Perceptions and Use of EMDR Therapy in Rape Crisis Centers

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Sexual violence is pervasive and generates significant trauma symptoms that can last a lifetime for survivors. Rape crisis centers provide critically important services for survivors of child sexual abuse and adult sexual assault, including individual and group counseling. Eye movement desensitization and reprocessing (EMDR) has been found to be an effective treatment for a wide array of trauma symptoms in both children and adults. This study sought to determine the extent to which rape crisis centers use EMDR therapy, practitioners' perceptions of EMDR, and the provider characteristics that might support or hinder implementation of EMDR in this setting. A statewide web-based survey generated responses from 76 counselors working within 47 rape crisis centers. Results indicate that there is a low-use rate of EMDR (8%) in this setting, perceptions of EMDR were predominately marked by uncertainty, reflecting a lack of familiarity, but there is strong interest in receiving training. The desire for training is complicated by the range of education levels of counseling staff in rape crisis centers with only 54% holding advanced degrees. There is an opportunity and need to build capacity for the implementation of EMDR in this vital service sector, but there are also significant challenges that will need to be addressed.

Keywords: eye movement desensitization and reprocessing (EMDR) therapy; rape crisis centers; provider perceptions; implementation research

Within the United States, 1 of every 5 women (18.3%) has been raped within her lifetime, which includes nearly 22 million women (Black et al., 2011). The first completed rape typically occurred before age 25 years for most female victims (79.6%) and for 42% before age 18 years (Black et al., 2011). Systematic reviews of the health effects of childhood sexual abuse and rape reveal a broad range of behavioral, social, psychological, and physical health problems that greatly impact the everyday lives of victims (Bohn & Holz, 1996; Wilson, 2010). Survivors of sexual assault often feel a need to move to a new residence, may employ safety rituals for up to 2 years following the rape, and may have difficulty with normal daily activities and routines (Bohn & Holz, 1996). Social ramifications include difficulty trusting people, extreme limit setting, sexual impairment, difficulties in intimate partner relationships, and being more vulnerable to subsequent victimization (Bohn & Holz, 1996). In cases where the sexual

assault/abuse affects and compromises parenting behavior, symptom ramifications can have multigenerational effects (Bohn & Holz, 1996; Wilson, 2010).

Sexual violence also has significant mental health consequences for many survivors, with posttraumatic stress disorder (PTSD), depression, and substance abuse being the most frequently observed (Chen & Ullman, 2010; Kilpatrick, Resnick, Ruggiero, Conoscenti, & McCauley, 2007). In a systematic review of the research on the psychological effects of sexual assault, Campbell, Dworkin, and Cabral (2009) found that 33%–45% of women with a history of sexual assault had PTSD in their lifetime. The impact of PTSD can severely compromise one's quality of life. Many of those who suffer from it experience a chronic condition with symptoms that are so persistent and debilitating that it substantially interferes with marital and social relationships, vocational abilities, and often results in the need for extensive psychiatric and social services (Foa, Keane, Friedman, & Cohen, 2009).

Moreover, greater PTSD symptom severity occurs among women who have experienced multiple lifetime victimizations (Schaaf & McCanne, 1998).

Eye movement desensitization and reprocessing (EMDR) therapy is a psychotherapeutic intervention composed of an eight-phased, three-pronged approach wherein past traumatic experiences, current triggers, and future concerns/potential challenges are addressed (Shapiro, 2001). The therapist supports and works with the client during the identification of past traumatic experiences pertinent to current symptoms the client is experiencing. Past traumatic events are addressed during the first prong of the protocol. The second prong is focused on present-day activation of symptoms resulting from trauma memories as a result of present-day triggers. Focus is then shifted in the third prong to the integration of adaptive responses addressing potential future challenges.

