as well as what might be developmentally reparative.

If you've got a little child all on her own in a bedroom at five, feeling "It's all my fault Mummy and Daddy are arguing downstairs" or stuck at the top of the stairs and completely bereft and despairing because there's no safe adult around, before the session finishes, you want to ask, "What does that child need?" And people get it. And if they've got the team, see, you can say, "Well, she needs somebody to give her a hug, to read her a bedtime story. Who can do that? - Jacob

The imaginal plays a strong role in parts work, not just in the conceptualising and imagining of the parts in the first place, but of then altering the conceptualisation of and perspective on those parts to offer an alternative understanding of those parts

I might say, "What would you say to that little girl who's 12, if it was your daughter?" - Tristan

Janet described how the language of parts allows her client to understand her own responses differently:

We can short circuit to aspects of them. For instance, clients who might push me away might say, "Oh, it's that bloody saboteur back again. It's been pestering me all week." By doing the parts work, they have a greater insight to be able to stand back and catch themselves when they've played out one of those parts in action.

4.7.3 Working with parts towards healing and integration

The core category of ‘individual unique integration’ will be examined in detail further on. However, integration in relation to parts work emerged as a theme throughout the data, so integration in relation to parts work will be examined here in the context of working towards the integration of parts, irrespective of modality, therefore the data suggests that without ‘parts’ there can be no integration.

Collette described the moment when she and her client, reached a collaborative understanding that the client’s parts had been integrated…

> *And then one day, they're done. And they know it. I remember ending with someone who, her parts were pretty much integrated. We did a full integration, including a teenage part who hadn't felt lovable or beautiful or anything. And the teenager was like, "I'm wearing tight jeans! Oh my god, this is so exciting! I've got this body finally that can wear jeans", and I said "Look how gorgeous you grew up to be", and she just left so excited because the teenager finally understood, look at this amazing body she's got now. And she went off, all excited. She was so happy to leave, she gave me the biggest hug. But we both just knew.*

Collette also described a more formal and structure process on integration and of checking that all the parts have been integrated where required…

> *We'd check on all the parts we discovered. Some will quite spontaneously integrate, some will do a more formal integration.*

Therapists described the integration of clients’ parts in different ways. Tristan and Bill both described working towards integration of the parts but developing and changing the relationships between the parts.

> *Yeah the aim is very much getting that connection with the child-self and looking after that child-self. - Tristan*

I challenged her, asking me for a hug, et cetera. But then it came a shift from the abused child to an adult who was scared and frightened. The erotic had gone. This was an adult who recognized her hurt and frightened child. – Bill

Jacob described the whole therapeutic process as a 'journey of integration', a journey which would not be possible without working with the client's 'parts':

And the whole journey is a journey of integration, Carl Jung, with the integrated personality. That's basically what we're aiming for, isn't it?

Not all my co-researchers explicitly described their therapeutic goal as being working towards the integration of parts, but many described working with clients to understand and change the relationships between their parts. Collette gave a couple of examples of this:

There's a child crying in another room, and we had to connect to those parts. And in the middle of processing, we might go and then find that part and give it what it needed and so on and bring it home.

Jacob described working curiously with dysfunctional parts to understand why they came into being, with the assumption even frightening parts came into being with a benevolent intent:

And by asking the part, "What's your benevolent intent," which is what they do in NLP, you're befriending the part, and you're saying to the part, the dysfunctional part, "Guys, we get it, you've got good reason to be there. You had a good reason to come into being in the first place, but we'd like to stand you down because actually you're past your sell-by date. It's time to send you off to the knacker's yard or put you out to grass"

Along with this understanding there is a respect towards the parts and a curiosity which both drives and informs the work:

There's a whole narrative going on. There's a whole drama going on between the parts. And the extent to which we as therapists can let those parts know, "Yeah, it's okay, guys. We know you're there, and that's okay. We're going to work with you one by one. But if you give us permission to be working with whoever's hurting the most at the moment..."

Interactions between adult and child parts were described by several co-researchers and using parts work in this way feels developmentally reparative:

The adult-self has feelings for the child-self, and then you need to therapeutically use those feelings for the child-self therapeutically to connect with that child….Sometimes there can't be, so the adult-self leaves a transitional object with the child, like a teddy bear or something, or a mobile phone so that the child can ring the adult to come and help them. - Tristan

So if anything the work we're doing with EMDR is to try and hold his wounded child, either with his resources or with his functional adult. That's where I was saying that's the part that's in the middle. That's the part that's perfectly imperfect, has healthy boundaries rather than walls or no boundaries, and reality is able to interpret one's own thoughts and feelings. - Olivia

4.7.4 Parts Work – Summary

The use of 'parts' to both understand the client's presentation and conceptualise the challenges and impact of their developmental history was used across the data set. The concept of achieving healing through the integration of these parts was also a common theme. It feels particularly important to understand the theory behind this way of working and this will be discussed in the following chapter.

4.8 Main Category 4 - Structure and Process

4.8.1 Introduction

As described in my introduction chapter, EMDR is trained as a protocol driven therapy with a succession of phases to be adhered to and followed. The formation of this category therefore did not come as a surprise and the construction of this category was comparably straightforward, but the relationship between this category and others was instrumental in formulating the core category and essence of this grounded theory as discussed later.

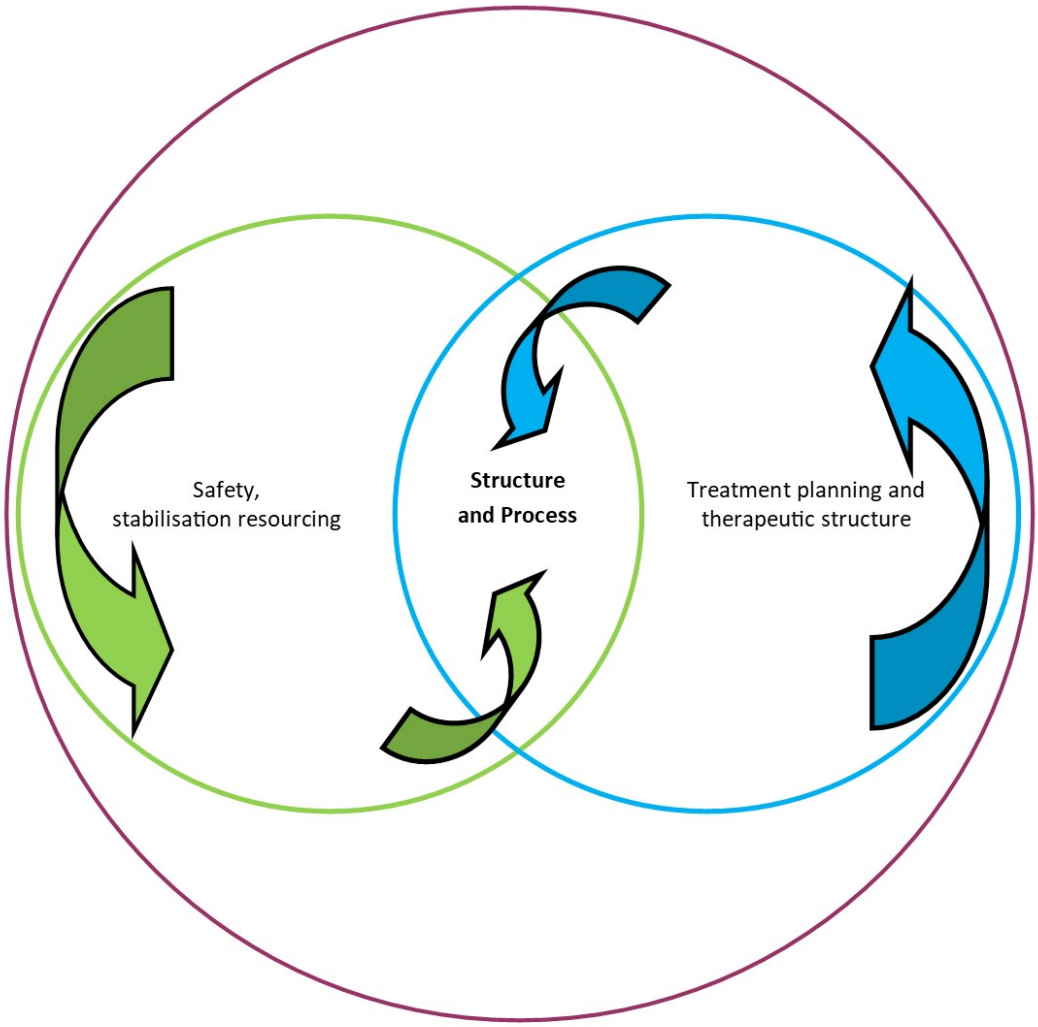

Figure 4: Diagrammatic Representation of 'Structure and Process'

Category	Sub-Categories
Structure and Process	Treatment planning and therapeutic structure
	Safety, stabilisation resourcing

Table 5: 'Structure and Process' - Sub-categories

4.8.2 Theory informed treatment planning and therapeutic structure

EMDR, both standard and modified protocols, uses a structured and phased approach to the treatment. These phases are: history taking and treatment planning, preparation, assessment including validity of cognition (VOC) scale and the subjective units of disturbance (SUD) scale, desensitisation, installation, body scan, closure and re-evaluation (Shapiro, 1999). References to therapeutic planning and structure were numerous throughout the data, both in relation to the EMDR protocol(s) and to a phased approach to working with trauma and complex trauma. Jacob described the 'eight-phased protocol of EMDR as a 'framework':

> *EMDR, then, gave me a structure, gave me a framework, a really good framework. Eight phases – Jacob*

The importance of preparation for working with clients with complex trauma was emphasised as a key phase in this process:

> *I would always prepare properly for EMDR. I wouldn't short circuit on that area – Janet*

The importance of the therapeutic structure and process was highlighted, both in terms of planning and structuring the work and in terms of the focus. Collette described the explicit way in which she does this with her clients:

“Let's do one, let's put everything on a piece of paper, see where we're at. What's fine now, what's still troubling you, where would you like to get?" And then from that, we can decide how to weave in the EMDR.

Tristan described how the structure of EMDR in useful in informing both his case conceptualisation and the direction of the work:

Whatever approach people have been trained in, it gives us the structure and the laser-like focus on the actual root of the presenting issue, and it gives us a very clear understanding of why it is we need to change.

Liz explained how she uses the structure to understand and check the progression of the work overall:

Yes. And you can go with it, and if it goes too far off, you go back to target and see if it's still part of what needs to be worked through. It's important to be aware of the framework and coming back to target and preparing the clients and checking in and strengthening.

Jacob described how he uses a clear structure within each individual session, so that each session is a complete piece of work which he felt is important when working with traumatised individuals:

And then, by the end of the session, it's session structure. We come back to the presenting target, so each session is complete in itself.

Jacob also spoke about the traditional ‘three phased’ trauma approach and how the phases of EMDR fit within this structure:

Then you do the processing, you do the work, and then you do the integration. Three phases of trauma treatment. And that's what brilliant about EMDR, because it's exactly what EMDR does, history taking, preparation, preparing the ground, then you've got the targeting, in phase 3, desensitization, and

reprocessing, the reworking, the rebuilding, rewiring the networks in phase 4, and then you consolidate it all with phase 5, 6, and 7.

Liz described her initial training as being transpersonal in origin and although she integrates many aspects of this training into her work, she found the lack of structure challenging:

The transpersonal can be seen as a bit woolly. Well, at least sometimes I got frustrated with it because I wasn't quite sure I knew where I was going with the client or where I thought the client and I were going together. But it was very difficult to present it in a coherent way and have kind of steppingstones to check where the work was. And with the EMDR eight phases, you have very clear guidelines to give the client and yourself, a way of checking in with milestones.

Understanding the process of EMDR in the context of theory felt like it added structure to the work, in the sense that the goal is understood neurobiologically and the work can therefore be focused with that goal in mind:

For EMDR to be effective the emotional networks, all the different, various networks, have to be activated – Steven

experience is stored as neurobiological networks, and if we've had a dysfunctional experience, we have a dysfunctionally stored, dysfunctionally linked neurobiological network running in the system. We'll break it – Jacob

4.8.3 Safety, Stabilisation and Resourcing

The importance of safety and stabilisation was significant across the data, but there were some interesting distinctions in terms of what served to stabilise clients more and differing viewpoints across the data set around this issue which I feel add depth to this sub-category. Resourcing is something that all co-researchers use as part of their work. Resourcing is seen as part of the preparation process and therefore could have been included in the previous sub-category ‘Theory informed treatment planning and therapeutic structure’. However, resourcing was shown across the data to take a

prominent role in EMDR work with complex trauma. I made the decision to include it in this sub-category because in terms of the process of EMDR it is usual for resourcing to take place prior to (Shapiro, 1999). However, resourcing is an imaginal process and features heavily in 'Category 5 – Right-Brain Processes'. The relationship between these two main categories will be examined closely under 'Core Category – Integration' as it was in some ways the catalyst for both the second round of interviews and the development of the core category.

My co-researchers all referred to the need for stabilization and preparation, but this process seemed individual, to both the individual client and therapist. Stabilisation here generally refers to helping clients to regulate their affect and ground themselves sufficiently, so as not to become completely dysregulated or dissociated during the work. Janet described how training in EMDR has made a significant difference to her approach to stabilisation work

> *I would do resourcing and stabilising with every client now. I've learnt that most efficiently through my EMDR training. The other thing I think I'm probably better at is grounding people before they leave. I was always conscious if they were driving a car, they had to be okay, but I think I'm slightly more purposeful in my grounding, re-stabilising people, so I think I'm probably safer working with serious trauma as a result of my EMDR training than I was prior to it.*

Melanie described the stabilisation process as providing 'grist for the mill' in terms of being vital in informing the work. She also acknowledged that some clients need relatively little stabilisation work, a view which was echoed by Jacob:

> *We need to stabilise that. I need to learn a lot more about what actually happened to her, otherwise I've not got enough material and enough of a detailed understanding of how she is now to be able to work with what happened then. Stabilisation is going to be a long road with her but there are some other clients where it might only be a couple of sessions – Melanie*

> *Obviously, I look at readiness and preparation. But if they're relatively ready and they're prepared then we go quickly into doing EMDR – Jacob*

The structured and process led nature of EMDR was interestingly seen as a safety container in its own right and it is the focused, targeted nature of the work that actually provides safety in response to extreme distress:

> *What is brilliant about EMDR protocol and the fundamental structure of EMDR, you bolt that onto it, you've got an incredibly powerful, safe container in which to do very focused work. And the bigger the distress, the more intense the distress, the worse and the deeper the trauma, the more EMDR is able to deal with it, because they get the tighter and tighter focus. The worse the experience, the tighter the focus needs to be – Jacob*

Stabilisation was considered universally important across the data, but therapists had quite different approaches. Melanie articulated this sense quite clearly in terms of the safety gained though stabilisation versus the safety lost though waiting to get to the heart of the matter. She described the tension between needing to stabilise the clients sufficiently to begin the work, but at the same time, it being the unprocessed trauma causing the destabilisation, so stabilisation may only be achieved through processing:

> *Often though, I think that's overrated just in my very, very humble opinion, I'm not an expert, but I think the stabilisation is overrated in the sense that often the self-harm is triggered by the trauma. So the unresolved trauma here, flashbacks to the rape or the sexual abuse is causing the problem, no amount of stabilisation is going to not get her completely, that the strategy that the person might have to self-harm, it's only with the resolution of the trauma that the self-harm goes away or reduces. You need to get stuck in...*
>
> *And with the complex people, I think phase two needs to be, when I say quite extended, not necessarily in time, because you can go on and on forever and never get around to processing – Collette*

Others had a slightly different approach; moving between stabilisation and processing depending on what the client needed:

I will oscillate between doing EMDR and then going back to stabilisation. You know what I mean, we have to sail, we have to move, we have to do some EMDR, we've got to be processing. But the CBT and the stabilisation sort of keep us on an even keel, and I'll oscillate towards moving more towards CBT, stabilisation if the patient becomes wobbly or self-harms and things like that – Tristan

Steven works cautiously with complex trauma clients and spoke of the safety aspects of integrating EMDR

EMDR has to be integrated into the work because with complex trauma they're often not ready to dive into their trauma Obviously the EMDR was able to get past some defences but it was done too quickly. I didn't prepare enough. In that way I think EMDR can be dangerous, if you're not being attuned and sensitive enough to clients' readiness and preparedness, especially with past history of trauma – Steven

Co-researchers described a wonderful range of individual ways they use to resource clients. This seemed to be introduced at the beginning of the work, but utilised and developed throughout:

I do this, as a matter of routine, a resource team, and that usually consists of three or so nurturing figures with the qualities of kindness, gentleness, love, tenderness, softness, holding, three or so protective figures. Determination, courage, steadfastness, reliability, ferocity, willingness, and ability to fight your corner, and a wisdom figure or two, just wisdom – Jacob

I may use, with someone like that I may do EMDR safe place for example – Tristan

EMDR may be brought in in a resourcing capacity, whether it's resourcing attributes and qualities that they need ... It could be something like any time they did something good or successful we would use BLS to kind of tap that in, to kind of install that so to speak – Steven

I'll be inviting them to have a boundary image. Maybe it's a shield or maybe it's an invisible cloak or maybe it's a shaft of light, but it's something that when other people's energy, feelings, thoughts. We're giving people permission to protect their energy, protect their thoughts – Olivia

4.8.4 Structure and Process – Summary

Although I have called this category 'Structure and Process', there is a nuanced gentler feel to the data than the name perhaps implies. I have reflected on this choice of category name extensively and having completed the process of analysis and theory development, I decided to keep it as it was fundamental in understanding the core process in the context of the other main categories. The relationship between this category and the following category 'right brain processes' was key in the development of this GT. This will be examined in the following sections.

