# ARTICLES

# Clinician Experiences With EMDR: Factors Influencing Continued Use

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This study investigated factors contributing to clinicians' use or discontinued use of eye movement desensitization and reprocessing (EMDR) as well as obtaining information pertaining to training experiences. Patterns emerged from a survey completed by 239 respondents highlighting some issues associated with discontinued use, specifically loyalty to other treatment modalities and discomfort with using EMDR. Factors investigated were not statistically significant; however, frequency analysis of the survey identified patterns in use and experience. Clinicians who continued to use EMDR reported that they did so because of both its effectiveness and the ongoing consultation they received. Practice setting surfaced as a statistically significant factor, with operating in private practice associated with greater participation in EMDR support activities. A discussion of the adequacy of the training format is presented as well as how prepared the participants felt after completion of EMDR training. Some findings were consistent with earlier studies, and the converging results of loyalty to previous modalities and discomfort using EMDR give rise to recommendations for future training and support of newly trained clinicians.

**Keywords:** eye movement desensitization and reprocessing (EMDR); use; discontinuation; therapist training; survey; clinical practice

Eye movement desensitization and reprocessing (EMDR) is an empirically validated treatment that has been in existence, albeit in an evolving fashion, since 1989 (Shapiro, 2001). In its guidelines for stress-related conditions, the World Health Organization (2013) recommended two psychotherapies, trauma-focused cognitive behavioral therapies and EMDR. EMDR's efficacy as a treatment for posttraumatic stress disorder (PTSD) is also widely acknowledged (Bisson & Andrew, 2007).

EMDR was initially developed to specifically address the needs of traumatized patients, but its use has grown in recent years because of advocates of the model (Luber, 2009). Over 100,000 clinicians worldwide have participated in EMDR training in the past 20 years, but, as with other therapies, not all EMDR-trained clinicians continued to practice the newly acquired technique (Cook, Schnurr, Biyanova, & Coyne, 2009; Farrell & Keenan, 2013; Lipke, 1995). Farrell and Keenan (2013) investigated the extent to which current EMDR trainings resulted in the therapy being integrated into clinical practice. They noted that a large proportion of clinicians seeking EMDR training identified as practicing from a cognitive behavioral orientation. They also noted that this group was the least likely to seek accreditation in EMDR in the United Kingdom. Their participants expressed that the primary factors involved in their discontinued use of the therapy were lack of opportunities for funding, lack of EMDR clinical supervision, and lack of confidence in using EMDR, respectively.

The decision to use a given modality appears to involve many factors. Research demonstrates that both the therapist and the client bring preconceptions to the therapy consulting room that can influence choices in treatment methods (Becker, Darius, & Schaumberg, 2007; Tarrier, Liversidge, & Gregg, 2006). In this current investigation, the preconceptions that the therapist brings are of interest, in addition to other factors highlighted in the following


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text. As such, the literature to date can be organized along the lines of five distinct and interrelated themes: (a) therapists' pretraining factors, (b) the training itself, (c) clients' experiences before and during EMDR treatment, (d) posttraining skill development, and (e) socioenvironmental contributors to therapist use or discontinued use of the therapy.

## Therapist Pretraining Factors

Therapist pretraining factors pertain to preconceptions about EMDR, therapeutic abilities in the area of trauma treatment, and original theoretical orientation, to name a few. Lipke (1995) wondered if there might be a relationship between work in private practice and clinicians' "willingness to investigate innovative treatment" (p. 378). He created a measure to survey the first 1,200 clinicians trained in EMDR and their experience of using it with some 10,000 clients. The majority of his participants were psychologists in private practice. Most clinicians had experience treating at least 10 patients with EMDR at the time of completing the survey. Of 342 responses, 239 (69%) reported comfort in using EMDR at a level comparable to comfort using other treatment modalities. A reduction of suicidal ideation or activity, fewer cancellations, and less violence were all perceived as benefits by the respondents. Additionally, 86% of clinicians reported their clients experienced the emergence of repressed material more often than with alternate therapies.

Lipke (1995) also sought answers regarding possible problems using EMDR. Of interest, when asked about "extreme agitation or panic," 31% of clinicians reported their clients experienced this more often than with other therapeutic modalities, 31% stated as often, and 34% reported less often. The question of clinicians' perceptions of EMDR within the therapy session and how uncomfortable they are with witnessing an increase in negative affect within the context of the therapy session arose in the wake of this finding.