EMDR has been shown to effectively treat a wide constellation of trauma symptoms in survivors of many different trauma types. The evidence base for EMDR comprises nearly 50 randomized controlled trials (RCTs) and several meta-analyses that illustrate its treatment effectiveness for PTSD and other trauma symptoms (Bisson et al., 2007; Bradley, Greene, Russ, Dutra, & Westen, 2005; Davidson & Parker, 2001; Seidler & Wagner, 2006; van Etten & Taylor, 1998). The participants in EMDR RCTs have often experienced a mixture of trauma types and frequently included childhood sexual abuse and adult sexual assault survivors in the samples (Edmond & Lawrence, 2015). In addition, several studies have tested the effectiveness of EMDR in samples composed entirely of female childhood sexual abuse or sexual assault survivors (Edmond, Rubin, & Wambach, 1999; Edmond & Rubin, 2004; Jaberghaderi, Greenwald, Rubin, Dolatabadim, & Zand, 2004; Rothbaum, 1997; Rothbaum, Astin, & Marsteller, 2005; Scheck, Schaeffer, & Gillete, 1998). Collectively, the existing empirical data on EMDR provide ample evidence of its effectiveness in treating PTSD, depression, and other trauma symptoms in child, adolescent, and adult sexual abuse/assault survivors.

Serving survivors of sexual violence is the focus of rape crisis centers (RCCs). RCCs are social service organizations that provide an array of services such as educational outreach, 24-hour crisis hotlines, advocacy, and psychotherapy for children and adults who have been sexually abused, sexually assaulted, or raped (Campbell & Martin, 2001). RCCs tend to serve highly vulnerable, low-income populations for whom few other resources are available, especially in rural communities. RCCs typically operate on extremely

limited funding leading to overuse and/or overworking of volunteers and staff (Maier, 2011). Both limited funding and geography (urban/suburban/rural) contribute to variation in organizational structure, agency focus, and services offered creating variability in the level of education and training of counseling staff as well as in the types of psychotherapeutic interventions used (Macy, Montijo, Fraga, Martin, & Giattina, 2011; Macy, Rizo, Johns, & Ermentrout, 2013; Maier, 2011).

The nature of the services provided by RCCs is unique relative to other community services in that client empowerment and feelings of safety are the principal goals with all services being client-centered, trauma-focused, and strengths-based (Illinois Coalition Against Sexual Assault, 2002; Ullman & Townsend, 2008). Survivors of sexual violence rate RCCs as more helpful and less retraumatizing than other mental health, legal, or health care services (Campbell & Martin, 2001; Macy et al., 2013; Wasco et al., 2004). However, little is known regarding the service sector itself and the particular intervention types and modalities employed. Scholars have described the sector as a “black box,” with well-articulated goals but little clarity regarding the intervention strategies agencies use to achieve them (Abel, 2000; Macy et al., 2013).

A review of the literature illustrates that (a) sexual violence is highly prevalent and induces significant trauma symptoms; (b) there is abundant evidence for EMDR’s effectiveness in treating sexual trauma; and (c) EMDR emphasizes the client’s role in his or her own healing with a minimum of clinician interference during trauma processing (Shapiro, 2001), which aligns well with RCC priorities of empowering survivors and using a strengths-based approach. Despite this apparent compatibility, the implementation of EMDR in RCCs heretofore has not been explored. The purpose of this article is to address the following three research questions: (1) To what extent is EMDR being used by counseling staff at RCCs? (b) What are counselors’ perceptions of EMDR as an intervention option for RCCs? (c) What counselor characteristics support or hinder the potential implementation of EMDR into RCCs?

Methods

Study Design

Although the services provided by RCCs are critically important, too little is known about the practice approaches employed, the extent to which they are evidence based, or how that might be influenced by organizational and provider characteristics. To deepen our understanding about these issues, a statewide, quantitative, cross-sectional, web-based survey of

RCCs in Texas was conducted in the summer of 2013. The survey consisted of two separate modules, one for RCC executive directors and one for direct practitioners who provide individual or group counseling. The executive director module collected information about demographics, leadership style, organizational characteristics, and funding. The direct practitioner module included questions related to respondent demographics, practitioner characteristics, services provided, clients served, interventions used, training acquired and desired, attitudes toward evidence-based practice in general, and perceptions of three specific evidence-based trauma treatments: EMDR, cognitive processing therapy (CPT), and prolonged exposure (PE).