4.9 Main Category 5 - Right Brain Processes

4.9.1 Introduction

This final category is comprised of four sub-categories. Each sub-category is described below with supporting quotes from co-researchers. As before the sub-categories within this category have many commonalities. Like the other categories the diagrammatic depiction below, represents a fluid and dynamic rather than a static process which is represented by the arrows, both within the individual sub-categories and between the sub-categories within the category.

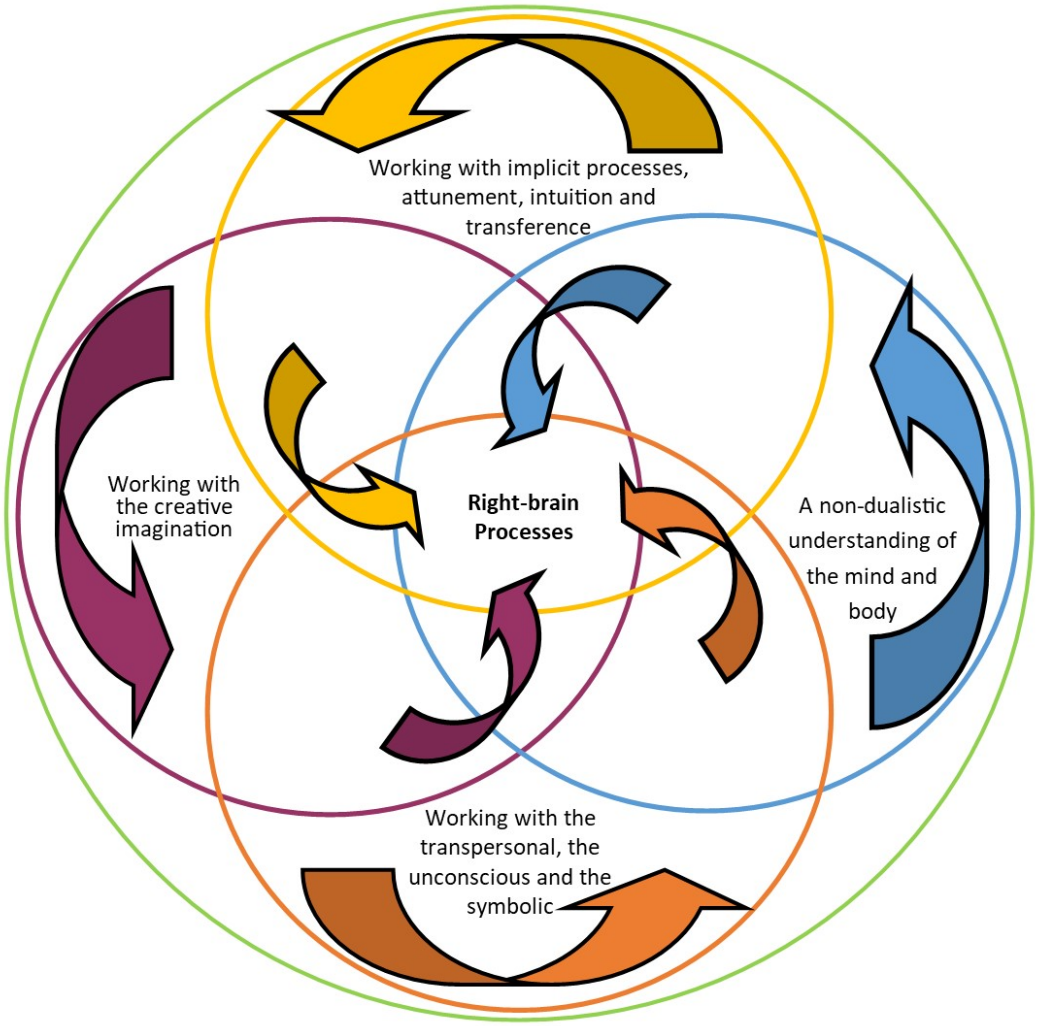

Figure 5: Diagrammatic representation of ' Right-Brain Processes'

Category	**Sub-Categories**
Right-brain Processes	Working with implicit processes, attunement, intuition and transference
	Working with the transpersonal, the unconscious and the symbolic

	A non-dualistic understanding of the mind and body
	Working with the creative imagination

Table 6: 'Right-Brain Processes' - Sub-categories

4.9.2 Working with implicit processes, intuition and countertransference

Paying attention to and working with the implicit processes between therapist and client was a common theme throughout the data, sometimes in place of what is often an explicit part of EMDR; The EMDR standard protocol requires clinicians to take scaled assessments: subjective units of disturbance (SUDs) and value of (positive) cognition (VoC), at various stages during the work so the therapist can understand the client's level of disturbance and how true the positive cognition (the client's preferred belief about themselves) feels to them. According to the standard protocol, these are taken on a SUDs scale (1-10) and a VoC scale (0-7) (ref). Co-researchers here described having an intuitive understanding of where their clients are in terms of both disturbance and positive cognition and sometimes using this understanding in place of an explicit, cognitive scale approach.

> *I will ask because it's important but generally, I kind of know what the answer's going to be by the time I get around to asking – Janet*

Some co-researchers felt that when working with complex trauma it was in fact inappropriate to ask explicit questions as it may be very clear that a client's levels of disturbance and distress are high and at that moment, they may not be able to conceive of a different way of understanding themselves and so asking for a 'preferred belief' may seem bewildering and totally unrealistic at that stage.

> *In extreme trauma I don't ask lots of questions. I know it's 10, I know the belief is I'm supposed to take it lower or whatever. And sometimes there isn't a positive cognition doing that, because for her, she's disgusting, there's no other*

way of looking at herself…. How do I know? I don't know, is the honest answer to that. I actually don't know, I think it's just instinctive. – Collette

In a similar way, Melanie spoke about the lack of need to ask explicitly for obvious levels of distress, but also when the clients affect has so clearly changed in a positive way:

I'll do the minimum to get us into some reprocessing work so I'm not always asking for SUDs before we start. It just doesn't seem necessary sometimes, and equally if we get to a place where the imagery is changed and they're giggling about something at the end, do I need to ask, "Are you a zero yet?"

Jacob gave an example of when his use of intuition really 'landed' and move the work forwards when working with a client who had been really 'stuck':

Nothing seemed to be shifting very much. And then intuitively I said, "Okay, just thinking, I'd like you to clarify something for you. Tell me about your sister. How much younger is she than you?" Three and a half years. So I said, "Okay. What was it like for you when she was born?" And she burst into tears.

Co-researchers also spoke with caution about the need to balance the use of intuition with cognitive reasoning and analytic skills. Collette spoke about the need to reflect on the right brain to right brain processes happening between therapist and client:

It's right brain to right brain… I think you should always be able to reflect on it. You should be able to watch a video and justify exactly why you did that. In the moment – Collette

Jacob spoke about the need to use therapeutic intuition, but "within a very, very clear targeted focus structure". Bill spoke about the need for 'judgement' alongside the use of intuition "there's a hard judgment that goes into that intuition, sometimes we get an image that comes up into our minds, you know? But then judging it carefully".

Steven also spoke about the necessity for intuition to be used within and spoke about the real dangers of relying too much on intuition and the need to mediate its use with analytic skills and therapeutic theory and training. He also spoke about the difficulty of distinguishing therapeutic intuition from the therapist's own ego:

> *You also have to constantly keep your analytic skills and keep your thinking online at the same time. Because if it's just intuition, that's where I think boundaries get crossed or you make mistakes. I think intuition has to be embedded within a sound framework and theoretic orientation and sound model if you will. I think there's a danger in that because how do you know if it's your intuition versus just your own ego.*

Therapeutic judgement in terms of unpicking what belongs to the therapist and what belongs to the client, also came into question when considering the use of countertransference responses in informing the work

> *You have to identify what the countertransference is if it's there, what your own protectionist, your own fears and issue are, trying to avoid the client's pain because of your own pain. Is it yours? Is it theirs? That's the judgment you have to work with. If you're picking up something from them, which says, "This person is not ready to go there yet." Then you have to explore that with the client to check, is it mine or is it theirs?*

The usefulness of counter-transferential understanding was also present in the data. Janet spoke about the way she uses bodily responses to intuit what was happening therapeutically. However, she also described how she often makes this implicit process explicit to the client in order to check her understanding:

> *I do use my body experience, not my head to make sense of decision making, therapeutically…. I also prepare my clients, I say, "Sometimes I might notice things in my body that you're not expressing" If that happens, I will put that in the gap between us and you can tell me if it makes any sense to you or not.*

4.9.3 Working with the transpersonal, the unconscious and the symbolic

The transpersonal aspects of working with EMDR in this way were apparent across the data. I have included a selection of quotes below to show the range of different aspects of the transpersonal that co-researchers spoke about. Jacob spoke about EMDR as actually being a transpersonal therapy and Olivia spoke about the sometimes 'amazing' accuracy of her transpersonal intuition:

> *EMDR is the ultimate transpersonal psychotherapy because the transformation, the adaptive transformation so often happens at this crazy magical intuitive transpersonal level – Jacob*

> *No, I encourage that (the transpersonal) I think is positively dangerous because every now and again I'll say something and it's so bang on I amaze myself – Olivia*

Liz gave a case example of how the transpersonal, the unconscious and the symbolic have come together in her work and how she integrates transpersonal understanding into processing using EMDR:

> *So that when you have somebody who says, "Oh this is really strange. This is really weird, but I'm getting this image," then we follow that. And going with metaphors and just go with it. There's always this possibility of 'just go with it' and see what happens. And that's how I think the transpersonal comes in. It's not there to say, "Now we're doing the transpersonal bit." It's more understanding, and if something presents itself, we can run with it. We can follow it. So, it feels like the transpersonal, through the EMDR is finding a focus to actually make the therapy more tangible.*

4.9.4 A non-dualistic understanding of the mind and body

Across the data, co-researchers spoke about the attention they pay to their clients' bodies, in terms of noticing what was happening psychosocially through locating it in the body, but also using the body in the service of change and to interrupt negative

patterns. There was a real sense of a lack of distinction between mind and body, that the two are seen as fully interconnected in the process. From the descriptions given to me of client cases, I understood that the nature of complex trauma cases meant that using cognitions and memories as 'targets' was not always possible, and therapists instead turned to affect and body sensations:

> *but it's the body, it is the limbic system, and it's the hippocampus, and it's the entire body that knows but hasn't got words for it, where the problem was. And quite honestly, most of the time, if you're working with attachment, it's no-good asking logically, "What do you think the touchstone memory is?" It has to come organically because the system knows much better than the left brain knows – Jacob*

Collette and Liz described how they interrupt negative patterns through the body:

> *I started thinking a little bit more and thinking about the sensory motor psychotherapy principle if interrupting patterns, whether it's through a movement or a statement or whatever. When someone is kind of hunched up in pain, and you say, if you don't want to stand up, maybe just stretch over the back of your chair, stretch out your shoulders and arch back a little bit. Then you're stretching the nervous system and you're interrupting that physical slump – Collette*

> *Because he was all like this, and all tense and like a cramp. And when I touched him on his hand, the hands calmed down, and that meant the whole body calmed down, and that meant that his whole... I guess his mind could focus on what needed to be integrated, what needed to be worked on – Liz*

4.9.5 Working with the creative imagination

The use of creative imagination in the service of healing was apparent throughout the data. Jacob described why he felt working with the imagination is so important:

A successfully EDMR session is very much like a dream. We go into a kind of dream state, but of course the left prefrontal cortex is still online, so we're working with the dream experience and the hippocampus and the right brain in ways that the dream can't… So creative interweaves and the use of creative imagination makes such a difference. Because ultimately it is at the imaginal levels of people that are ill. Because the trauma's only happening at an imaginal level anyway in the nervous system, and so that's what the human system does.

There were so many examples of working with the creative imagination, that it was difficult to select which to include here. The use and encouragement of a client's creative imagination was used extensively throughout the data in very different ways.

Jacob described using the imagination to work with parental introjects:

It is like an autonomous mother, an autonomous father. Dysfunctional, because you've internalised both the functional parenting but also the dysfunctional parenting. That's not my stuff. That's my dad's stuff. That's my mum's stuff. So let's work with... using your creative imagination, let's work with the mother who's in the system. Let's sort her out.

Tristan described how he uses the imagination to create a corrective imaginal experience from a traumatic memory:

And then sometimes get a picture of themselves as a child and put it in their house, mentally connect to them, that they are now looking after that child. "where's the child now? The child's on her own, she's crying, she's in bed. She thinks it's a dream dah dah dah. Okay, can we switch on the light? Can we go to her? What does she look like? What would she say to you?"

Melanie gave a case example of a complex trauma client that illustrates a reparative imaginal experience:

My client was able to watch the mother helping this slow little girl get dressed, no tellings off, nothing wrong, lots of love and affection. It was all fine. For my client, it was like she was watching herself being treated nicely and with love and affection rather than what she'd actually experienced, which is being told off the time, and it made her cry watching this mum with her daughter.

Jacob described how he has begun to use the creative imagination to work intergenerationally with the client and a parent:

But 'Big Katie', will you come with me and be my interpreter? Can you tell me what your mother is going through at the moment? So let's sit Mother down, with permission from your mother, let's say it's your mother, and we do EMDR on her in the imagination. It's really exciting.

4.9.6 Right Brain Processes – Conclusion/Summary

This feels like a big category, aspects of which in many ways could be attributed to all of the others. The data showed so many rich creative nuanced ways of working, of understanding the client and facilitating healing. However, as with 'parts work' it is the relationship between this category and the others that elucidated the route to the core category.

4.10 Development of the Core Category

4.10.1 Introduction

As I have mentioned previously, in grounded theory the relationships between the different categories are of particular importance (Urquhart, 2013). The diagram above represents each of the five main categories. You will notice that the circle representing each category overlaps with each of the other categories and it is these overlaps that I will explore here. The arrows in the diagrams represent the fluid and dynamic nature of this representation, both within and between the categories. The movement within

the categories meaning between the relevant sub-categories; moving circles within moving circles.

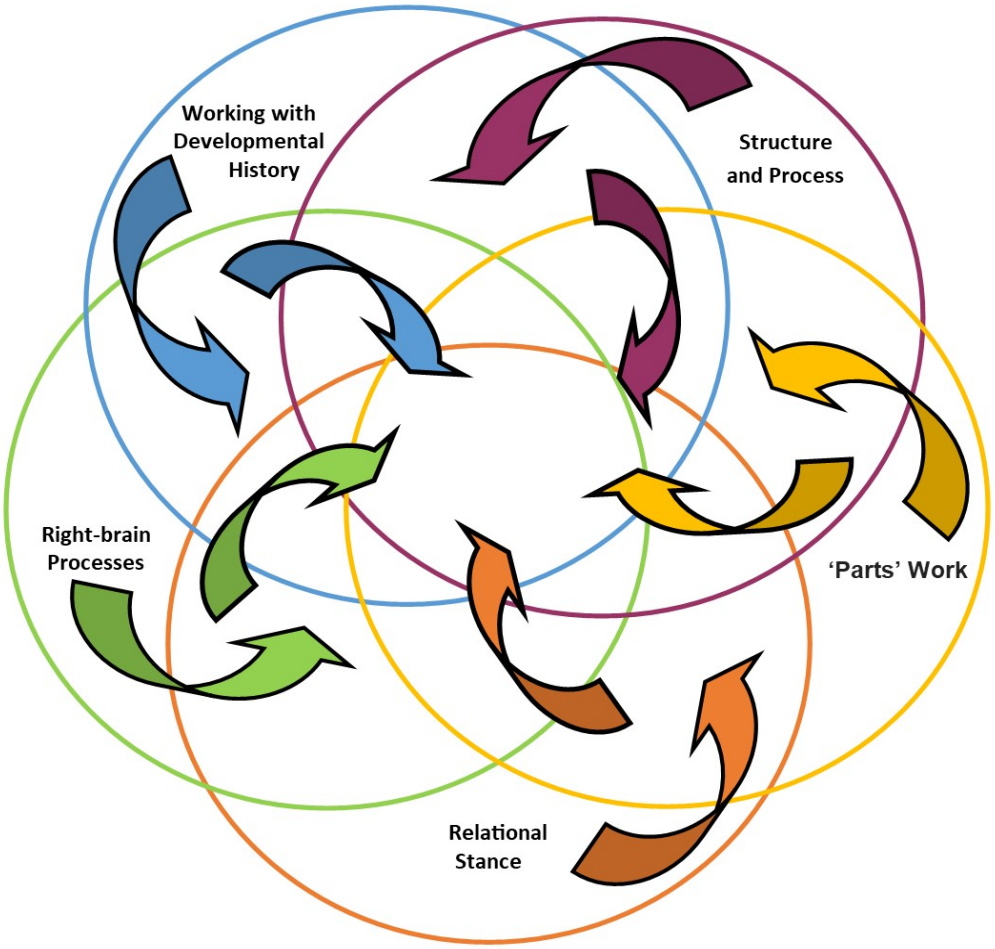

Diagram 6: Diagrammatic representation of the interactions between and within the main categories

Explicitly representing all of the sub-categories within the categories within one diagram would be confusing, but each category includes the sub-categories discussed earlier as shown in the following 'satellite diagram:

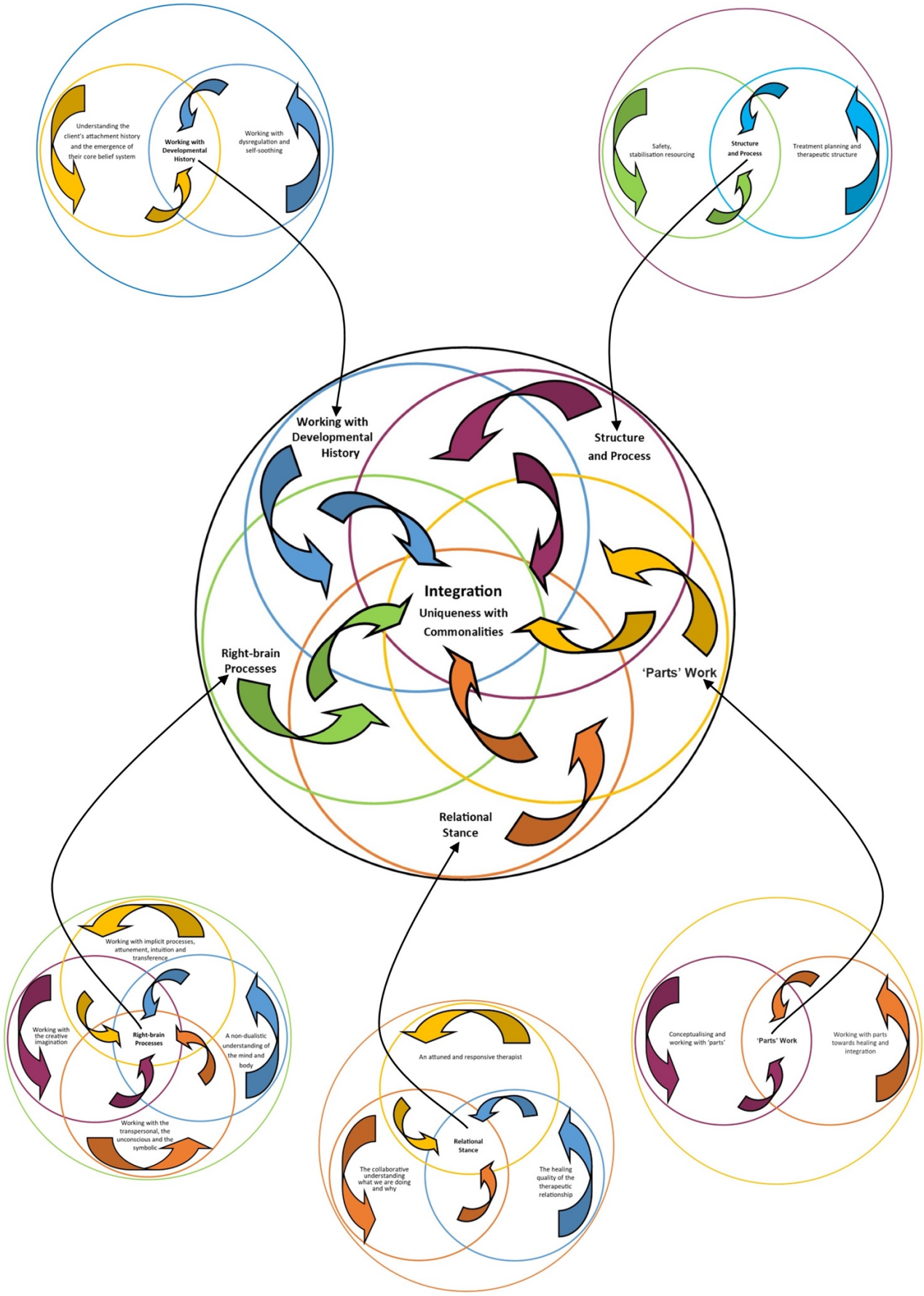
Understanding the client's attachment history and the emergence of their core belief system
Working with Developmental History
Working with dysregulation and self-soothing
Safety, stabilisation resourcing
Structure and Process
Treatment planning and therapeutic structure
Working with Developmental History
Structure and Process
Integration
Uniqueness with Commonalities
Right-brain Processes
'Parts' Work
Relational Stance
Working with implicit processes, attunement, intuition and transference
Working with the creative imagination
Right-brain Processes
A non-dualistic understanding of the mind and body
Working with the transpersonal, the unconscious and the symbolic
An attuned and responsive therapist
Relational Stance
The collaborative understanding what we are doing and why
The healing quality of the therapeutic relationship
Conceptualising and working with 'parts'
'Parts' Work
Working with parts towards healing and integration

Diagram 7: Integration of five main categories into core category 'Integration - uniqueness and commonalities'

4.10.2 Relationships between categories

In the previous sections, I explored the different sub-categories within each category and the relationships between them i.e. the relationships 'within' the categories. Here I want to explore the relationships 'between' categories. Charmaz (2014) emphasises the importance of the relationships between the conceptual categories in order to understand the core category which is central to the framework of a theory grounded in the data. There are numerous examples of this, but I have selected quotes from my co-researchers which I feel best demonstrate the relationships between the categories.

Attempting to understand the relationships between the categories I needed to further dialogue with my co-researchers and clarify the findings which led me to conduct a second round of interviews. This second round of data collections also served as a useful 'audit' in terms of the development of my theory, in a way that felt entirely appropriate to the co-created nature of CGT. This data allowed me to develop the core category which forms the basis of my grounded theory. I present this data below, but firstly I will look at how I began to understand and examine the relationships between the categories prior to the second round of interviews.

In the following example, Liz is talking explicitly about self-compassion:

> *I think the self-compassion is really important but not as a thing, as I observe it. It's more as just looking at themselves when they come up with when they were five and something or other and they tell themselves that I should have been able to stop this guy abusing me. Then you can just look at the little girl that you were. Just look at her. What do you see? Now some clients hate their little child. And then you need maybe to bring somebody else in, but clients often they then say, "Well, she was very little. She was really small, and it's very sad that it happened to her," and then the compassion comes in.*

This short quote sits across several of the main categories; the therapist is describing understanding childhood experiences of abuse, so ‘working developmentally’, he then describes working with their ‘child’ which falls under ‘parts work’ and bringing someone else in which falls under ‘right-brain processes’ (working with the creative imagination). However, the key to this piece feels like the implicit relationality of the work which would fall under ‘relational stance’.

In the next example Collette is describing a case example:

> *And then maybe see, do you want to go here? And bit by bit, the child and I were connecting. And the child started to come to life, and so it was someone there. And then suddenly the child just looked at me and I said, "You look sad". And he cried. And the child cried through his eyes, because someone could see him, but the adult was there too. But the way we got to the child, because the child was preverbal, was through movement, and play. You know the way you might get a baby who's listless or whatever, you just gently up regulate them.*

In this piece she describes working with the ‘child’ part of the client and she is clearly working developmentally in this piece and the implicit understanding she shows her client by saying ‘you look sad’ falls under right brain processes. But again, there is an overall sense of attunement and of the healing quality of relational presence.

> *Most of the diagnoses have their roots in attachment experience and the capacity to self-soothe or not appropriately and functionally and adaptively….and that, in 99 times out of 100, goes back to how they learned affect regulation in their primary attachment experiences.*

This understanding also falls under ‘Understanding the client’s attachment history and the emergence of their core belief system’ these two sub-categories are particularly hard to distinguish fully from each other and many of the examples sit across both to some extent.

Collette described the moment when she and her client, reached a collaborative understanding that the client's parts had been integrated…

> *And then one day, they're done. And they know it. I remember ending with someone who, her parts were pretty much integrated. We did a full integration, including a teenage part who hadn't felt lovable or beautiful or anything. And the teenager was like, "I'm wearing tight jeans! Oh my god, this is so exciting! I've got this body finally that can wear jeans", and I said "Look how gorgeous you grew up to be", and she just left so excited because the teenager finally understood, look at this amazing body she's got now. And she went off, all excited. She was so happy to leave, she gave me the biggest hug. But we both just knew.*

This quote clearly sits comfortably within both with 'right-brain processes' and 'relational stance' demonstrated by the implicit, co-created understanding that therapist and client shared. Working with 'parts' seems to be strongly related to other categories, particularly with 'right-brain processes' and 'Working with Developmental History' in the sense that understanding and identifying a client's parts can help to understand the client and the root of their dysfunction, in turn, this overlaps with 'Structure and Process' as it informs both the therapist's formulation and target identification.

The above quote was used earlier in this chapter to illustrate how co-researcher's use working with 'parts' towards healing and integration. Collette also described a more formal and structured process on integration and of checking that all the parts have been integrated which overlaps more with Structure and Process'.

> *We'd check on all the parts we discovered. Some will quite spontaneously integrate, some will do a more formal integration.*

I have attempted to illustrate above how closely enmeshed and related the majority of my main categories seemed to be. I started describing these relationships as 'overlaps' as I was thinking in accordance with my diagrams. However, they seem more like the ingredients of a cake. The coding process had produced these five

separate categories, but the more time I spent with them, the more enmeshed with each other these separate ingredients seemed to become. I had a sense of integration from this analogy, but two of the categories felt as though they would ‘curdle’ if mixed together, so I returned to my co-researchers for their input.

4.10.3 Relationship between ‘right brain processes’ and ‘structure and process’

The relationship between the categories ‘right brain processes’ and ‘structure and process’ was initially hard for me to understand. It felt like there was a tension between them and the relationship seemed in some ways paradoxical. Interestingly having returned to my co-researchers to understand this better and having developed the core category from this data, coming back to what I was grappling with prior to this now feels difficult to explain as the conclusion seems so clear. Perhaps it was my own experience of being a newly trained EMDR therapist and the structure and protocol sitting very uncomfortably with my relational, integrative framework, which really caused me to question the relationship between these two categories. However, it was partly this that led me to do this research in the first place and which had led me to have the requirement of experienced EMDR therapists in my recruitment criteria, so the second round of interviews also served to understand my subjectivity as a researcher and to develop my understanding through the research process.

Jacob spoke explicitly about working with the ‘left brain’ and the ‘right brain’ and although it is clear now (following the second round of interviews) from what he said that the process of integrating EMDR allowed the two to working in tandem, at the time I struggled to conceptualise this:

> *The trouble about the left brain, it is the emissary, not the master and the trouble with the left brain is that the therapist, even the well-trained EMDR therapist, will ask the client, "What do you think might be the cause of your problems?" And the instant you say "What do you think might be the cause," you're giving the game away, because you're getting the left brain to do the work. The trouble with the left brain is, it's usually the problem.*

> *What's so brilliant about that bridging is it bypasses all of the cognitive functions and it goes into, usually, the memory before the age of eight or so, usually, very often around seven, six or seven, because that is the point at which the hippocampus comes online, the left prefrontal cortex comes online, and we lock down narrative sense of self, explicit narrative sense of self. Until the age of about seven, we have experiences, but we don't have a narrative coherence to it because the brain can't do it. So at the age of seven, the prefrontal cortex comes online, as does the hippocampus, and starts actually joining the dots. And it's astonishing how often we go back to around the age of seven. Right-brain to right-brain dance, very much with working with Allan Schore's understanding. And in a sense, it's a kind of an attachment dance that we're doing with our clients, and we're actually giving them an experience of right-brain to right-brain attunement.*

My struggle with this quote, is that I could understand how the left brain 'gets in the way' of the "attachment dance" and "right brain to right brain attunement", but it felt like there was a need here to separate the two to bypass the cognitive functions and I couldn't understand therefore how the category of 'right brain processes' related to the seemingly very 'left brain' category of 'structure and process'

Liz also spoke about the interactions between the two, but I still found it impossible to understand the relationship between the "transpersonal way of working" and being "goal oriented" as below:

> *What in EMDR are more guided than in the pure and transpersonal way of working, we can run with it, but then come back to the target to give it the guidance and the goal-oriented part. But you're still following what comes out of the past, their own inner symbolism, their own pictures, their own metaphors.*

I grappled with the quotes above, but something was blocking my understanding, very probably my own clinical experience and the struggle I had to integrate these two concepts which is what led me to this research in the first place.

4.10.4 Core Category – Integration

Each of the follow up interviews pointed to integration as a key concept, but each of the co-researchers came to this conclusion from a different perspective which added depth to this data. I briefly describe each co-researcher's perspective below, along with a quote which highlights and illustrates each co-researcher's understanding.

Janet described how she feels 'right brain processes' and 'structure and process' are "totally complemented". Her perspective on this is that training and structure inform and support intuitive processes. She described a client case which illustrated her use of intuition and the transpersonal within a structured protocol and then went on to describe why she felt it was important that the two were enmeshed:

> *So that was a good example to me about why you need both, because I have both a right brain and a left brain, and you really need to know the structure that you're working to…. Anyway, just a couple of those magic, intuitive moments. But to me you really need the structure and the stabilization of the neurobiological processes, the safety, the resourcing, and what the standard protocol is and what you're trying to do. To me, having the background of the standard protocol, modified protocol, whatever, and what we're trying to do is really important to stabilize my own intuition really. So, that's how I see it. So, I see them as working together and I can't do one without the other. I need both of them to support each other. It is that trust in those two parts of yourself. And you need both. All so, so important, and that's what all the training and the structure is about, to inform that. Because otherwise you'd just be going off all over the place.*

To Collette, integration is having the capacity to incorporate both 'right brain processes' and 'structure and process' and 'dance the line' between them:

> *I would notice when I become more structured and I would notice when I become more creative and wonder why that might be in that moment. So both are good. Neither were better. For me, the integration is having the capacity to dance that line.*

For me, the paradox always interests me, because it could be both that are important. It's not either/or. So for me, having the capacity in my brain to incorporate both is what I would say was important.

Jacob understood the process as a partnership between 'right brain processes' and 'structure and process', the structure and process being critical to holding and processing the right brain experiences as they happen:

It is an exquisite partnership between the left brain and the right brain. That's the only way it works. There is no other way, there is literally no other way to do this. You can desensitize the affect arousal in the right brain, but unless you then re-process it, a bit like going down the curve, and then up the other side, with integration. Unless you integrate it, the work is not done. The meaning is not made. The meaning needs to then become explicit through the observation of the left brain. Reflecting how the different quality of attention the right brain and left brain pay to information. It isn't just that the left brain thinks and the right brain feels. It's much more complex than that. A healthy human being, a mentally well, emotionally well human being, is one where both hemispheres are dancing in a kind of really elegant partnership.

Liz understood the relationship between 'right brain processes' and 'structure and process' as the structure acting as a container in which the right brain processes can take place and likened the process to meditation:

I call it an intimate communion with oneself. I think it is like meditation. It is like in the Christian tradition, the contemplative prayer, it is like the Buddhist said, "You allow things in and let them go." You observe, which is the dual attention that you have in meditation…. It's the same thing as EMDR during the processing phase. It's the dual attention…..In EMDR, we have the cues and we have the interviews. So what we're doing, we are accelerating a meditative process. That is my theory. And I think this is where the two meet, the structured one, the left brain ... the structure that Francine Shapiro gave, is really a facilitative process. And I think the protocol gives a container for those processes to happen, because it's kind of a closed container. The client feels

held within the structure and because there are the interviews to bring in new elements, that then further the process.

Steven described how integration becomes more possible and natural with experience and the work becomes more client based:

Now I think any, any experienced therapist is going to know that the longer you see clients, the more you realize how important the right-brain processes are. The feeling, the intuition…but that's always grounded within theoretic ... once you really get the protocol, or once you really get the theory, then you can kind of integrate and trust more of the right-brain processes. That's where the richness will come.

But I don't see them as incompatible. I think they are ... in the beginning they're hard, but naturally as you get more comfortable with it, then I think you can usually adapt it, and then it actually works much more effectively, and it's much more client-based.

Bill described the relationship between 'right brain processes' and 'structure and process' as "going with the flow":

It certainly is not a separate, it's a process. And EMDR is very much about left and right work and the whole-body experience. So I don't think there is a separation. It's literally going with the flow and seeing what's coming up. And that you mentioned about that attunement, is what you're picking up within the session. And it's also keeping that balance between that left and the right hemispheres and process of dual attention, that you're keeping them in the present but at the same time you're allowing them to work through the past and then bringing them back in.

Melanie talked about the relationship between 'right brain processes' and 'structure and process' as a "spiral process":

Therapy isn't straight lines, it's not a straight lines process, if it's any kind of line it probably a spiral process. Right? So you're revisiting things, each time you get around the spiral, but hopefully you've got up a level... So I'm kind of doing

both of these at the same time I think, and I wouldn't even occurs to me to think, how I integrated two different things… the techniques are very important to the EMDR because it has, it can facilitate processing trauma and not every technique can do that, but the way I work with these people, into which I am embedding whatever we do with the EMDR is this much more creative, transpersonal kind of thing.

Tristan answered with an analogy to describe the relationship between the two "Its like white water rafting… stabilising, going with the flow, or paddling"

Yeah. And then I think when you're going with the EMDR flow, when you're in the raft with the person and you're going through the EMDR there is a sort of intuition about stabilizing the boat or saying to them, "Okay take a deep breath. Relax. Bring in the nurturing figure, or go with that." You have to nurture, it's a bit like somebody who's white rafted before, you've got to know when to go with the river. To steer a little bit in a certain direction to avoid certain things.

Yes, I would say that there is a ... I think the best analogy I can come up with is the white-water rafting. When to go with the water and when to start paddling so that you get through certain bits more quickly or you avoid certain things.

The second round of interviews therefore confirmed what had emerged from examining the relationships between the categories, that at the core of this theory lies integration. Integrating EMDR seemed to be about working with the deep relational unconscious, about working developmentally, intuitively, imaginatively and with parts, but critically, working within a framework or a container of structure safety and process.

I added the word 'uniqueness' to my core category to emphasise explicitly the unique nature of the integration of these common factors in every single therapeutic dynamic. This may have been implicitly communicated by the term 'integration', but I wanted to make the point clearly that there is a unique quality to the commonalities in this GT.

The core category of 'Integration – Uniqueness with Commonalities' in the diagram below and is at the core of this fluid theory. Each category sits and moves within this framework of integration, the component parts constantly moving both within and

between the categories so there is a constant ebb and flow of the different elements in the work. The image that I had in mind when developing this representation of my theory, is that of a kaleidoscope: a collection of component parts which all interact, evolve, overlap and reflect each other, constantly changing whilst being held within a frame.