One of the primary purposes of the study was the identification of the types of interventions that RCCs are using to assess the extent to which they appear to be employing evidence-based treatments. EMDR was one of several forms of therapy that was included in the survey. This article will focus on the data that is specifically about the practitioners' perceptions and use of EMDR.

Conceptual Model

The Consolidated Framework for Implementation Research (CFIR) was used to guide the construction of two survey modules—one for executive directors to capture primarily organizational level data and one for direct practitioners who provide individual or group counseling to capture data about services and provider characteristics. Damschroder and colleagues (2009) developed the CFIR, which is a consolidation of 19 conceptual frameworks; hence, they characterize it as “metatheoretical.” In the CFIR model, there are five domains that capture key implementation influences for advancing the adoption of evidence-based practices: intervention characteristics (evidence, complexity, adaptability, advantages), outer setting (external policies, incentives, pressure from peers or clients), inner setting (organizational structure, characteristics, culture, climate, and readiness), characteristics of individuals involved (knowledge, skills, attributes), and process of implementation. Each domain has a set of corresponding constructs that have been identified and defined. The expectation is for researchers to select the constructs most salient to a particular study to guide the assessment and evaluation of aspects of the implementation process rather than using all domains and constructs in one study.

Measures

For this article, data were drawn primarily from questions in the direct practitioner module that capture

counselor characteristics, practice approaches used, amount of training received in those approaches, degree of interest in obtaining training, and perceptions of specific evidence-based treatments. One variable, agency location was taken from the executive director survey. That was a simple categorical variable of rural, suburban, or urban. To examine practice approaches used, a list of methods was generated by the first author (TE) based on her experience in this field and expanded on by a group of community practitioners affiliated with Texas Association Against Sexual Assault (TAASA), our partner agency. This resulted in a list of 15 practice methods with an option to add other approaches. In addition to EMDR therapy, the list included CPT, PE, cognitive behavioral therapy, trauma-focused therapy, family therapy, psychodynamic therapy, feminist therapy, empowerment, substance abuse treatment, art/play therapy, and mind-body interventions such as somatic experiencing, sensorimotor psychotherapy, and mindfulness. The counselors were asked, “How often do you use any of the following?” The response options ranged from *never*, *seldom*, *sometimes*, *often*, to *most of the time*.

The same list of practice approaches was used to assess training. Given concerns for respondent burden and the wide variation in specific training requirements across this long list of practice approaches, the counselors were simply asked, “How much training have you received in any of the direct practice methods listed?” The response options ranged from *none*, *a little*, *a fair amount*, to *a great deal*. To assess interest in obtaining training in any of the practice methods listed, counselors were instructed to check all that apply.

Intervention characteristics have been identified in the CFIR (Damschroder et al., 2009) as a key factor in the adoption of evidence-based treatments. The intervention characteristics that have been identified as most salient include understanding the procedures and techniques involved, the strength and quality of evidence of effectiveness, relative advantages it offers, adaptability, complexity, acceptability, appropriateness, feasibility, and resources/constraints. To assess RCC counselor perceptions of EMDR therapy, 10 items were constructed to reflect these intervention characteristics. Respondents were asked to provide their level of agreement on a 1–5 scale ranging from *disagree strongly* to *agree strongly* for each of the 10 items tapping this CFIR domain (Table 1). Items were evaluated individually and as a total scale reflecting counselor overall perceptions of EMDR therapy. Scale scores were constructed by adding together individual item scores, with Items 4 and 10 reverse scored.

TABLE 1. Practitioner Perceptions of EMDR

Survey Items Assessing Practitioner Perceptions of EMDR	<i>n</i>	Strongly/Disagree (%)	Uncertain (%)	Strongly/Agree (%)
1. I have a good understanding of procedures and techniques.	60	55.0	18.3	26.7
2. There is a high-quality, strong base of evidence demonstrating the effectiveness of EMDR in treating PTSD in rape and sexual abuse survivors.	56	7.1	55.4	37.5
3. The quality and strength of the evidence base makes me want to use it with my clients.	55	8.3	60.0	31.7
4. The procedures and techniques involved in EMDR are too complex to use with clients at a sexual assault program.	55	25.5	61.8	12.7
5. EMDR could be adapted, modified, and tailored to meet the needs of our clients within our program.	56	7.1	58.9	33.9
6. EMDR has advantages over other treatments for PTSD that make it a better choice for sexual trauma survivors.	57	8.9	66.1	25.0
7. I believe the use of EMDR is an acceptable treatment option for treating sexual trauma survivors with PTSD.	57	7.0	47.4	45.6
8. Within our program, EMDR would be viewed as an appropriate treatment option for clients.	56	7.1	58.9	33.9
9. With training and supervision, I would be likely to use EMDR with my clients on an ongoing basis when appropriate.	54	7.4	53.7	38.9
10. It is not feasible to use EMDR in our program because of resource constraints and training requirements.	55	20.0	63.6	16.4

The summated scores were then divided by the total number of items in the scale to obtain a scale score that is directly comparable to individual item scores.

Once the survey instrument was constructed, it was pilot tested with a purposively selected group of five individuals with extensive experience and expertise in clinical and administrative RCC work. Based on the feedback received, the research team made modifications to the language of some questions to enhance clarity and to more accurately reflect the practice context. In addition, the feedback informed decisions to delete several items from the modules to reduce the length and potential respondent burden.

Procedures

In collaboration with the TAASA, the state coalition of RCCs, a comprehensive list of all RCCs in Texas was constructed ($N = 83$). An invitation to participate in this study was sent through postal mail and e-mail to executive directors of the 83 RCCs in Texas with an endorsement from TAASA. The request was for the executive director and each staff member

providing individual or group counseling to complete their respective modules of the web-based survey. The director was asked to send the web-survey link to all of the eligible counseling staff. As an incentive, each individual who participated received a \$20 gift card and each agency that submitted at least one director and one counselor survey was entered into a random drawing for \$500 that was given to the RCC. Data collection took place during the summer and fall of 2013. Prior to dissemination of the survey instrument, approval for study procedures was gained from the Washington University Institutional Review Board.

Statistical Analysis and Missing Data

Items were analyzed via descriptive statistics, and relationships between variables were tested with chi-square analyses and *t* tests. Some missing data occurred because of attrition over the course of the survey. Missing data were treated in an available-case analysis fashion such that, in the case of a missing response on an individual item, that response was

excluded from analysis. The actual number of responses for each item is listed in each table.

Sample

In the full study, at least one response was received from 60 RCCs resulting in an overall response rate of 72%. The sample used in this article comes solely from respondents to the counselor-focused survey. Cases in which respondents indicated that counseling tasks were not a part of their job description were excluded from analysis. The sample included 76 counselors representing 47 of 83 agencies; thus, 57% of Texas RCCs are represented in this sample.

Results

Demographic characteristics of responding practitioners ($N = 76$) are presented in Table 2. Practitioners were overwhelmingly female (94.7%), with an average of just less than 8 years of experience working in the field of violence against women. The majority (67%) identified as White, whereas 23% identified as Hispanic/Latino. More than 60% reported being currently licensed or pursuing licensure in their professional fields. Respondents were split in terms of educational attainment with approximately 24% having less than a bachelor's degree, 22% possessing a bachelor's degree, and 54% having an advanced degree. Nearly 60% of respondents worked in an agency located in an urban or suburban area.

EMDR Use, Training, and Interest in Training

As shown in Table 3, almost three-quarters (72.4%) of practitioners in RCCs have never used EMDR, and only 12.1% indicated that they use EMDR at least sometimes in their work with survivors of sexual violence. Across the 15 interventions assessed, EMDR therapy had the lowest endorsement among RCC practitioners. Approximately one in four (26.2%) reported having a little training, with only 8.2% having a fair amount or a great deal of training in EMDR therapy. However, more than half of the sample (56.0%) expressed interest in receiving training in EMDR. There were no statistically significant differences in use, $\chi^2(4) = 1.8$, $n = 58$, $p = .8$; training, $\chi^2(3) = .19$, $n = 61$, $p = .9$; or interest in training, $\chi^2(1) = 0.1$, $n = 59$, $p = .8$, by agency location (urban/suburban or rural). Likewise, there were no statistically significant associations between use, $\chi^2(8) = 3.8$, $n = 58$, $p = .9$; training, $\chi^2(6) = 5.6$, $n = 61$, $p = .5$; or interest, $\chi^2(2) = 2.2$, $n = 59$, $p = .3$, and practitioner educational level. Sixty percent of