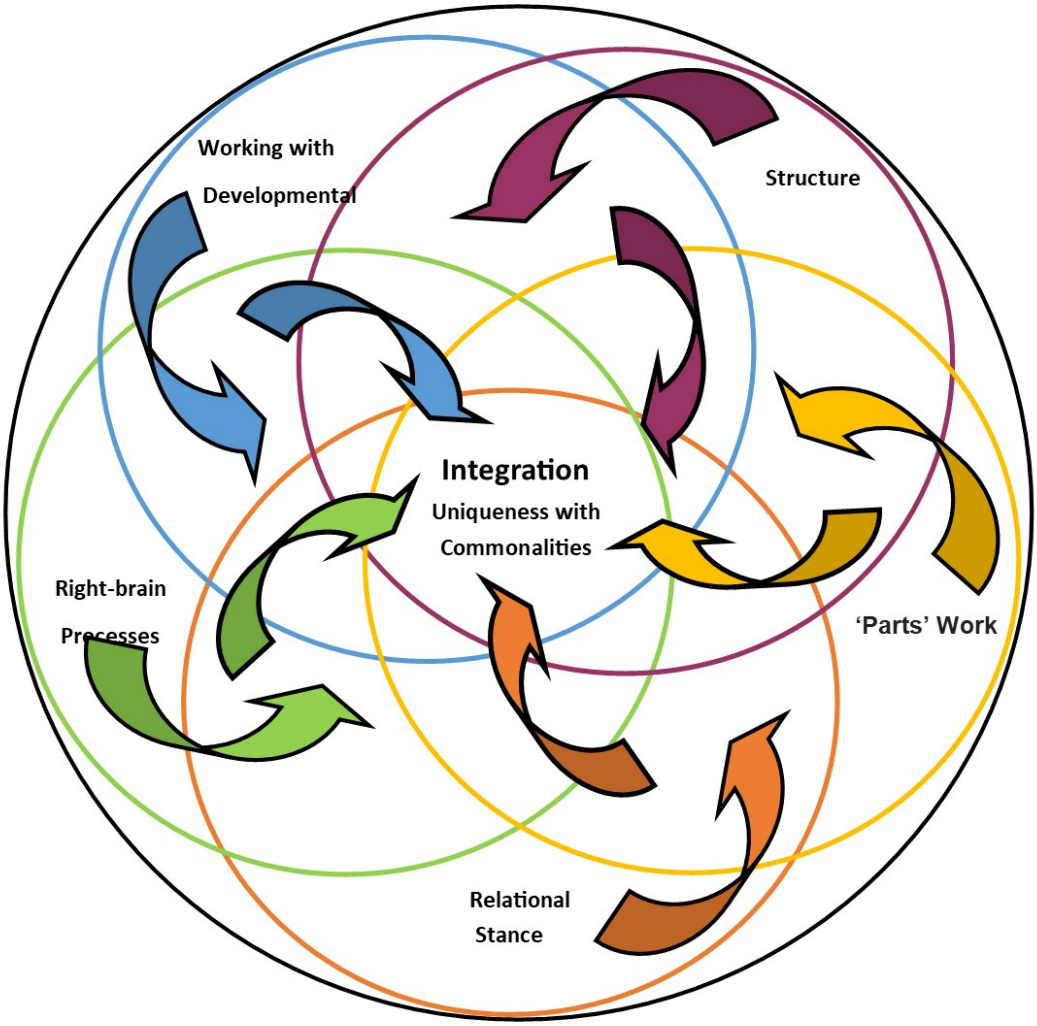

Diagram 8: Diagrammatic Representation of Grounded Theory

4.10.5 Summary

In this chapter, I have presented the development of five main categories for a Grounded Theory and a final core category. The core category generated through the analysis was termed ''Integration – Uniqueness with Commonalities' to indicate what was at the core of how my co-researchers worked with EMDR and complex trauma.

This was derived from the development of the five main categories and the relationships between them. The five main categories were identified as; ‘Relational Stance’, ‘Working with Developmental History’, ‘Parts Work’, ‘Structure and Process’ and ‘Right-Brain Processes’. These categories are comprised of sub-categories which I have presented and described in detail above.

Chapter 5: Discussion

5.1 Overview of Chapter

In this chapter I will discuss the findings and resulting theory, detailed in the previous chapter. As I stated previously, this chapter will form the second part of my review of the literature with my findings discussed with reference to the related literature, according to the process of CGT. First, I will briefly summarise my findings. I then consider the notion of integration and discuss what 'integration' means in the context of both this research and the existing literature around integration. I follow this with a similar discussion about the concept of 'uniqueness'. I will then discuss the construction of the core category of 'Integration – 'Uniqueness with Commonalities' from the five categories I identified in the results chapter. Following this, I present and discuss my understanding of the results of this research along with the relevant literature. These include, understanding a client's developmental and attachment history, working with client's 'parts', the importance of structure, process, implicit understanding communication and processes. I then discuss the role of creativity and the creative imagination in work with EMDR and complex trauma and examine complex trauma in the context of the findings of this study.

Following this, I present the strengths and limitations of the study, reflect on the process and findings and suggest how current research, along with my understanding of the field in question, have contributed to my suggestions for practice to inform the field of Counselling Psychology and Psychotherapy. Finally, I make recommendations for future work in this area.

5.2 Summary of findings

Following the grounded theory process, I identified five main categories from the data, 'Relational Stance', 'Working with Developmental History', 'Parts Work', 'Structure and Process' and 'Right-Brain Processes'. From these categories, I generated a 'core category' of ''Integration – Uniqueness with Commonalities'.

5.2.1 The notion of integration in the context of this research

As discussed in the methodology chapter, I had significant doubt, as a result of my PAP panel, as to whether the analysis of my data would demonstrate integration. This doubt instilled a sense of rigour in the analysis and led to me engaging in theoretical sampling, by returning to my participants to explore the uncertainly I was experiencing around the notion of integration. This second round of data collection led to the construction of the core category of ‘‘Integration – ‘Uniqueness with Commonalities’.

5.2.2 ‘Integration’

As referenced in the initial literature review, most therapists would describe themselves as ‘integrative’ (Lapworth & Sills, 2010). Many practitioners whose practice takes the form of ‘technical eclecticism’ may describe themselves as ‘integrative’. Technical eclecticism is an eclectic, technique driven approach and therapists select their interventions from a range of therapeutic techniques without consideration of the theory behind the techniques they have selected (Norcross and Goldfried, 2005). Technical eclectics can tailor their range of techniques to suit individual client’s needs (Norcross and Goldfried, 2005). However, this approach requires high levels of competence in the techniques employed and the addition of a particular technique can feel like an ‘add-on’ to the work (Mcleod, 2013). This was my experience when I first started to introduce EMDR into my practice.

Theoretical integration on the other hand, combines or blends two or more approaches, but from a theoretical perspective as opposed to technique (Cooper and McLeod, 2007). McLeod (2013) suggested that one way of achieving this is to develop a ‘practitioner map’ to demonstrate what he referred to as, a ‘transtheoretical approach’ to link and bring together the ideas and theoretical concepts in a particular model of integration. Theoretically, this appears to be similar to that demonstrated by my model, but there are elements of ‘technique’, ‘structure and ‘process’ as categories in my grounded theory. I have therefore considered the literature in the context of my grounded theory more thoroughly.

5.2.3 ‘Commonalities’

The term ‘commonalities’, within the core category, refers to the processes described by the five main categories. These were derived through analysis of the data and represent the primary processes therein. ‘Common factors’ has been described as a form of integration which identifies the ‘active ingredients’ across the range of therapies considered (Cooper and Mcleod, 2007). This seems applicable to the current research. Norcross and Goldfried (2005) defined these factors as being outside theory and technique, in this case, “the therapeutic relationship, the instillation of hope and positive expectations for change and structure of therapeutic work” (Norcross and Goldfried, 2005, p.372). There are elements of the ‘common factors’ in my GT which fall under this definition, such as ‘relational stance’, but others that are driven by theory or technique such as ‘structure and process’ or ‘working with developmental history’. A key component of ‘common factors’, which reflects a key component of my grounded theory, is the therapist’s explicit collaboration with the client as to whether these common factors have been or are being met (Cooper and Mcleod, 2007). The theme of collaboration within the therapeutic relationship and around the content and direction of the therapeutic work, featured strongly in my data. However, the common factors approach does not describe how therapists actually work and so is largely incongruent with my grounded theory.

5.2.4 ‘Uniqueness’

As described in section 4.10.4, ‘uniqueness’ is a key component of the core category and this GT and speaks to each of the five main categories. Understanding the uniqueness of each individual in terms of their developmental history, their ‘parts’ and the ability to meet the client in their uniqueness is key to the core of this GT. This understanding may be implicitly communicated and the creativity which is required to meet and work with each client in their uniqueness, sit within the realms of ‘right-brain processes’. The Intersubjective space between therapist and client and the therapeutic relationship is unique to each dynamic dyad between therapist and client. The ‘structure and process’ which frames the therapeutic endeavour in the context of this GT is populated and enriched by a unique combination of the other main categories.

The integration approach of pluralism is based on philosophy and ethics as opposed to theory, techniques or common factors. This relatively recent version of integration was developed by McLeod and Cooper (2007). Their definition of pluralism "the doctrine that any substantial question admits a variety of plausible, but mutually conflicting responses" (Rescher, 1993 p.79), speaks to my grounded theory, in that, the diversity of people's experiences and understanding, together with multiple causes of psychological distress, suggests there can never be a single approach which will be appropriate for all clients. This principle sits well with my grounded theory, the core being 'Integration – Uniqueness with Commonalities': the unique combination of the client and the therapist, both of whom bring their own individual and unique experiences into an equally unique combination. One of the fundamental principles upon which pluralism is built is the commitment of collaboration with the client and complete willingness to be attuned with the client's subjective experience of reality. Both of these principles featured strongly in my data.

5.2.5 Integration – Uniqueness with Commonalities

The five categories I identified in the results chapter were in many ways difficult to define as the boundaries between them went between being 'blurred' to positively running into one another. Returning to the literature here to examine it in the context of my findings posed a similar problem.

I had intended to examine the literature in relation to each of the five main categories, but almost invariably, the studies and literature considered examined more than one of the main categories in my theory. The literature is broadly presented under the headings of the five main categories, although much of it could be discussed in the context of more than one of the main categories. This parallel between my struggle to extrapolate discreet categories both in my own findings and in the existing literature, supports the notion of a form of integration between them.

The notion of integration is that it is kept fluid as a construct or term in the way that it might be operationalised and individual clinicians need to develop their own framework of integration, requiring a cohesive organisation both in terms of its practical application and theoretical robustness. In the context of this research, together with

consideration of the relevant literature, integration means uniqueness with commonalities. Each therapist brings their unique model of theoretical integration, by blending two or more theoretical approaches (Evans & Gilbert, 2005) and this theoretical integration sits within the ethical, pluralistic principle of understanding. There is also an element of technical eclecticism in this theory. In the context of using EMDR with complex trauma, both the ethical backdrop and theoretical integration fall within the framework of Shapiro's eight-phase protocol and the technique of applying bilateral stimulation is applied.

5.3 Importance of an active, attuned and collaborative therapeutic relationship

When using EMDR integratively with clients presenting with complex trauma, the importance of the therapeutic relationship including both the connection between client and therapist and the ability to take a relational stance at all times, appears to be key. This was clearly indicated in the data presented in the analysis chapter and is supported by the literature relating to both the therapeutic relationship in general and the therapeutic relationship in EMDR.

Roscoff (2019) emphasised the importance of the therapeutic relationship in working with patients with complex trauma using EMDR, describing the need for an "extremely active therapist". This is counter to the guidance given in the basic training. Roscoff's (2019) findings echo many of the findings in the current study in terms of the need for a relational way of working in order to support other areas of practice. These include maintaining the patient's safety and stability and staying attuned to countertransference, co-regulation and other implicit processes. Roscoff's (2019) research also echoes the need for a co-created decision-making process in terms of treatment, and the need for a solid therapeutic relationship to support this.

Rosoff's (2019) research also supports my findings in terms of 'The Collaborative Understanding of What We are Doing and Why' and 'An Attuned and Responsive Therapist' which were both sub-categories of the category, 'Relational Stance'. My findings highlighted the importance of a collaborative endeavour between client and

therapist rather than a ‘doer/done to’ approach. The therapist needs to have the ability to work collaboratively with the client to understand their presentation and responses and to achieve a joint understanding of the direction of the therapeutic endeavour. This ensures the approach meets the client’s complexity and facilitates the client to have agency. This is particularly important for those clients who have had the experience of being helpless or powerless in trauma

‘Collaboration’ in this research context, describes actively working together as opposed to an experience. When using EMDR as part of integrative practice with complex trauma, this means developing a shared understanding of what you are doing and why, and a shared curiosity around the therapeutic endeavour. However, Rosoff (2019) also points to the importance of implicit processes which echo the findings here and the resulting category of ‘right-brain processes’ which includes ‘working with implicit processes, intuition and countertransference’. Rosoff (2019) also pointed to the need for safety and stabilisation and emphasised the need for a relational stance in order to maintain this. This illustrates my reference to the literature supporting my understanding of the relationships between my categories in a way that was not explicit in my findings. However, this position is supported by polyvagal theory (Porges. 2003), which asserts that the therapeutic presence facilitates feelings of safety and security and when the nervous system detects safety and security an ‘optimal therapeutic state’ is created (Geller and Porges, 2014).

In a review of twelve studies on EMDR utilising a variety of research methodologies, Marich et al (2020) found the value of the therapeutic relationship and the therapist’s attunement to their client to be of primary importance. This echoes my findings in terms of the importance of ‘an attuned and responsive therapist’. Marich et al (2020) also emphasised the importance of structure and process in terms of the eight-phase protocol as well as preparation for the process, which also supports my findings. Dworkin’s (2013) book ‘EMDR and the Relational Imperative’ also emphasises the importance of the eight phases of EMDR and of holding a relational position when working in this way.

Royal and Kerr (2010) demonstrate the steps taken in using EMDR with a client with Dissociative Identity Disorder (DID). They emphasise that the work must take place in

the context of the safety of a therapeutic relationship and follow the eight-phase protocol to the extent that they are able to incorporate 'ego state therapy' and imagery. This echoes my findings in terms of the use of 'parts' and 'right brain processes'.

In Marich's (2011) book 'EMDR Made Simple: 4 Approaches to Using EMDR with Every Client', emphasis is placed on both the importance of the therapeutic relationship and of structure and process, in particular, in the form of treatment planning and case conceptualisation. However, as echoed in the findings here, there is recognition of a dualism between these two aspects of the work; that it is the relationship that is of primary importance, whilst holding structure in mind. This is reflective of my findings in terms of understanding the therapist's ability to hold multiple positions within their framework of integration.

Although in my findings, the therapeutic relationship as a theme emerged quickly across the data set, Skinner (2021) asserted that there is little known about the therapeutic relationship within EMDR. Skinner (2021) conducted a mixed-methods study into the impact of the therapeutic relationship on the outcome, the fluctuations in therapeutic alliance throughout the work and an exploration of how the relationship is experienced by both therapist and client throughout treatment. The findings suggested the importance of a therapeutic alliance in a protocolised driven therapy (Skinner, 2021). Skinner suggests that further research is needed into the "relational imperative" in guiding the practice of EMDR.

Dworkin and Errebo (2010) focus on the therapeutic relationship in EMDR from a neurological perspective and the potential for rupture and repair within the intersubjective space. They suggest the need for greater emphasis on the therapeutic relationship in training due to the possibility of the process of rupture and repair mirroring clients' previous experiences which have led to dysfunction. This paper caused me to reflect on the shadow side of EMDR and consider what happens when things go wrong and how the findings of this research and resulting GT may be able to support this. I consider this in more detail in 'Limitations of this study and recommendations for future research'.

I have also considered my findings in the context of the literature not directly related to EMDR. De Young (2015) supported the finding that the therapeutic relationship is reparative in itself. On an explicit level, this relationship can allow clients to explore their developmental experiences in the safety of the therapeutic relationship (Gilbert and Orlans, 2011). However, this relationship generally has a more implicit feel and a sense of what was developmentally missed and needed, perhaps perceived through attunement (Stern, 2004). In addition, it has an open and creative stance of 'meeting' the client in the room at a variety of developmental stages. Attuning to the client in this way can allow the therapist to facilitate a 'corrective emotional experience' for the client, by offering an alternative experience in the present to the one offered by a parent in the past (Alexander and French, 1946). In this sense, each 'relationship' can be seen as 'reparative' (Clarkson, 2003) as each can give the client the opportunity for a new kind of experience which is different to their developmental past (Gilbert and Orlans, 2011). This aligns with the concept of neuroception whereby the client's automatic perception of safety in their social engagement system is generated through the therapeutic relationship. It has been suggested that this enables a down-regulation of affect, a loosening of psychological defences and the opportunity for new neural pathways to develop in the context of relationships thus facilitating lasting change (Geller and Porges, 2014). This connection with the client is supported by the therapist's connection with their own embodied self being grounded and self-aware and therefore able to be open to the other.

5.4 Understanding Clients' Developmental and Attachment History

In a case study, Shapiro (2013) emphasised the importance of the therapeutic relationship in the context of working with complex developmental trauma and understanding the patient's history of childhood abuse and experiences. Forgash (2019), emphasised the need for a full and through understanding of each patient's developmental history, including the use of the Adverse Childhood Experiences (ACE) questionnaire, to gain a full understanding. The importance of this understanding is to inform case conceptualisation and to ascertain what needs to be targeted in phases four to seven of the eight phase protocol. This supports my findings that understanding clients' developmental history is key.