TABLE 2. Demographic Characteristics of Responding Practitioners

Characteristics	<i>n</i>	<i>M/SD (Range)</i>
Current age	74	39.5 / 12.1 (23–65)
Years of experience	76	7.8 / 6.2 (0–28)
Agency tenure (years)	59	3.3 / 3.6 (0–18)
Frequency (%)		
Sex	75	
Female		71 (94.7)
Male		4 (5.3)
Race	75	
Hispanic/Latino		17 (22.7)
American Indian/AN		1 (1.3)
Native Hawaiian/PI		1 (1.3)
African American/Black		3 (4.0)
White		50 (66.7)
More than one race		3 (4.0)
Educational attainment	76	
No bachelor's degree		18 (23.7)
Bachelor's degree		17 (22.4)
Advanced degree		41 (54.0)
Licensure status	76	
None		29 (38.2)
Pursuing licensure		15 (19.7)
Certified/licensed		32 (42.1)
Agency location	76	
Urban/suburban		45 (59.2)
Rural		31 (40.8)

practitioners with advanced degrees and 60.0% of those with no degree reported interest in EMDR training, whereas only 33.3% with bachelor's degrees expressed interest. However, again, these differences were not statistically significant, $\chi^2(2) = 2.2$, $n = 59$, $p = .3$.

Perceptions of EMDR therapy Among Rape Crisis Center Practitioners

Ten items related to the intervention characteristics were used to examine practitioner perceptions of EMDR therapy (Table 1). More than half of the practitioners indicated that they did not have a good understanding of the procedures and techniques involved in EMDR therapy (55.0%), and another 18.3% were uncertain about their understanding. Similarly,

TABLE 3. Practitioner Self-Reported EMDR Use, Training, and Interest by Agency Location and Education Level

Location	Use EMDR in Practice (<i>n</i> = 58)			Have Received EMDR Training (<i>n</i> = 61)			Interest in Training (<i>n</i> = 59)	
	Never (%)	Seldom (%)	Sometimes/Often/ Most of Time (%)	None (%)	A Little (%)	Fair Amount/ Great Deal (%)	Yes (%)	No (%)
Urban agency	74.3	14.3	11.4	65.7	25.7	8.6	57.1	42.9
Rural agency	69.6	17.4	13.1	65.4	26.9	7.7	54.2	45.8
Urban and rural total sample								
%	72.4	15.5	12.1	65.6	26.2	8.2	55.9	44.1
Proportion	(42/58)	(9/58)	(7/58)	(40/61)	(16/61)	(5/61)	(33/59)	(26/59)
Clinician education level								
Less than bachelor's	62.5	25.0	12.5	81.3	12.5	6.3	60.0	40.0
Bachelor's	77.8	11.1	11.1	70.0	30.0	0.0	33.3	66.7
Advanced	75.8	12.1	12.1	57.1	31.4	11.4	60.0	40.0

55% reporting being uncertain about the evidence base for the effectiveness of EMDR with sexual trauma survivors, whereas 60% were uncertain if the evidence base made them want to use EMDR with their clients. Most respondents were uncertain about the feasibility, advantages, acceptability, or appropriateness of using EMDR in their practice. However, nearly 46% view EMDR therapy as an acceptable treatment option, approximately one-third view it as an appropriate option, and one-quarter believe it has advantages over other treatments. In addition, nearly 40% of the practitioners indicated that with training and supervision, they would be likely to use EMDR with their clients on an ongoing basis.

No significant differences were observed between urban and rural practitioners on responses to individual scale items (see Table 1); however, *t* test results show that practitioners at urban/suburban agencies had significantly higher overall scale scores than those at rural agencies (urban mean = 3.3, rural mean = 2.9, *t* = -2.2, *p* = .03). This indicates that RCCs located in urban/suburban areas have a stronger appraisal of the acceptability of EMDR therapy as a treatment option, a greater level of understanding of EMDR methods and procedures, and a higher view of the evidence base for EMDR effectiveness. A *t* test between practitioners with and without an advanced degree revealed no significant differences in perception of EMDR therapy as a treatment modality (advanced degree mean = 3.2, less than advanced degree mean = 2.9; *t* = -1.8, *p* = .07).

Discussion

Although RCCs are serving children, adolescent, and adult survivors of sexual trauma, which EMDR is effective at treating, it is rarely used in this service setting. Nearly three-fourths of the practitioners who participated in the study report never having used EMDR therapy, and only 12.1% indicated doing so with any regularity. Those who did report using EMDR therapy with any frequency are found across all educational levels ranging from no degree to bachelor's, master's, or doctoral degrees. An even smaller percentage (8.2%) of the sample reported receiving a fair or great amount of training in EMDR. Even though information about the nature and length of training was not captured, it is possible that some of the respondents with advanced degrees who endorsed "a fair amount" or "a great deal" of training may have acquired it through EMDR International Association (EMDRIA) or the EMDR Institute. Given that EMDRIA requires 50 hours of training including 20 hours of lecture, 20 hours of supervision, and 10 consultation hours, this cannot be the case for the 26.2% of the sample that reported receiving "a little" training. In all likelihood, those who indicated having "a little" EMDR training learned about it from a colleague, read a book about it, and/or attended an informational workshop or webinar.

The findings suggest that it is likely that many of those who are using EMDR therapy in RCCs are doing so without the basic amount of training recommended

by EMDRIA. This raises serious concerns about the degree to which EMDR therapy is being implemented with treatment fidelity. Several studies have illustrated that fidelity to a treatment model has been shown to improve therapeutic outcomes (Henggeler, Melton, Brondino, Scherer, & Hanley, 1997; Henggeler, Pickrel, & Brondino, 1999; Maxfield & Hyer, 2002; Schoenwald, Henggeler, Brondino, & Rowland, 2000). In a recent EMDR study, Farrell and Keenan (2013) found a significant difference between certified and noncertified EMDR-trained clinicians in the number of clients who reached full resolution. Consequently, it is important that efforts be made to ensure that RCC counselors using EMDR therapy receive sufficient training, supervision, and consultation to implement it with fidelity to maximize the likelihood of treatment effectiveness with sexual trauma survivors.

It is encouraging to note that when asked about interests in training across a wide range of modalities, nearly 56% proactively selected EMDR. A clear majority of counselors at RCCs want to be trained in EMDR, particularly those in urban areas and those holding advanced degrees. Surprisingly, those without degrees are as enthusiastic in their interest in EMDR therapy training as those with master's and PhDs, whereas those with a bachelor's degree express the least interest. Clearly, there is a need for and interest in getting counselors in this service sector appropriately trained. However, EMDRIA-approved training in EMDR therapy is only available to licensed mental health professionals with advanced degrees or graduate students in mental health disciplines. This means that nearly half of the practitioners at RCCs who are providing counseling services are not eligible to receive training in EMDR therapy. Moreover, those counselors who are ineligible to receive the training because of lack of education and credentials are as likely to be using it in their current practice as those with advanced degrees.

This raises a challenging question about whether it is ever reasonable, appropriate, or feasible to train counselors with a bachelor's degree or less in EMDR therapy. In considering this question, it is important to note that the counselors in this sample have nearly 8 years of experience working with survivors of sexual trauma. Familiarity with trauma and an ability to tolerate client distress are strengths that have been found to be important in practitioner confidence and continued use of EMDR therapy (Grimmett & Galvin, 2015). One can be eligible to receive EMDR training without any experience working with trauma as long as they hold an advanced degree in a counseling profession, even though a lack of experience and comfort with trauma has been associated with discontinued use of

EMDR (Greenwald, 2006). The salience of this question is particularly important for rural programs where the local RCC may be the only source of counseling available for sexual trauma survivors and only 36% of practitioners have an advanced degree. Even in urban areas where there is a greater likelihood of making referrals to EMDR-trained therapists in the community, there are often resource constraints that limit access for survivors. The vast majority of RCCs provide counseling services for free, whereas the sliding scale rate of a private practitioner may still be out of reach for low-income survivors. Therefore, a model that relies on referrals to community EMDR therapists is going to be insufficient to meet the needs of the RCC clients.