Developing an understanding of clients' attachment experiences and the emergence of their core belief system was evident throughout the data set and a sub-category to the main category, 'working with developmental history'. These findings are supported by the literature. Verardo, Zaccagnino and Lauretti (2014) were guided by attachment theory (Bowlby, 1969) and the understanding of dysfunctionally stored traumatic memories to guide case conceptualisation and targeting for EMDR. Verardo and Zaccagnino (2016) expanded on this and explored the impact on their participants' attachment status of targeting their Internal Working Models (IWMs) of attachment using the eight-phase protocol. In 2015, Verardo and Cioccolanti (2015) systematically reviewed the literature on the role of EMDR in treating attachment disorders resulting from adverse childhood relationships and experiences. They concluded that a thorough understanding of a clients ACEs and dysfunctional attachment relationships, can assist clinicians in providing interventions and treatment which may influence the client's future pathological outcome.

The results in the current study place the understanding of a client's developmental history and attachment experiences as the focal point from which the structure of this work stems. It is the understanding of the developmental process and events that led to the client presenting in a particular manner. This should include an understanding of the clients self-soothing strategies and ability to regulate affect. This will enable the clinician to understand what needs to change, what to target and what is the desired outcome of the process. Parnell (2013) developed a modified version of the standard EMDR protocol with the direct and explicit intention of discovering, focussing on and healing attachment wounds. The modifications are around target identification focusing on the root of the dysfunction or the original attachment wounds.

As well as an absolute emphasis on working with developmental history, Parnell (2013) emphasises the importance of the therapeutic relationship and works with the creative imagination. This refers to both resourcing and imaginal interweaves within which the concept of ego states is integrated. The GT produced from the current research, echoes many of the components of Parnell's (2013) modified protocol. However, the development of this protocol was underpinned by clinical experience as opposed to research and at the point of writing, there has been no research published

on the efficacy of either Parnell's modified protocol or an adaptation of such. However, I understand that such research in the field has just received approval and funding.

5.5 Working with clients' 'parts' to aid understanding and healing

'Parts works' is a main category in my grounded theory. However, as I explained in 4.7.2, the term 'parts' was used to broadly cover the range of terminology to describe different 'parts' of the psyche by my co-researchers. Co-researchers used Bowlby's (1969) terminology of 'Internal Working Models', the Jungian concept of 'Complexes', the transpersonal language of 'sub-personalities', the Transactional Analysis language of 'parent, adult, child' and Richard Schwartz's 'Internal Family Systems' model (Schwartz, 2019). The most common language used for referencing 'parts' among co-researchers however, was ego-states and this is reflected in the current literature.

Schwartz & Maiberger (2018) use the terms 'parts' and 'ego-states' interchangeably. Paulson (2010) has written extensively about using EMDR with 'ego-state therapy' and describes working with a client with DID and incorporating the eight stages of the standard EMDR protocol with ego state therapy. Forgash and Knipe (2012) also wrote about 'Integrating EMDR and ego state treatment for clients with trauma disorders' and found incorporating a focus on ego-states helped clients to process traumatic memories. Twombly and Schwartz (2008) considered the integration of Schwartz's 'Internal Family Systems' model with EMDR and found that, when an 'ego state treatment modality' was used in conjunction with EMDR, there was an increase in efficacy.

5.6 The importance of structure and process when working with EMDR and complex trauma

Each Co-researcher spoke about the importance of structure and process in the context of the EMDR standard eight phase protocol (Shapiro 2001). There are numerous other protocols in the literature, for example 'Loving Eyes' (Knipe 2008) which seeks to preserve emotional safety when working with trauma and dissociation

and Miller (2016) who created the ‘Feeling State Addiction Protocol’ to process trauma behind addictive behaviour. The many other presentation specific protocols available are all largely based on the standard protocol. As discussed above, Parnell (2013) developed a modified version of the standard protocol which focusses on the root of the attachment trauma.

Although there are variations, the EMDR eight-phase protocol can be seen as fitting into the traditional three phased approach to the treatment of trauma. These phases are an initial stabilisation phase, processing of the traumatic memories and then integration of the individual’s functioning and rehabilitation into normal life (Steele & van der Hart, 2005). This literature echoes the findings in this research in terms of stabilisation, processing and then integration, in terms of the sub-categories: ‘Theory Informed Treatment Planning and Therapeutic Structure’ and ‘Safety Stabilisation and Resourcing’, which together make up the category of ‘Structure and Process’. The term ‘Integration’ in the context of the final phase of trauma treatment, was used across the data set, both in terms of the integration of the adapted trauma and the integration of a client’s ‘parts'.

5.7 Importance of implicit understanding, communication and processes

The findings from this study suggest that implicit communication and processes are an important part of the process and that therapists need to listen to their intuition and use it in a considered way. There are some references in the literature to what I have termed ‘right brain processes’ in relation to EMDR. Piedfort-Marin (2018) explored the use of ‘Transference and Countertransference in EMDR therapy’ and described how both the therapist’s and client’s conscious and unconscious processes can intertwine, potentially impacting the efficacy of EMDR. An interweave is suggested to help prevent counter transference responses from blocking the process thereby, particularly in complex cases, increasing the effectiveness of EMDR. The need to work with countertransference and implicit processes is evident in my findings. However, the data suggested using countertransference responses to inform the work as opposed to potentially blocking the process. As mentioned previously, there are inevitably

problematic aspects associated with working in this way with this presentation that did not feature in the current findings and this will be considered in section 5.10.

There have been some interesting qualitative studies that explore the integration of EMDR with transpersonal psychotherapy. Miller (2015) explored the integration of these two modalities when working with complex trauma. The results demonstrated that application of EMDR with a transpersonal approach was helpful in several ways. First, the resourcing phase of EMDR was seen to have been both strengthened and used throughout the whole process and second, the therapist participants reported shifts in both the relationship their clients had with their traumatic experiences and alleviation of symptoms.

Krystal et al (2002) developed a transpersonal protocol which sought to target distractions to a client's awareness of their personal integration and transformation. It is recommended for use when clients have experienced and made progress with the standard protocol. Working with the transpersonal is a sub-category to the category 'right-brain processes' and was evident across the data, but in a more implicit way than is evident in Miller (2015) and Krystal et al (2002). It was arrived at through analysis of the data as opposed to being part of the research question.

Examination of the literature related to the main categories of my GT in the context of EMDR has shown that these concepts are increasingly appearing in the literature. Sometimes they appear in tandem, although are yet to all appear in conjunction with each other in the context of an integrative way of working with EMDR. The notion of integration in relation to EMDR has been widely used in the literature but with reference to the efficacy of EMDR when used with another modality as opposed to the process of integrating EMDR.

5.8 Creativity and the creative imagination to facilitate understanding and richness of therapeutic work with EMDR and complex trauma

Use of creativity and the creative imagination formed a sub-category of the main category 'right-brain processes'. This felt as if it should have taken up more space as

there was a strong sense across the dataset of a rich and creative way of working. 'Safety, stabilisation and resourcing' formed part of the main category of 'structure and process', which has a more 'left-brain' feel to it. However, the resourcing described in the data often took the form of imaginal resource figures, animals, historical figures and intricately constructed imaginal places which clients create and can 'go to' to regulate themselves. These findings are supported by the work of Parnell (2013) who advocates for the use of a 'resource team' for use, not only in stabilisation, but also in the service of imaginal interweaves to support the client's processing.

Using the creative imagination to facilitate change and healing was widely demonstrated across the data set and in a number of different ways. This included the use of metaphor, imagery, developing a shared language and a 'world within a world (Hycner, 1993) and working creatively with a client's 'parts'. Working with a client to come up with a unique model to them and treating every case as an opportunity to develop the therapeutic approach, is working creatively. Marich & Dansiger (2018) offer a creative approach to working with complex trauma with EMDR and mindfulness. Although the use of mindfulness did not appear explicitly in the data set in the current study, Marich and Dansiger's (2018) use of creative practice and intuition echo some aspects of my findings, in the sense that individual creative practice and imaginal resourcing were interwoven throughout the eight phases of the EMDR protocol (Shapiro, 2002).

5.9 'Complex trauma' in the context of the results of this study: 'working with a client's complexity and developmental trauma'

Conducting this research has led me to re-examine the concept of 'complex trauma'. Throughout the data, it became clear that co-researchers were referring to events throughout their clients' developmental history when referring to 'complex trauma'. The emphasis placed by my co-researchers on 'working with the client's attachment history and the emergence of their core belief system' and 'Working with Dysregulation and Self-Soothing', is in line with Van der Kolk's (2014) understanding of 'complex trauma'. This refers to trauma often being of early-life onset, interpersonal in nature and 'multiple, chronic and prolonged' and often occurring within the child's caregiving

environment (Van der Kolk, 2014, p2). Van der Kolk (2014) proposed a new diagnosis of 'Developmental Trauma Disorder' for inclusion in the DSM-V. Van der Kolk and colleagues at the National Child Traumatic Stress Network, developed a set of criteria for the new diagnosis including affective and physiological dysregulation, self and relational dysregulation and exposure to trauma (Van der Kolk, 2014, p5).. These criteria were developed to conceptualise and describe the distress that was endured in the form of early and chronic trauma. This diagnosis was not accepted into the DSM-V but appears to encapsulate the understanding of 'complex trauma' in the context of the results of this research.

The data highlights the importance of developing an understanding of each client's uniqueness and complexity, in terms of their developmental history, current presentation and 'parts'. This complexity changes and evolves during the course of the work. The ability to embrace the complexity, not only of the client, but of the intersubjective dynamic between therapist and client, is crucial in this complex and nuanced way of working.

5.10 Limitations of this study

5.10.1 Recruitment Criteria

I am mindful of the limitations of this research and I describe them in this section. I deliberately put together a specific selection criterion in terms of therapists who described their clinical practice as 'integrative' and who used EMDR as part of their practice when working with 'complex trauma'. This resulted in a sample of co-researchers who largely work in a similar way and with which I was able to achieve 'theoretical sufficiency' from a sample of nine, which is unlikely I would have been able to do with wider recruitment criteria. This enabled me to answer the research question in terms of 'how' these practitioners work i.e., the commonalities. However, it doesn't look at efficacy from this way of working and is limited to practitioners who work in a particular way.

5.10.2 Being an 'Insider Researcher'

I have discussed the implications of being an 'insider researcher' and this could be considered a limitation in that I have become so closely involved in the training and development of EMDR there could be a risk of me making assumptions when examining literature, in interviewing and in data analysis and interpretation. To mitigate these risks, I took a reflexive stance to maintain curiosity and try to avoid making assumptions. In contrast, this connection with EMDR training can also be considered a strength in providing insight into the processes involved in integration of EMDR that aided development of the model produced.

5.10.3 Social and Political context

Reflecting back on the research process and the resulting grounded theory, there is an absence of social and political context within the emergent categories and discussion. I have considered this from a variety of perspectives: the absence of context around EMDR and Complex Trauma in general and absence of context in this piece of research specifically, which is not reflective of how the social and political context of trauma and EMDR are live, both in my own thoughts and in exchanges and discussions with peers and colleagues.

The social and political context to the emergence and development of EMDR is fascinating. In the last forty years our understanding of trauma, neurobiology and EMDR has grown exponentially. As described in the initial literature review, the diagnosis of PTSD first appears in the DSM in 1980 and is associated with the legacy of the Vietnam war disaster. Prior to this, what is now termed PTSD was described as 'soldier's heart', 'shell shock' and 'war neurosis', but was not recognised as a psychiatric diagnosis. Trauma training for Psychologists and Psychotherapists was virtually non-existent which meant that clinicians were ill-equipped to treat trauma. Nine years after the introduction of PTSD to the DSM, Francine Shapiro began to develop EMDR and many of her early clinical studies were conducted using veterans of the Vietnam war presenting with PTSD. The development of EMDR has in many ways paralleled the development of the treatment and understanding of trauma and PTSD and this has allowed EMDR to

have real impact and become as widely used as it is today. As the understanding of PTSD has developed from a response to single incident trauma to a response that is largely informed by the individual's attachment and developmental history as described in the literature review, so the way we treat this presentation has developed. The social and political context of the time also parallels these developments. This research was largely developed during the pandemic, which impacted people in a variety of ways including traumatic loss and social isolation. Clinicians were able to respond to what we now understand to be complex trauma in appropriate and nuanced ways which increasingly involve the use of EMDR within both the NHS and the private sector as it has been developed to meet the needs of patients with this presentation. The social and political considerations was part of what drove my interest in the area of trauma and EMDR because the greater the understanding we have of a particular presentation, the more we are able to develop appropriate and effective treatments and both of these are impacted by the social and political context within which they are developing.

Social and Political context could potentially have been an additional category developed in this research and which could have potentially broadened and contextualised the research. However, as by maintaining a focussed approach, recognising that this was a small-scale research study and staying close to the data, I was honouring the GT process of analysis and the development of categories, this material did not emerge from the interviews and data. However, I could have asked participants about their perspectives on social and political context explicitly in the interviews which would have elicited such data which may have enriched and broadened the theory. On reflection, an understanding of the contextual conditions the participants were subject to may have provided an additional understanding into the ways they are able to work with EMDR. An example of this on which there is data from the recruitment criteria (see Methodology Chapter) which shows that all of the participants work in private practice rather than in the NHS or within organisational settings. My experience working within the NHS and within a training capacity, has allowed me to reflect that clinicians working in private practice have more freedom to practice in autonomous ways, in terms of duration, applications and focus of the work. Clinicians working in institutions such as the NHS may experience more contextual restrictions in the way they practice in terms of permitted duration of their

work and the expectation of certain outcomes which would influence the focus of the work and potentially impede upon a more integrative way of working. Therefore, their experience of working with EMDR with clients presenting with complex trauma and the fluidity of this way of working, deduced from the data and described by the grounded theory, may not be representative of the experience of all EMDR therapists, potentially particularly those working within the NHS and other organisations. It is entirely possible that their experience of attempting to integrate EMDR into their practices could be different and they may well experience some of the same challenges I describe in the introduction chapter around attempting to integrate EMDR. Therefore, along with a lack of social and political context in this research, another limitation could be that all the participants were working in private practice and not working in a range of diverse settings.

5.10.4 The Use of Supervision and Wider Services

The absence of examination of supervision and wider services in this research could also be considered a limitation, although discussion of the role of supervision and the use of wider services did not appear explicitly in the data and I did not want to include something which did not appear organically in data collection. However, as an insider researcher I fully recognise the critical value of supervision and the role it plays in helping clinicians to integrate EMDR into their practice and in the same way the use of Continuing Professional Development (CPD) and training is extremely beneficial. Retrospectively, I realise that exploration of the use of supervision for the participants, may well have added value to the data and richness to the grounded theory.

Some of the limitations of the insider researcher position I inhabited have meant I made some possible assumptions and was not explicit enough in some important areas of exploration because I had an implicit understanding and conjectures of my own. I have found that the status as an inside researcher, had meant that my focus was about finding out '*what I didn't know'*. Upon reflection, I realise that the importance of good supervision is something I am familiar with and thus potentially 'blinded to' the need for exploration in the area in my quest to understand better what I wanted to discover. My layers of reflexivity were influenced by my position as an

insider researcher and I acknowledge that this research could be improved by challenging my assumptions and making more specific and identifiable references as to how the use of supervision and training served the participants and influenced and impacted upon their integration.

5.10.5 Negativity and the 'Shadow Side' of EMDR

I mentioned previously in the context of Piedfort-Marin (2018), the lack of understanding from the data about the potential pitfalls in using EMDR with complex trauma, when not to use EMDR and what happens when, as discussed in Piedfort-Marin (2018), ruptures are experienced within the work. Arguably this was not an explicit part of the research question of 'how' clinicians work in this way, but it presents both opportunities for future research and reflections on the sample in the current research. Responding to a 'call for participants' indicates an active desire to be heard and my co-researchers were very much advocates of EMDR. Therefore, this may have resulted in the 'shadow side' of EMDR not being explored.

Rosoff (2019) also addresses the shadow side of EMDR in her work which I feel is an area which could have been explored at greater depth with my co-researchers. Safety, stability and resourcing were very much present in the data, but largely in a preventative way, in terms of adequate preparation work to ensure the client is stable and regulated enough to begin processing. This is likely to be because my co-researchers were all advocates of EMDR and wanted to share its potential benefits. However, greater exploration of how therapists work with EMDR and complex trauma when things go wrong, could have added complexity to the data. Ways in which we can be helped in managing impasses, enactments and mistakes could have added to its contribution to the field. The omission of exploration of negativity is a limitation of this study.

I wondered whether the absence of negativity in the research may have been in some ways because I was 'swept along' by the enthusiasm of my participants. Reflecting back on the data collection process, my overall sense if one of positivity and considerable enthusiasm and this led to the negative/shadow side of EMDR being unexplored in the interview process. Reflecting on my own biases, assumptions and

holding a position of greater criticality, would have enabled me to explore my own shadow and that of the participants with regard to the use of EMDR for integrative practitioners which could have been valuable learning.

5.11 Additional Reflexivity

5.11.1 Theoretical Saturation and the Development of the Grounded Theory

The process of analysing the data and developing a grounded theory was a daunting process with a myriad of contradicting emotions. I wanted to develop a tangible theory to inform practice, but at the same time, the development of such a theory felt a little grandiose. In addition, the CGT process of data analysis and theory generation felt in some ways to be a containing structure to this process, but in other ways, the scope for researcher interpretation and subjectivity felt a little over-whelming and uncertain. As described in the methodology chapter, I managed this though keeping a reflexive journal of this process and by reflecting on the process with peers and my research supervisor. Henwood & Pidgeon (1992) suggest that from the initial unstructured chaos of raw data, the lenses become sharper as order is generated and I found this very much to be the case. Blumer (1979) suggests that the emerging theory should be seen as the result of a constant flip-flop between ideas and research experience; a suggestion I found reassuring and which seems to fit with Glaser & Strauss' (1967) observation that each glance at the data could stimulate fresh perspectives, thus acknowledging the emergent, fluid properties of a GT. The challenge that arose from this was knowing when to stop and which material to incorporate into the theory.