Recommendations

Most counselors in this service sector are unfamiliar with EMDR. The most frequent response to questions related to their perceptions of EMDR was "uncertain." This suggests the respondents did not have a sufficient amount of familiarity with EMDR to have an opinion about the appropriateness, acceptability, or feasibility of using EMDR therapy in their agency. They lack a basic understanding of the approach, the phases, and protocols. They are unaware of the substantial volume of evidence available that demonstrates the effectiveness of EMDR in treating sexual trauma in adults and children. At a minimum, therapists trained in EMDR for the treatment of trauma could volunteer to conduct in-service sessions at individual RCCs, or introductory workshops on EMDR at the regional or state level meetings that RCCs hold annually. This type of dissemination would at least allow the counselors the opportunity to determine whether or not they want to invest the time and money needed to become formally trained in EMDR. A study conducted by Allen, Gharagozloo, and Johnson (2011) found that perceived empirical support for an intervention predicted likelihood of receiving training in that intervention which was associated with likelihood to use the intervention (Allen et al., 2011). Therefore, increasing knowledge of the empirical evidence of the effectiveness of EMDR therapy among counselors at RCCs could increase the likelihood of them getting trained and using it in this service sector with fidelity.

The Humanitarian Assistance Program (HAP) provides reduced cost trainings to nonprofits, but given how unfamiliar RCC practitioners are with EMDR, they are unlikely to be aware of HAP. Consequently, HAP is encouraged to engage in targeted outreach efforts to individual RCCs and state coalitions to offer free or reduced cost training. Because most

counselors at RCCs earn modest salaries, scholarships could be made available to cover the cost of registration, training, and travel. This is particularly important considering findings from Farrell and Keenan (2013) that showed that funding constraints were a common reason for not finishing EMDR training. Individual EMDR therapists could partner with their local RCC to provide therapy, supervision, and/or consultation on a pro bono basis. This could increase self-confidence and mastery of EMDR, which has been shown to increase the likelihood of sustained use of a new treatment approach (Cook, Schnurr, Biyanova, & Coyne, 2009). A train-the-trainer model could be implemented so that some clinical supervisors at RCCs could become certified to serve as consultants for newly EMDR-trained RCC counselors to build capacity and sustainability of the use of EMDR in this service sector.

These strategies are most relevant for the practitioners with advanced degrees, which is only about half of those who are providing counseling services in RCCs. In this sample, 42% of the practitioners working in rural RCCs have no college degree but are providing individual and/or group counseling services. They are typically serving highly vulnerable, low-income survivors in multiple counties where there are often no other existing counseling services. Ethically, it is imperative that we also consider how to put evidence-based trauma treatments into the hands of practitioners with bachelor's degrees as well as those without degrees when it is evident that they are the best resources available for survivors.

Bass and her colleagues (2013) tested the assumption about the necessity of advanced degrees and credentials with the implementation of CPT, another evidence-based trauma treatment, with "psychosocial assistants" in the Democratic Republic of Congo. The psychosocial assistants had between 1 and 9 years of experience with case management and supportive counseling with survivors of sexual trauma and the equivalent of a high school education. After 2 weeks of training, the psychosocial assistants used the cognitive-only (no trauma narrative) CPT group protocol and achieved significant reductions in symptoms of PTSD, depression, and anxiety. Bass and her colleagues devised a way to bring an evidence-based treatment into a low-resource context with a highly traumatized population. If this could be achieved in the Congo, it seems reasonable to think it could be done in low-resource RCCs in the United States. If this could be done with CPT, which involves relatively complex treatment elements, could it be done with EMDR?

Rolf Carriere, the former UNICEF Director in Asia, seems to think not only that it can be done but also

that it is an essential element of a much needed global trauma plan. He states that "EMDR lends itself well to be incorporated not only into community based psychological first aid . . . done by volunteers . . . but also potentially into a higher level response for mild to moderate disorders undertaken by a specifically trained paraprofessional cadre to whom well-defined roles could be assigned" (Carriere, 2014, p. 191). He suggests that EMDR therapy could be modified and simplified so that aspects of the model could be implemented by community workers and paraprofessionals as a way to address trauma treatment needs in resource constrained environments. He is specifically concerned with international contexts in developing countries, but given the limitations of the mental health system in the United States and the resource limitations of RCCs, a case can be made for such applications in this service sector as well.

It is notable that Dr. Francine Shapiro, the developer of EMDR therapy, has recognized the need for an EMDR protocol that can be implemented by paraprofessionals. At her initiative, Jarero, Amaya, Givaudan, and Miranda (2013) conducted a randomized clinical trial to test the effectiveness of EMDR protocol for paraprofessional (EMDR-PROPARG) use in acute trauma situations, a modified form of EMDR developed for use by paraprofessionals as an early intervention to treat acute traumatic stress. EMDR-PROPARG was adapted from the EMDR Protocol for Recent Critical Incidents (EMDR-PRECI). The results demonstrated that the PROPARG intervention was significantly more effective than supportive counseling in reducing posttraumatic stress. However, it is important to acknowledge that although the intervention protocol was developed for use by paraprofessionals, in this study, the protocol was implemented by experienced EMDR therapists. There is also a group protocol that has been implemented with paraprofessionals called the *EMDR Integrative Group Treatment Protocol*. Given that RCC practitioners are often the first responders immediately after a sexual assault and many of them are paraprofessionals, it would seem that EMDR-PROPARG and the EMDR Integrative Group Treatment Protocol could be useful interventions for this service sector.

Limitations

Despite the important practice implications of this study, there are several limitations that must be acknowledged. Although the overall study response rate was 72%, only 57% of RCCs ($n = 47$) had counselors ($n = 76$) that responded to the survey. This resulted in a smaller sample size than was desired. As previously mentioned, no data were captured about

the length of EMDR training acquired or who provided the training making it impossible to determine the number of counselors using EMDR that have received the EMDRIA-recommended and EMDRIA-approved level of training. This study includes data from one state, and RCCs in other states might look different in their staff attributes, practices, and perceptions of EMDR. However, a national survey of domestic violence and sexual assault services providers ($N = 1,234$) conducted in 2003 found a similar but slightly higher rate of EMDR use (12%; Edmond, 2004).

Implications for Future Research

The findings in this study raise several interesting research questions that need to be empirically examined. What implementation strategies would be needed in this low-resource service sector to facilitate successful uptake of EMDR therapy? What level of training, supervision, and consultation would be needed to increase their levels of use of EMDR therapy? What strategies would be needed to build sufficient capacity to ensure sustainability of the use of EMDR therapy in this service sector? Would RCC practitioners generate comparable outcomes in this real-world setting as have been found in other EMDR studies? Would EMDR-PROPARA and EMDR Integrative Group Treatment Protocols be appropriate, acceptable, and feasible to implement in RCCs? If implemented in RCCs, would they generate comparable outcomes found in other settings? Are there other ways that EMDR therapy could be modified for use by practitioners in RCCs with a bachelor's degree or less that would be effective in treating survivors with PTSD or other complex trauma symptoms? These questions must be examined if we are to find ways to more effectively bring evidence-based treatments to sexual trauma survivors being served by RCCs.

Conclusion

RCCs are serving a vital role in communities across the country by providing free counseling to often highly traumatized, low-income sexual trauma survivors who have limited access to alternative sources of trauma-informed treatment. These practitioners are deeply committed to the clients they serve and eager for training in effective trauma treatments. They, like their clients, have limited resources, which limits their access to affordable training and consultation. By partnering with this critically important service sector, EMDRIA, HAP and the vast community of EMDR consultants and therapists across the country could contribute to the development of more effective services and the more rapid alleviation of prolonged suffering.

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