5.11.2 Theoretical Saturation

This leads me to consider as to whether theoretical saturation was achieved, both in the context of what was included from the data collected and also, as described in the previous section, which was not included.

I have needed to be selective with the data presented in order to achieve the necessary depth of thought and analysis required and was mindful of only including

data which contributed towards answering the posed research question. The data collected focussed on specific components of working with EMDR with complex trauma and on therapists who work in a particular context. It is unknown as to whether the resulting theory would generalise to other contexts. This study also had a tight focus around the therapeutic stance and interventions used by the participants.

The second round of data collection, as described in the methodology chapter, focused on the emerging categories with the aim of saturating existing categories. Having received data from the second round of interviews, I felt confident I had reached theoretical saturation; no new properties were emerging, and patterns could be seen within the data (Charmaz, 2014), therefore further fulfilling the methodological stipulations of CGT. However, a more generalised theoretical saturation (exploring the full scope of the research question), could have been achieved if the areas described in the limitations above had been included in the data collection and resulting theory and inclusion of these areas is recommended for future research.

5.12 So What? Implications for practice

How can this research help others and what does it mean for the use of EMDR with people with complex trauma? When considering this, I wondered about my co-researchers and their training backgrounds and how different my grounded theory might have looked if for example, my recruitment criteria had simply been 'EMDR Practitioner'. I might then have had a sample comprised of Psychologists and Psychotherapists, but also Counsellors, Mental Health Nurses, Psychological Wellbeing Practitioners, Social Workers, General Practitioners, Occupational Therapists and anyone else satisfying the current requirement of having a professional accreditation with one of the awarding bodies deemed acceptable by EMDR Europe. From a therapeutic perspective the amount and level of training varies enormously, and I wondered about the current EMDR training and what would be required to deliver more than a technique, to respond to the complexity of what it is to be a human being with another in their suffering and what constitutes an adequate and creative response to that. I considered what is at the heart of really good therapeutic work.

Clinicians wishing to integrate EMDR into their practice when working with complex trauma, could consider this GT in terms of the 5 main categories and the core category identified in the research to reflect on their own practice with EMDR and complex trauma'. This may support the identification areas of their practice that they could further develop.

5.12.1 Contribution to the field of Counselling Psychology and Psychotherapy

My personal and professional interest in this piece of research let me to a relatively narrow recruitment criteria in terms of theoretical orientation and training. However, this has led to many questions around the training for EMDR. From my experience as a clinician and more recently in working for a training organisation that advocates the use of advanced EMDR in a highly integrative and attachment informed way, the basic EMDR training I experienced was only sufficient as to providing the basic skills of EMDR i.e. a working knowledge of the standard protocol. The length of the training is such that there would not be the time to include anything else. However, the basic training model could be adapted and extended to help clinicians integrate EMDR successfully into their existing practice.

The EMDR community is currently experiencing a period of change. As I mentioned in my introduction, in 2019 the Council of Scholars: The Future of EMDR Project was initiated (Matthijssen et al., 2020). This international project bought together 50 of the world's leading researchers and clinicians in EMDR and several working groups were established to consider the future of EMDR therapy from the perspectives of research, training and clinical practice. A primary aim of the council of scholars (COS) is to facilitate a change in perception around EMDR, from an intervention to a psychotherapy (McGoldrick, 2021). The working group established to consider training and credentialing of EMDR is currently considering what constitutes the best EMDR training, how this can be delivered most effectively and how a training curriculum can "ensure best integration of EMDR into clinical Practice" (McGoldrick, 2021, p3).

In the last few months, I have discussed this research project with a member of the COS and with a member of the board of the EMDR Association of Australia who wrote the article referenced above, McGoldrick (2021). Although this is a small-scale project,

the research question and resulting theory are pertinent to the endeavours of the COS and when presented to them may serve to inform their work; in particular, the integration of EMDR in psychotherapeutic practice, which may make a contribution to their thinking in terms of the development of training practices in EMDR.

I have also shared information about my research and the findings with the EMDR training organisation I am associated with and this research is due to be included in the research section of a training manual due to be published in 2022. This training manual will be available to the EMDR community I spoke about in my introduction and will inform supervision and practice as well as training.

5.13 Recommendations for future research

Future qualitative research could replicate this work to contribute additional evidence to the field and understand whether the findings of this work would be replicated in a different sample of practitioners, for example, 'mental health nurses who use EMDR as part of their practice'. This would enable comparison between groups of EMDR therapists with different professional backgrounds, providing further evidence to inform our understanding of and training in the use of EMDR with complex trauma. Efficacy studies are also needed examining the use of EMDR by professionals trained in EMDR, but with different professional backgrounds.

The social and political context of EMDR, both the wider context and the different contexts within which clinicians' practice, could be explored in future research. Exploration of practice in different contexts may well also inform the exploration of negativity and the shadow in the practice of EMDR. The use of supervision and wider services utilised by the participants and the implications in terms of the way they practice would also enrich and expand future research in this area.

The 'shadow side' of working with EMDR in this way is also grounds for further research, in order to inform practice when working with EMDR and complex trauma when the therapy results in rupture or efficacy is in question. We need to know more regarding instances where incorporation of EMDR has not gone well, and future

investigation of this would benefit the field so that we can work as ethical therapists wishing to do no harm and identify when it would not be an appropriate therapeutic approach as well as when it is.

5.14 Conclusion

In my introduction chapter, I described my own journey and how I have become immersed in the EMDR community; clinical work, training, EMDR technology and research, each of which influence and inform the other. I was mindful of the potential pitfall of going beyond the scope of this research within the discussion chapter and of making global statements. However, immersion in this world has increased my understanding of what may be required in terms of additional research possibilities and has also presented practical opportunities for this research to be utilised in the field.

I have constructed a theory around how a small group of participants integrate EMDR into their practice, what the main commonalities are in their ways of working and what is at the core of the theory behind this way of working. I described in my introduction, my initial bewilderment at the prospect of using this seemingly awkward and formulaic process alongside my existing integrative practice, let alone attempting to integrate it. It has been a few years since my PAP and my clinical practice has evolved significantly since that first awkward EMDR session with a client. I feel that this research has significantly contributed to the development of my own practice.

This research concluded that there are five main processes that characterise the ways that clinicians integrate EMDR into their practice when working with complex trauma: taking a relational stance, working with client's developmental histories, 'parts' work, the use of structure and process and working creatively with right-brain processes. The interactions between these processes and the essence of this way of working is encapsulated by the core process; the process of integration unique to each therapeutic dyad, but with the commonalities related to the other five processes. Using a full constructivist version of grounded theory, a model was developed representing these core elements of therapeutic practice, derived from analysis of the data from

nine co-researchers. Further work is needed to inform the developing field of EMDR and this study with its strengths and limitations can inform future work.

Having just completed the write up of what felt like such an enormous endeavour, it feels in some ways like a tiny, insignificant drop in the ocean in terms of research. However, the impact on me as described in my introduction has been far reaching and the dissemination and impact of this research on the field will be more far reaching because of my immersion than it would otherwise have been.

Conducting this piece of research as an 'insider' has been hugely rewarding and has opened many doors for me and at same time, the opportunities it has given me have been hugely impactful on me personally, professionally and in terms of this research. I am deeply passionate about this way of working and have found a way of using EMDR which feels congruent and in keeping with an integrative way of working. Having met many therapists with the same clinical capabilities and similar working practices as those in my sample, I am determined to work towards developing this field, to help facilitate the integration of EMDR into clinicians' practice and to bring this way of working to as many clients as possible.

References

Adler, P., & Adler, P. (1994). Observational Techniques. In N. Denzin & Y. Lincoln, *The Sage Handbook of Qualitative Research* (3rd ed., pp. 729-745). Sage.

Adler, P., & Adler, P. (2000). *Membership roles in field research*. Sage.

Alexander, F., & French, T. (1946). *Psychoanalytic Therapy* (1st ed.). Ronald Press.

American Psychiatric Assn., Mental Hospital Service. (1952). *Diagnostic and statistical manual* (1st ed.).

American psychiatric Association. (1994). *DSM-4.*.

American Psychiatric Association. (1968). *Diagnostic and Statistical Manual of Mental Disorders* (2nd ed.).

American Psychiatric Association. (1980). *DSM-III Diagnostic and statistical manual of mental disorders*.

American Psychiatric Association. (1987). *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.).

American Psychiatric Association. (2000). *Diagnostic criteria from DSM-IV-TR*.

American Psychiatric Publishing. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).

Arad, H. (2018). *Integrating relational psychoanalysis and EMDR*. Routledge, Taylor & Francis Group.

Bager-Charleston and Mcbeath (2020) *Enjoying Research in Counselling and Psychotherapy, Qualitative, Quantitative and Mixed Methods Research.* Palgrave Macmillan

Bessel A. van der Kolk, & Courtois, C. (2005). Editorial comments: Complex developmental trauma. *Journal Of Traumatic Stress*, *18*(5), 385-388. https://doi.org/10.1002/jts.20046

Birks, M., & Mills, J. (2015). *Grounded Theory: A Practical Guide*. Sage.

Bongaerts, H. *et al.* (2022) 'Fully remote intensive trauma-focused treatment for PTSD and complex PTSD', *European Journal of Psychotraumatology*, 13(2).
Bowlby, J. (1969). *Attachment and loss* (1st ed.). Basic Books.

Braun, V. and Clarke, V., 2021. Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and Psychotherapy Research*, *21*(1), pp.37-47.

Blumer, M. (1979) Concepts in the analysis of qualitative data. *Sociological Review.* 27, 651-677.

Charmaz, K. (2006). *Constructing grounded theory*. Sage.

Charmaz, K. (2014). *Constructing grounded theory* (p. 17). Sage.

Charmaz, K. (2017). The Power of Constructivist Grounded Theory for Critical Inquiry. *Qualitative Inquiry*, *23*(1), 34-45. https://doi.org/10.1177/1077800416657105

Charmaz, K., & Thornberg, R. (2020). The pursuit of quality in grounded theory. *Qualitative Research In Psychology*, *18*(3), 305-327. https://doi.org/10.1080/14780887.2020.1780357

Chemtob, J., Tolin, D., van der Kolk, B., & Pitman, R. (2000). Eye movement desensitisation and reprocessing. In *Effective treatments for ptsd: Practice guidelines from the International Society for Traumatic Stress Studies*. Guildford Press. Retrieved 21 August 2021, from.

Choi, J., & Kim, D. (2004). Eye movement desensitisation and reprocessing for disorder of extreme stress: A case report. *Journal Of The Korean Neuropsychiatric Association*, *43*, 760-763.

Clarkson, P. (2003). *The therapeutic relationship* (1st ed.). Whurr.

Clarkson, P. (2014). *The therapeutic relationship*. Whurr.

Code of Ethics and Conduct (2018) | BPS. Bps.org.uk. (2021). Retrieved 30 August 2021, from https://www.bps.org.uk/news-and-policy/bps-code-ethics-and-conduct.

Cooper, M., & McLeod, J. (2007). A pluralistic framework for counselling and psychotherapy: Implications for research. *Counselling And Psychotherapy Research*, *7*(3), 135-143. https://doi.org/10.1080/14733140701566282

Corbin, J., & Strauss, A. (1990). Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative Sociology*, *13*(1), 3-21. https://doi.org/10.1007/bf00988593

Corbin, J., & Strauss, A. (2015). *Basics of qualitative research*. Sage.

Crotty, M. (1998). *The foundation of social research: Meaning and perspective in the research process*. Sage.

Denzin, N., & Lincoln, Y. (2005). *The landscape of qualitative research*. Sage.

de Jongh, A. *et al.* (2019) 'The status of EMDR therapy in the treatment of posttraumatic stress disorder 30 years after its introduction', *Journal of EMDR Practice and Research*, 13(4), pp. 261–269.

DeYoung, P. (2015). *Relational Psychotherapy* (2nd ed.). Routledge.

Dunne, C. (2011). The place of the literature review in grounded theory research. *International Journal of Social Research Methodology*, *14*(2), 111-124. https://doi.org/10.1080/13645579.2010.494930

Dunne, C., & Gamze, B. (2020). Successfully Managing the Literature Review and Write-up Process When Using Grounded Theory Methodology - A Dialogue in Exploration. *Qualitative Social Research*, *21*(1), Art. 25. Retrieved 19 July 2020, from.

Dworkin, M. (2003). Integrative Approaches to EMDR: Empathy, the Intersubjective and the Cognitive Interweave. *Journal Of Psychotherapy Integration*, *13*(2), 171-187.

Dworkin, M. (2013). *EMDR and the Relational Imperative*. Taylor and Francis.

Dworkin, M., & Errebo, N. (2010). Rupture and Repair in the EMDR Client/Clinician Relationship: Now Moments and Moments of Meeting. *Journal Of EMDR Practice And Research*, *4*(3), 113-123. https://doi.org/10.1891/1933-3196.4.3.113

Dwyer, S., & Buckle, J. (2009). The Space Between: On Being an Insider-Outsider in Qualitative Research. *International Journal Of Qualitative Methods*, *8*(1), 54-63. https://doi.org/10.1177/160940690900800105

Evans, K., & Gilbert, M. (2005). *An introduction to integrative psychotherapy* (1st ed.). Palgrave Macmillian.

Fonagy, P., Roth, A., Woods, R., Target, M., & Parry, G. (2004). *What works for whom?: a critical review of psychotherapy research* (2nd ed.). Guilford Publications.

Ford, J. D., & Courtois, C. A. (Eds.). (2020). *Treating complex traumatic stress disorders in adults: Scientific foundations and therapeutic models* (2nd ed.). The Guilford Press.

Forgash, C. (2019). The impact of complex PTSD and attachment issues on personal health: An EMDR therapy approach. In M. Luber, *Eye movement desensitisation and reprocessing: EMDR therapy scripted protocols and summary sheets: Treating eating disorders, chronic pain and maladaptive self-care behaviours* (pp. 431-462). Springer Publishing Company.

Forgash, C., & Knipe, J. (2012). Integrating EMDR and Ego State Treatment for Clients With Trauma Disorders. *Journal Of EMDR Practice And Research*, *6*(3), 120-128. https://doi.org/10.1891/1933-3196.6.3.120

Geller, S., & Porges, S. (2014). Therapeutic presence: Neurophysiological mechanisms mediating feeling safe in therapeutic relationships. *Journal Of Psychotherapy Integration*, *24*(3), 178-192.

Gilbert, M., & Orlans, V. (2011). *Integrative therapy*. Routledge.

Glaser, B. (1978). *Theoretical sensitivity*. The Sociology Press.

Glaser, B. (2010). The future of grounded theory. *The Grounded Theory Review*, *9*(2), 1-14. Retrieved 30 August 2021, from.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory. Strategies for qualitative research*. Aldine Transaction.

Guba, E., & Lincoln, Y. (1985). *Naturalistic inquiry*. Sage Publications.

Guba, E., & Lincoln, Y. (1994). Competing paradigms in qualitative research. In N. Denzin & Y. Lincoln, *Handbook of qualitative research* (pp. 105-117). Sage Publications.

Hase, M., Balmaceda, U., Ostacoli, L., Liebermann, P., & Hofmann, A. (2017). The AIP Model of EMDR Therapy and Pathogenic Memories. *Frontiers In Psychology*, *8*.

Hase M, Brisch KH. (2022) The Therapeutic Relationship in EMDR Therapy. *Frontiers in psychology*, *13*, 835470.

Hennik, R. (2021) 'Practice Based Evidence Based Practice, part II: Navigating complexity and validity from within', *Journal of Family Therapy*, 43(1), pp. 27–45.

Henton, I. (2012). Practice-based research and counselling psychology: A critical review and proposal. *Counselling Psychology Review, 27*(3), 11–28.

Herman Judith Lewis 1942- Aut, M D Judith Lewis Herman, & Herman, J. (2011). *Trauma and Recovery: The Aftermath of Violence--From Domestic Abuse to Political Terror*. Tantor Media.

Herman, J. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal Of Traumatic Stress*, *5*(3), 377-391. https://doi.org/10.1007/BF00977235

Hogan, K., & Hart, N. (2003). Second Response: Training Counselling Psychologists: What role for evidence-based practice?. *Counselling Psychology Review*, *18(3)*.

Hollanders, H. (1999). Eclecticism and integration in counselling: Implications for training. *British Journal Of Guidance & Counselling*, *27*(4), 483-500. https://doi.org/10.1080/03069889908256285

Hycner, R. (1993). *Between person and person, towards a dialogical psychotherapy* (1st ed.). Gestalt Journal Press.

J, M., & Friedman. (2013). PTSD in the DSM-5: Reply to Brewin (2013), Kilpatrick (2013), and Maercker and Perkonigg (2013) - Friedman - 2013 - Journal of Traumatic Stress - Wiley Online Library. *Journal Of Traumatic Stress*, *26*. Retrieved 31 May 2015, from http://dx.doi.org/10.1002/jts.21847.

JoAn, R. (2000). Using eye movement desensitization and reprocessing to treat complex PTSD in a biracial client. *Cultural Diversity And Ethnic Minority Psychology*, *6*(4), 399-408.

Kemal Kaptan, S. and Brayne, M. (2022) 'A qualitative study on clinicians' perceptions of Attachment-Focused eye movement desensitisation and reprocessing therapy', *Counselling & Psychotherapy Research*, 22(3), pp. 594–605.

Kessler, R. (1995). Posttraumatic Stress Disorder in the National Comorbidity Survey. *Archives Of General Psychiatry*, *52*(12). https://doi.org/10.1001/archpsyc.1995.03950240066012

Knipe, J. (2021). Loving eyes: Procedures to therapeutically reverse dissociative processes while preserving emotional safety. In C. Forgash & M. Copeley, *Healing the heart of trauma and dissociation with EMDR and ego state therapy* (pp. 181-225). Springer Publishing Company.

Korn, D. (2009). EMDR and the Treatment of Complex PTSD: A Review. *Journal Of EMDR Practice And Research*, *3*(4), 264-278. https://doi.org/10.1891/1933-3196.3.4.264

Krystal, S., Prendergast, J., Phyllis, K., Fenner, P., Shapiro, I., & Shapiro, K. (2002). Transpersonal psychology, Eastern nondual philosophy, and EMDR. In F. Shapiro, *EMDR as an integrative psychotherapy approach* (pp. 3319-339). American Psychological Association.

Laliotis, D. *et al.* (2021) 'What is EMDR therapy? Past, present, and future directions', *Journal of EMDR Practice and Research*, 15(4), pp. 186–201.

Laliotis, D (2022) 'Relational EMDR Therapy' Psychotherapy Networker

Lapworth, P., & Sills, C. (2010). *Integration in counselling and psychotherapy*. Sage.

Leeds, A., & Korn, D. (2002). Preliminary evidence of efficacy for EMDR resource development and installation in the stabilization phase of treatment of complex posttraumatic stress disorder. *Journal Of Clinical Psychology*, *58*(12), 1465-1487. https://doi.org/10.1002/jclp.10099

Levers, M.J.D., 2013. Philosophical paradigms, grounded theory, and perspectives on emergence. *Sage Open*, *3*(4), p.2158244013517243.

Lilienfeld, S., O'Donohue, W., Nickerson, A., & Bryant, R. (2013). *Treatment of complex PTSD: The case of a torture survivor*. Oxford University Press.

Lobenstine, F., & Courtney, D. (2013). A Case Study: The Integration of Intensive EMDR and Ego State Therapy to Treat Comorbid Posttraumatic Stress Disorder, Depression, and Anxiety. *Journal Of EMDR Practice And Research*, *7*(2), 65-80. https://doi.org/10.1891/1933-3196.7.2.65

Luber, M., & Hofmann, A. (2009). In *'The inverted EMDR standard protocol for unstable complex post-traumatic stress disorder'*. Springer Publishing Company.

MARGISON, F. (2000). Measurement and psychotherapy: Evidence-based practice and practice-based evidence. *The British Journal Of Psychiatry*, *177*(2), 123-130. https://doi.org/10.1192/bjp.177.2.123

Marich, J. (2009). EMDR in the addiction continuing care Process
 case study of a cross-addicted female's treatment and recovery. *Journal Of EMDR Practice And Research*, *3*(2), 98-106. https://doi.org/10.1891/1933-3196.3.2.98

Marich, J., & Dansiger, S. (2018). *EMDR therapy and mindfulness for trauma-focused care*. Springer Publishing Company.

Marich, J., & Marich-Merkin, J. (2012). *EMDR made simple: 4 approaches to using EMDR with every client*. Eau Claire.

Marich, J., Dekker, D., Riley, M., & O'Brien, A. (2020). Qualitative Research in EMDR Therapy: Exploring the Individual Experience of the How and Why. *Journal Of EMDR Practice And Research*, *14*(3), 118-134. https://doi.org/10.1891/emdr-d-20-00001

Matthijssen, S., Lee, C., de Roos, C., Barron, I., Jarero, I., & Shapiro, E. et al. (2020). The Current Status of EMDR Therapy, Specific Target Areas, and Goals for the Future. *Journal Of EMDR Practice And Research*, *14*(4), 241-284. https://doi.org/10.1891/emdr-d-20-00039

McGoldrick, A. (2021). Council of Scholars Publishes Deliberations on the Future of EMDR Therapy. *EMDR Therapy Quarterly*, (3). Retrieved 29 August 2021, from https://etq.emdrassociation.org.uk/2021/01/03/council-of-scholars-publishes-deliberations-on-the-future-of-emdr-therapy/.

McLeod, J. (2013). Developing Pluralistic Practice in Counselling and Psychotherapy: Using What the Client Knows. *The European Journal Of Counselling Psychology*, *2*(1), 51-64. https://doi.org/10.5964/ejcop.v2i1.5

Melia, K. (1996). Rediscovering Glaser. *Qualitative Health Research*, *6*(3), 368-378. https://doi.org/10.1177/104973239600600305

Meskunas, H.M. (2022) *Development and evaluation of an integrative group therapy treatment for survivors of complex trauma*, *Dissertation Abstracts International: Section B: The Sciences and Engineering*. ProQuest Information & Learning.

Michell, J. (2003). The Quantitative Imperative: Positivism, Naive Realism and the Place of Qualitative Methods in Psychology. *Theory & Psychology*, *13*(1), 5-31. https://doi.org/10.1177/0959354303013001758

Miller, M. (2015). Healing complex trauma through eye movement desensitization and reprocessing and transpersonal psychotherapy: Psychotherapists' heuristic exploration of integration compatibility and transformative value. *Dissertation Abstracts International: Section B: The Sciences And Engineering.*

Mills, J., Bonner, A., & Francis, K. (2006). Adopting a constructivist approach to grounded theory: Implications for research design. *International Journal Of Nursing Practice*, *12*(1), 8-13. https://doi.org/10.1111/j.1440-172x.2006.00543.x

Muraoka, M., Hedlund, N., Rusnak, K., Chemtob, C., & Carlson, J. (1998). Eye movement desensitization and reprocessing (EDMR) treatment for combat-related posttraumatic stress disorder. *Journal Of Traumatic Stress*, *11*(1), 3-24. https://doi.org/10.1023/a:1024448814268

Norcross, J., & Goldfried, M. (2005). *Handbook of Psychotherapy Integration. Oxford Series in Clinical Psychology*. Oxford University Press, USA.

Norcross, J.C. and Wampold, B.E., (2011). Evidence-based therapy relationships: research conclusions and clinical practices. *Psychotherapy*, *48*(1), p.98.

Nowill, J. (2010). A critical review of the controversy surrounding eye movement desensitisation and reprocessing. *Counselling Psychology Review*, *25*.

Olson-Morrison, D. (2017) 'Integrative play therapy with adults with complex trauma: A developmentally-informed approach', *International Journal of Play Therapy*, 26(3), pp. 172–183.

Parnell, L. (2013). *Attachment-focussed EMDR: Healing relational trauma*. W W Norton & Co.

Paulsen, S. (2010). ACT-AS-IF and ARCHITECTS Approaches to EMDR treatment of dissociative identity disorder (DID). In M. Luber, *Eye movement desensitisation and reprocessing (EMDR) scripted protocols: Special populations* (pp. 357-386). Springer Publishing Company.

Paivio, S. C., & Pascual-Leone, A. (2010). *Emotion-Focused Therapy for Complex Trauma: An Integrative Approach*. American Psychological Association.

Plagaro, I. (2022) 'HEALING THE WOUNDS OF REJECTION: An EMDR-informed approach offers a time-efficient way to work with attachment trauma', *Therapy Today*, 33(7), pp. 42–45.

Pidgeon, N. (1996). Grounded Theory: Theoretical Background. In J. Richardson, *Handbook of qualitative research methods for psychology and the social sciences* (pp. 75-85). British Psychological Society.

Pidgeon, N., & Henwood, K. (1997). Using grounded theory in psychological research. In N. Hayes, *Doing qualitative analysis in psychology* (pp. 245-273). taylor & Francis.

Piedfort-Marin, O. (2018). Transference and Countertransference in EMDR Therapy. *Journal Of EMDR Practice And Research*, *12*(3), 158-172. https://doi.org/10.1891/1933-3196.12.3.158

Ponterotto, J.G., 2005. Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of counseling psychology*, *52*(2), p.126.

PORGES, S. (2003). Social Engagement and Attachment: A phylogenic perspective. *Roots Of Mental Illness In Children, Annals Of The New York Academy Of Sciences*, *1008*(1), 31-47.

Porges, S. W. (2011). *The polyvagal theory: Neurophysiological foundations of emotions, attachment, communication, and self-regulation.* W W Norton & Co.

Rescher, N. (1994). Pluralism: Against the Demand for Consensus. *Philosophical Books*, *35*(4), 264-266. https://doi.org/10.1111/j.1468-0149.1994.tb02895.x

Reserved, W. (2015). *Posttraumatic stress disorder: A history and a critique*. Retrieved 3 September 2016, from http://www.brainline.org/content/2011/01/posttraumatic-stress-disorder-a-history-and-a-critique_pageall.html.

Resick, P., Kaplan, S., Mandel, F., Roth, S., van der Kolk, B., & Pelcovitz, D. (1997). Development of a criteria set and a structured interview for disorders of extreme stress (SIDES). *Journal Of Traumatic Stress*, *10*(1), 3-16. https://doi.org/10.1002/jts.2490100103

Richards, P.S. and Barkham, M. (2022) 'Enhancing the evidence base for spiritually integrated psychotherapies: Progressing the paradigm of practice-based evidence', *Psychotherapy*, 59(3), pp. 303–306.

Rosoff, A. (2019). How We Do What We Do: The Therapist, EMDR, and Treatment of Complex Trauma. *Journal Of EMDR Practice And Research*, *13*(1), 61-74. https://doi.org/10.1891/1933-3196.13.1.61

Rouanzoin, C., & Perkins, B. (2001). A critical evaluation of current views regarding eye movement desensitization and reprocessing (EMDR): Clarifying points of confusion. *Journal Of Clinical Psychology*, *58*(1), 77-97. https://doi.org/10.1002/jclp.1130

Royle, L., & Kerr, C. (2010). *Integrating EMDR into your practice*. Springer.

Schwartz, A., & Maiberger, B. (2018). *EMDR Therapy and Somatic Psychology: Interventions to Enhance Embodiment in Trauma Treatment*. W. W. Norton & Company.

Schwartz, R. (2019). *Internal Family Systems Therapy, Second Edition*. Guilford Publications.

Seligman, M. (1995). The effectiveness of psychotherapy. *American Psychologist*, *50*, 965-974.

Shapiro, F. (1989). Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories. *Journal Of Traumatic Stress*, *2*(2), 199-223. https://doi.org/10.1002/jts.2490020207

Shapiro, F. (2001). *Eye Movement Desensitisation and Reprocessing (EMDR)*. The Guildford Press.

Shapiro, F. (2001). *Eye Movement Desensitization and Reprocessing - Basic Principles, Protocols, and Procedures.*. Guilford.

Shapiro, F. (2002). EMDR and the role of the clinician in psychotherapy evaluation: Towards a more comprehensive integration of science and practice. *Journal Of Clinical Psychology*, *58*(12), 1453-1463. https://doi.org/10.1002/jclp.10104

Shapiro, F. (2013). The Case: Treating Jared Through Eye Movement Desensitization and Reprocessing Therapy. *Journal Of Clinical Psychology*, *69*(5), 494-496. https://doi.org/10.1002/jclp.21986

Shapiro, F. (1999). Eye movement desensitization and reprocessing (EMDR). (1999), *13*(6), 621. https://doi.org/10.1016/s0887-6185(99)00031-6

Shapiro, R. and Brown, L.S., (2019). Eye movement desensitization and reprocessing therapy and related treatments for trauma: An innovative, integrative trauma treatment. *Practice Innovations*, *4*(3), p.139.

Shapiro, F., & Leeds, A. (2000). In *EMDR and resource instillation: Principles and procedures for enhancing current functioning and resolving traumatic experiences*. Zeig/Tucker.

Shapiro, F., Silver, S., & Rogers, S. (2002). *Light in the heart of darkness: EMDR and the treatment of war and terrorism survivors*. Norton, W. W. & Company.

Sharipo, F. (1995). *Eye movement desensitising and reprocessing: Basic principles, protocols and procedures*. Guilford Press.

Sharipo, F. (2002). EMDR twelve years after its introduction: Past and future research. *Journal Of Clinical Psychology*, *58*, 1-22.

Siegel, D. J. (2012). *The developing mind: How relationships and the brain interact to shape who we are* (2nd ed.). The Guilford Press.

Sikes, V., & Sikes, C. (2003). EMDR: Why the controversy?. *Traumatology*, *9*(3), 169-182. https://doi.org/10.1177/153476560300900304

Skinner, D. (2021). *A mixed methods case study examination of the role of the therapeutic alliance in EMDR within primary care* (D. Clin. Psy). The University of Nottingham.

Solomon, R., & Shapiro, F. (2008). EMDR and the Adaptive Information Processing ModelPotential Mechanisms of Change. *Journal Of EMDR Practice And Research*, *2*(4), 315-325. https://doi.org/10.1891/1933-3196.2.4.315

Steele, K., van der Hart, O., & Nijenhuis, E. (2005). Phase-Oriented Treatment of Structural Dissociation in Complex Traumatization: Overcoming Trauma-Related Phobias. *Journal Of Trauma & Dissociation*, *6*(3), 11-53.

Stern, D. (2004). *The present moment in psychotherapy and everyday life* (1st ed.). W.W. Norton.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Techniques and Procedures for Developing Grounded Theory* (1st ed.). Sage.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and Procedures for Developing Grounded Theory* (2nd ed.). Sage Publications.

Taylor, S., & Van Etten, M. (1998). Comparative efficacy of treatments for post-traumatic stress disorder: a meta-analysis. *Clinical Psychology & Psychotherapy*, *5*(3), 126-144.

Topham, G.L. and VanFleet, R. (2011) 'Filial Therapy: A Structured and Straightforward Approach to Including Young Children in Family Therapy', *Australian & New Zealand Journal of Family Therapy*, 32(2), pp. 144–158.

Treharne, G., & Riggs, D. (2014). Ensuring quality in qualitative research. In P. Rohleder & A. Lyons, *Qualitative research in clinical and health psychology*. Red Globe Press.

Twombly, J., & Schwartz, R. (2008). The integration of the internal family systems model and EMDR. In C. Forgash & M. Copeley, *Healing the heart of trauma and dissociation with EMDR and ego state therapy* (pp. 295-311). Springer Publishing Company. Retrieved 31 August 2021, from.

Urquhart, C. (2013). *Grounded theory for qualitative research*. SAGE.

van Balkom, A., Draijer, N., Veltman, D., Hoogendoorn, A., Thomaes, K., & Dorrepaal, E. (2014). Evidence-based treatment for adult women with child abuse-related Complex PTSD: a quantitative review. *European Journal Of Psychotraumatology*, *5*. https://doi.org/10.3402/ejpt.v5.23613

van der Kolk, B., Simpson, W., Korn, D., Hopper, E., Hopper, J., Blaustein, M., & Spinazzola, J. (2007). A Randomized Clinical Trial of Eye Movement Desensitization and Reprocessing (EMDR), Fluoxetine, and Pill Placebo in the Treatment of Posttraumatic Stress Disorder. *The Journal Of Clinical Psychiatry*, *68*(01), 37-46. https://doi.org/10.4088/jcp.v68n0105

van der Kolk, B., Spinazzola, J., Sunday, S., Pelcovitz, D., & Roth, S. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal Of Traumatic Stress*, *18*(5), 389-399. https://doi.org/10.1002/jts.20047

van Deurzen, E., Blackmore, C. and Tantam, D., 2006. Distance and intimacy in internet psychotherapy training. *International Journal of Psychotherapy*, *10*(2), pp.15-34.

Verardo, A., & Ciocccolanti, E. (2015). Intrafamilial child abuse: EMDR treatment and return to safety. *Childhood And Adolescence*, *14*(2), 174-193.

Verardo, A., & Zaccagnino, M. (2016). Working on attachment issues with EMDR therapy: The attachment protocol. In M. Luber, *Eye movement desensitisation and reprocessing EMDR therapy scripted protocols and summary sheets: Treating trauma and stressor-related conditions* (pp. 45-96). Springer Publishing Company.

Verardo, A., Zaccagnino, M., & Lauretti, G. (2014). Clinical applications in the context of attachment: The role of EMDR. *Childhood And Adolescence*, *13*(3), 172-184.

Wade, T., & Wade, D. (2001). Integrative Psychotherapy: Combining Ego-State Therapy, Clinical Hypnosis, and Eye Movement Desensitization and Reprocessing (EMDR) in a Psychosocial Developmental Context. *American Journal Of Clinical Hypnosis*, *43*(3-4), 233-245. https://doi.org/10.1080/00029157.2001.10404279

Walker, M., Kiely, B., & Darongkamas, J. (2016). A CAT envelope to deliver EMDR: Cognitive analytic therapy around eye movement Desensitization and Reprocessing. *Journal Of Psychotherapy Integration*. https://doi.org/10.1037/int0000034

Walter, R., Lyhus, K., Glass, C., Arnkoff, D., & DiGiorgio, K. (2004). EMDR and theoretical orientation: A qualitative study of how therapists integrate eye movement Desensitization and Reprocessing into their approach to psychotherapy. *Journal Of Psychotherapy Integration*, *14*(3), 227-252. https://doi.org/10.1037/1053-0479.14.3.227

Wesleyan University Press. (1985). *Writing on women: Essays in a renaissance*.

Williams, E., & Morrow, S. (2009). Achieving trustworthiness in qualitative research: A pan-paradigmatic perspective. *Psychotherapy Research*, *19*(4-5), 576-582. https://doi.org/10.1080/10503300802702113

Willig, C. (2013). *Introducing Qualitative Research in Psychology*. Open University Press [Imprint].

World Health Organization. (2019). *International statistical classification of diseases and related health problems* (11th ed.).

Young, R.A. and Collin, A., 2004. Introduction: Constructivism and social constructionism in the career field. *Journal of vocational behavior*, *64*(3), pp.373-388.

Young, W., Puk, G., Luber, M., Rouanzoin, C., Paulson, S., & Fine, C. (1995). In *EMDR dissociative disorders task force recommended guidelines: A general guide to EMDR's use in the dissociative disorders* (pp. 365-369). Guildford Press.

Appendix 1 – Participant Information Sheet

METANOIA INSTITUTE & MIDDLESEX UNIVERSITY

PARTICIPANT INFORMATION SHEET

You are being invited to take part in a research study. Before you decide to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If there is anything that is not clear or if you would like more information, please email Katherine.smith@metanoia.ac.uk.

Take time to decide whether or not you wish to take part.

Thank you for reading this.

Research Title

An Exploration of How Integrative Therapists Working with Clients Presenting with Complex Trauma Use EMDR as Part of Their Practice: A Grounded Theory Study

What is the purpose of the study?

This research aims to find out how therapists are integrating EMDR into their practice when working with clients presenting with complex trauma. The analysis of data obtained from the experiences of clinicians, will be used to form a theory behind integrating EMDR into therapeutic work with clients presenting with complex trauma. This research will take place between November 2018 and May 2019.

What will happen?

In this study, you will be asked to participate in a semi-structured conversational interview exploring the ways in which you work with clients presenting with complex trauma and how you integrate EMDR into your practice.

The interview will be recorded on a digital recording device and then transcribed. Both forms of data will be stored securely with a password on a Mac Book laptop and will not include

any names or references that will identify you or your clients. You will receive a copy of the transcript for approval.

Time commitment

Each interview will take between 45 minutes to 90 minutes. You may be invited to participate in a follow-up interview which will be shorter in duration. The interviews will be conducted face to face if possible or via skype, with subsequent conversations via skype or phone.

Participant's Rights

You may decide to stop being a part of the research study at any time without explanation. You have the right to ask that any data you have supplied to that point be withdrawn or destroyed.

You have the right to omit or refuse to answer or respond to any question that is asked of you.

You have the right to have your questions about the procedures answered. If you have any questions as a result of reading this information sheet, please ask the researcher before the study begins.

Confidentiality/Anonymity

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you which is used will have your name and address removed so that you cannot be identified. Furthermore, if talking about your clinical work, the utmost care will be taken to ensure that no case you have discussed is remotely identifiable.

All data will be stored, analysed and reported in compliance with GDPR.

What will happen to the results of the research study?

The results of this study will be analysed in depth and written up as part of a doctoral award in counselling psychology and psychotherapy. I will be aiming to publish my research findings in relevant publications.

Who has reviewed the study?

The Metanoia Research Ethics Committee were responsible for the reviewing of this study to ensure that it meets the ethical standards demanded of research of this nature. The research proposal and ethics approval has also been reviewed by the EMDR Association UK & Ireland prior to the call to participate being sent out.

For Further Information

If you have further questions, please contact Katie Smith (researcher) or Dr. Saira Razzaq (research supervisor):

Metanoia Institute,13 North Common Road, Ealing, W5 2QB

Katherine.smith@metanoia.ac.uk

saira.razzaq@metanoia.ac.uk

Thank you for considering participating in this study.

Katie Smith

Appendix 2 – Copy of 'Call for Participants' sent out by the EMDR Association

Call for research participants: *Are you an integrative therapist who uses EMDR as part of your practice and have you worked in this way with clients presenting with complex trauma?*

I am currently in the final year of a Clinical Doctorate in Counselling Psychology (DCPsych) at the Metanoia Institute/Middlesex University. I work in private practice as an integrative psychotherapist using EMDR as part of my practice and I have a clinical interest in working with complex trauma.

Francine Shaprio (1995) stated that one of the basic principles of EMDR is that its application should dovetail with other established areas of clinical practice. Every integrative practitioner has his or her own unique framework of integration. This research aims to explore commonalities that individual integrative practitioners with different integrative frameworks share when integrating EMDR into their practice while working with this presentation, with the aim of forming a theory behind this.

The title of my research is: 'An Exploration of How Integrative Therapists Working with Clients Presenting with Complex Trauma Use EMDR as Part of Their Practice: A Grounded Theory Study'.

I am looking for experienced Psychologists or Psychotherapists who work relationally and integrate EMDR into their practice when working with complex trauma, whose experience could make a valuable contribution to this research. Participation will take the form of an interview and careful consideration has been paid to maintaining the confidentiality of the clients/situations that would be discussed when speaking about your practice.

Dr Saira Razzaq is my supervisor for this reseach and I have received ethical approval from the Metanoia Research and Ethics Committee.

If taking part in this research is something you would consider, or you are wondering if you are eligible to take part, please do email me for further information and/or clarification. My email address is Katherine.smith@metanoia.ac.uk and I can be reached at 07590 198 232 if you would prefer to speak with me in person.

Warm regards,

Katie Smith

Appendix 3 – Consent Form

METANOIA INSTITUTE & MIDDLESEX UNIVERSITY

CONSENT FORM

An Exploration of How Integrative Therapists Working with Clients Presenting with Complex Trauma Use EMDR as Part of Their Practice: A Grounded Theory Study

1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions.

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

3. I understand that the interview will be recorded on digital a digital recorder and transcribed.

4. I understand that what I say will be confidential. Names will be coded and won't be used in any writing.

5. I agree to take part in the above study.

Name of participant Date

Signature

Name of researcher Date

Signature

Appendix 4 – Ethics Committee Approval

13 Gunnersbury Avenue
Ealing, London W5 3XD
Telephone: 020 8579 2505
Facsimile: 020 8832 3070
www.metanoia.ac.uk

Katie Smith
Doctorate in Counselling Psychology and Psychotherapy by Professional Studies (DCPsych)
Metanoia Institute

24th September 2018

Ref: 24/09-18

Dear Katie,

Re: An Exploration of How Integrative Therapists Working with Clients Presenting with Complex Trauma Use EMDR as Part of Their Practice: A Grounded Theory Study'.

I am pleased to let you know that the above project has been granted ethical approval by Metanoia Research Ethics Committee. If in the course of carrying out the project there are any new developments that may have ethical implications, please inform me as research ethics representative for the DCPsych programme.

Yours sincerely,

Dr Sofie Bager-Charleson
Director of Studies DCPsych
Faculty of Post-Qualification and Professional Doctorates

On behalf of Metanoia Research Ethics Committee

Appendix 5 – Example of Transcript to Illustrate Initial and Focussed Coding

Interview	Initial Coding	Focussed Code
So in phase 4 of the protocol, we're in there, and the point is, when we're working with a Jungian state, we're a bit like social workers. You cannot expect a five-year-old to be able to work out their own solutions, so you give enough space for the adult brain to be able to come organically, intuitively to bear on the childhood experience. Good EMDR does that. Simply that's just what happens in EMDR. It's how EMDR works. Because you've got a childhood ego state that is sort of running rampant, if you like, that is blocking access to the adult capacity, if it's not resolving itself organically, we get busy with, use all the standard interweaves, which you'll learn on part 3, when you do	Following Protocol Working with a child ego-state Interactions between child and adult parts Use of client's intuition Problematic child ego-state Use of standard interweaves	An integrated phased approach to trauma Making connections and building awareness of the client's different parts Working with intuition and attunement

EMDR, about educational interweaves and restarting block processing and all the standard stuff. But what we also do is, we say, "Well, before the end of the session, what does that child need?" If you've got a little child all on her own in a bedroom at five, feeling "It's all my fault Mommy and Daddy are arguing downstairs" or stuck at the top of the stairs and completely bereft and despairing because there's no safe adult around, before the session finishes, you want to ask, "What does that child need?" And people get it. And if they've got the team, see, you can say, "Well, she needs somebody to give her a hug, to read her a bedtime story. Who can do that?" And guess what? Mary Poppins can. Would you like to imagine that? It's really like working with a child, and you need to tap that. And then the brain just goes into overdrive	Understanding the needs of the child ego-state Working with an imaginary developmental experience Use of imaginal resource figures Working with child ego-state	Collaborative formulation/relationship Use of Creative Imagination imagery and metaphor

and actually rewires the dysfunctional circuits. You're actually changing the past as it's stored in the nervous system. It's very exciting. I even now work transgenerationally. I actually do EMDR on the interject, on the parental interject.	Nervous system adaptations Working with EMDR on an introject	

Appendix 6 – Illustration of Analytic Process

Focussed Codes	**Sub-Categories**	**Categories**
Collaborative formulation/relationship Therapist as a real and authentic person The dynamic nature of boundary making The welcoming and reciprocal nature of the therapist's invitation for the clients input and feedback The stance of 'alongsidedness' and self-compassion Importance of Psycho Education	An attuned and responsive therapist The collaborative understanding what we are doing and why The healing quality of the therapeutic relationship	Relational Stance

Understanding and targeting primary attachment experiences Finding and understanding the root cause of the client's dysfunction Understanding client's core belief systems Understanding how clients regulate themselves and affect soothing	The client's attachment history and the emergence of their core belief system Working with dysregulation and self-soothing Working with Developmental History	Working with Developmental History
Making connections and building awareness of the client's different parts Working towards the integration of parts Conceptualising trauma through parts work	Conceptualising and working with 'parts' Working with 'parts' towards healing and integration	'Parts' Work

An understanding of Neuro-biological theories and their clinical application Clear focus and structure around targeting ⇨ Assessing safety and stabilisation in readiness for EMDR Making implicit processes explicit where appropriate ⇨ Treatment plan for work around Past present and future An integrated phased approach to trauma	Treatment planning and therapeutic structure ⇨ Safety, stabilisation resourcing	Structure and Process

Working with intuition and attunement Processing emotional material and unconscious memories Trusting the phenomina of the Transpersonal and its use in EMDR Use of Creative Imagination imagery and metaphor Working with the embodied Working with the implicit and countertransference processes	Working with implicit processes, attunement, intuition and transference Working with the transpersonal, the unconscious and the symbolic A non-dualistic understanding of the mind and body Working with the creative imagination	Right-brain Processes

Appendix 7 – Examples of Memos used During Analysis Process

Memos from the Analysis Process

22/6/19

- Created f/c under ‘how’ – ‘Preparation work and resourcing’. Later added ‘as stabilisation’ to this.
- Changed f/c ‘imagery and metaphor’ by adding ‘imagination’
- Need to consider merging ‘intuition’ and ‘right brain’ in f/c
- ‘past, present and future’ – possible merging in some way with ‘affect regulation’ i.e. why clients present for therapy – distressed in the present and concerned about the future. Maybe link to ‘attachment experience’ too… Possible future category.
- Found it difficult to find f/c quickly in Nvivo, so labelled them differently by beginning with the most relevant word i.e. changing ‘working with clients’ parts’ to ‘Parts – Working with clients’ parts’.
- F/c ‘Right brain’ to possibly merge with felt sense/body work… possible future category?

11/7/19

- Merged several focussed codes relating to working with clients parts under new focussed node ‘Parts - Working developmentally with and making connections between client's parts e.g. adult-child and functional and dysfunctional’
- Focussed coding from interview three – with each piece of text, constantly re-evaluating the focussed codes they are placed under and adjusting the name or merging as I progress through the transcripts.
- Having merges the FC around parts, then created a new one specifically around working with child ego states – felt like too large an area to be included in ‘parts’.

- Needed another new parts related f/c – ‘Understanding and conceptualising developmental trauma through parts work’
- Changed ‘Use of Imagination imaginary and metaphor’ to ‘Use of Creative Imagination imagery and metaphor’ to emphasise the imagination as a ‘tool’
- Changed ‘Right Brain - Working with the right brain’ to ‘Right Brain - Working with the right brain and attunement’ as right brain to right brain attunement (Schore) feels very relevant

12/7/19

- Transpersonal theme becoming more emergent/explicit – Possible category around this
- New F/C around neurbiological understanding – poss link to psycho-education
- There seems to be s strong and seemingly paradoxical link between structure and science and intuition and the transpersonal – explore as move forwards
- Poss merge the f/cs ‘EMDR reaches the parts that other therpies cannot’ and ‘use of BLS’ as this is basically what makes EMDR different…?
- Have ‘got over’ feeling ‘frozen’ in terms of moving forward with deeper levels of coding… it is an evolving beast and will just keep changing, but can’t change unless it is able to progress
- Added ‘targeting’ to ‘Attachment - Understanding and targeting primary attachment experiences’ as participants talking about using EMDR on early attachment experiences rather than later traumas.
- Emerging theme around the importance of integrating EMDR – possible category? Maybe alongside attachment/developmental requirements??
- Chose not to code detailed background descriptions of case examples… firstly because of confidentiality for the clients of my participants and secondly because that background is not relevant to the research qu or to the ‘why’ qu… I started coding when the description of the case example went into description of the therapeutic work
- New f/c – ‘Collaborative formulation - Understanding what we're doing and why’ – possibly merge with ‘collaborative working?
- New f/c ‘Gestalt influences’ – poss combine with influences from other modalities, or ‘parts’ or both??

- Finding out how clients got to be that way… what happened? Maybe join add to attachment category with something around this… also part of collaborative working and joint formulation.
- Not coding participants personal anecdotes due to confidentiality and lack of relevance
- Core belief systems (new f/c) but probs in same category as Attachement
- Political point under 'why' – leaving out parts of text which talk specifically about members of the association

- There seems to be a strong and seemingly paradoxical link between structure and science and intuition and the transpersonal – explore as move forwards – I wrote this memo earlier today and it seems more and more pertinent… it feels like there should be a tension between the structure of the various protocols and the transpersonal/intuition/rightbrain to rightbrain communication, but they acutely seem to complement each other and somehow integrate. Leaving these F/Cs separate for now though as not exactly sure what this could look like

- Possible link between psycho education and the transpersonal, but has only arisen in interview 4, so may be specific to this participant

- The link between structure and intuition I have mentioned twice earlier keeps emerging… Going to create new F/C for this, then merge other F/Cs later on

- New F/C – 'self compassion' – Feel like I have coded or been around this before, but can't find so created this to come back to

- New child node under 'transpersonal'… 'looking for and strengthening the positive'

- Interview 5 – at beginning, realised that didn't match my recruitment criteria in terms of being 'integrative'. On the face of it, technical eclecticism. However, the data was still rich, but I had to interpret more as his training did not provide him with language around integration, but he was communicating

more about integration that he was perhaps aware of. Very mindful here of my own subjectivity, but also not taking the language at face value. During the interview I clarified my understanding of his answers, so when coding, this gave a degree of assurance that I was coding his intention if not exactly his words.

- However, not entirely sure how to code statements like: ‘I mean, I've done multiple run throughs on this incident of abuse with this long term client, where several men abused her at the same time and that's gone down to five. I don't think it's going to go any lower because something like that, at the age of 12 is... I don't think it is going to go to zero, maybe some text book somewhere says it will, but I don't think it will. I think it's as resolved as it could be, and we have to leave it there for the moment. It may be that there's other stuff that might influence that to go lower than zero even outside the therapy session. So the fact that she's got a boyfriend, and he loves her and he can be physically intimate with her and she can experience that, that might bring it low, but there's lots of other things that might do that. But I don't think that EMDR on that incident is going to bring it below five’. As a more developmental understanding would have moved this work forwards. But perhaps this can be excluded as it isn’t really relevant to the research qu… Actually Im going to code it under ‘why’… under pre-emdr training

- Didn’t code participant talking in detail about the development of other modalities he uses

- The client mentioned above who wasn’t truly integrative comcluded the interview by saying: ‘What I think I got out of this, I think I'll need to explore more, I think what I'm getting out of this is why this interview really was for my deficiencies in understanding the early attachment styles and psychodynamic therapy because I've had no training at all in psychodynamic therapy. I know it obviously, from my psychology degree and reading and stuff, I understand some ideas about psychodynamic therapy but I'm basically ignorant of it.’

13/7/19

- Coding Interview 6 – talked about countertransference… created new F/C
- Not actually sure this F/C is relevant… realised that I 'led' the participant to talk about CT, but misunderstanding something he had said in a previous answer

- Coding interview 7 – initially stated that she only uses standard protocol, so took a bit of 'digging' to uncover her framework. Poss because of association pressure?

- New F/C – 'challenges of integrating EMDR'

- Interview 8 – Added f/c – 'Longer work with Complex trauma' – This has appeared before, but has been coded differently as more applicable to a different code

- Overriding theme here of following the client rather than the technique and integrating accordingly

- Need to broaden the above theme in terms of ethics… perhaps an ethical philosophy/stance

- Merge category with "SP not suitable for all clients' but need to think about what to call it, so do this later

- Added 'attunement' to 'Therapist use of intuition and attunement'. Think it's already in a f/c somewhere, but couldn't find it

- New F/C 'Shaming client by squeezing them into SP'. This will go with following client etc in terms of category

- Maybe merge 'transpersonal' and 'collaborative working' as seeing both client and therapist as whole and equal

- Remember to look at CT f/c with intuition as connections here

- Really nice quote re following the client and working integratively… 'I'm sure you've heard this a lot. EMDR is as much art as it is science, like any therapy. If you take music, you could learn the chords but how you play is going to be very different.'

- Coding interview 9 – big emphasis here on working towards health and resourcing… poss category or part of category

- No new codes in interview 9 – just some thoughts about potential catagories as above.

- 61 F/C at the end of final interview

Appendix 8 – Example of Reflexive Memo

Memo following PAP:

One of my PAP panellists was extremely sceptical about the possibility of being about the possibility of EMDR being integrated… this experience made me consider how I would feel if my data revealed that EMDR was not 'integrated' by my participants and was indeed used as a 'add on'. It felt important to reflect on this at this stage and examine my own responses to this, particularly taking the importance of researcher's subjectivity into account. The place I arrived to integrally prior to data collection was a philosophical one. My panellist (who was also one of my most respected and admired teachers) had doubted what I had hoped was possible and although I knew a valid piece of research was still possible if the data showed the integration of EMDR was not possible, I began my data collection feeling a little despondent and with the sub-question of 'is it actually possible to integrate EMDR' firmly in my mind.