The results of Lipke's survey (1995) suggested psychologist respondents overwhelmingly supported PTSD symptom alleviation with EMDR. Results were positive when comparing EMDR to exposure treatments. EMDR was rated as being more effective than exposure therapy by 57% of the respondents. EMDR was also rated as being less stressful to the client (59%) and less stressful to the therapist (47%).

Finally, Lipke (1995) asked clinicians to discuss their decreasing use of EMDR through an open-ended format. The primary reason provided for decreased use was a change in client load or work situation. Other reasons offered were "preference of other procedures owing to their success or EMDR failure, need for more training to feel comfortable using EMDR, client rejection of the procedure, and lack of supervision" (p. 384).

## Loyalty to Other Treatment Methods

Cook, Schnurr, et al. (2009) reported that despite interest in new techniques, practitioners tend to remain loyal to the approach they learned early in their training. Based on this finding, it may be inferred that even though a clinician engages in training of a new method, he or she may resume practicing the approach with which he or she was familiar. Although it is not clear how many new EMDR clinicians avoid or stop using the method or why, the presented literature suggests some do (Cook, Schnurr, et al, 2009).

The likelihood of adopting a new approach is increased if it is suggested by a personal acquaintance and if it is clear how to integrate and synthesize new techniques with existing modalities in the clinician's repertoire (Cook, Schnurr, et al., 2009). EMDR is described as an "integrative, comprehensive treatment approach that contains many elements of effective psychodynamic, cognitive-behavioral, experiential, interpersonal, and physiological therapies" (Schubert & Lee, 2009, p. 120); thus, it may be assumed to be easily integrated into existing practice.

Cook, Schnurr, et al. (2009) found clinicians to be less concerned about empirical validation of a therapeutic modality when making treatment decisions despite the efforts of others to validate EMDR in the research community. Although the research community is invested in evidence-based therapies, this interest does not translate with ease to the clinical practitioners to whom the community wishes to disseminate. Social factors played a much more significant role than evidence-based therapies in training decisions. Clinicians were found to pay heed to supervisors and colleagues whom they respected more than research evidence supporting various modalities. Remarkably, the study yielded a difference between new and seasoned clinicians in terms of adoption of new techniques. New therapists were more likely to adopt an approach if they read or learned about it in graduate school at the beginning of their career. Seasoned clinicians were responsive to respected clinicians when considering a new approach (Cook, Schnurr, et al., 2009). The authors also suggested retention of the new technique may be achieved by focusing on confidence building and mastery of the new therapy. This applied to new and seasoned clinicians, alike.

Becker et al. (2007) and Tarrier et al. (2006) described investigator biases against EMDR, which potentially influenced the outcomes of their studies. Such bias in

the literature could be influential when dealing with decisions to pursue EMDR training and whether or not clinicians continue to use it. Of interest is whether clinicians undergoing EMDR training approach the training with the same bias and if the bias is overcome through training and subsequent use of the treatment.

## Lack of Comfort With Trauma

Greenwald (2006) reported many experiences of EMDR-trained clinicians not using EMDR. His article presented issues pertaining to retention of learned concepts. Greenwald highlighted many training issues that he attributed to both discontinuation and dilution of EMDR treatment. He expressed concerns about clinicians not necessarily being familiar with trauma concepts prior to training. It may, therefore, be premature to teach a trauma treatment without an adequate foundation of knowledge. This perceived lack of knowledge or proficiency may affect the clinician's confidence in using EMDR. Greenwald conjectured that clinicians' fear of using EMDR following initial training would contribute to discontinued use. Lack of experience with trauma treatment may also cause therapists to experience discomfort with the intensity of their clients' emotions during recall and treatment. Tarrier et al. (2006) and Becker et al. (2007) suggested that therapists may avoid exposing their clients to perceived discomfort, regardless of empirical support. Interestingly, clients in these studies were more willing to consider potential discomfort because of perceived benefit. Both Tarrier et al. (2006) and Becker et al. (2007) discussed the discrepancy between patient preference and therapist preference with other treatment modalities. Exposure therapies appear to be resisted despite heavy support in the literature (Becker et al., 2007).

Foa, Riggs, Massie, and Yarczower (1995) discussed the importance of fear activation during the treatment process and how this promotes successful outcome in exposure therapy. Given the inherent distress that traumatized patients bring to the therapy arena, outlined by the findings of Tarrier et al. (2006) and Becker et al. (2007) regarding therapist avoidance of discomfort, clinician anxiety within the context of EMDR treatment may be an important topic to include in the training process.

## The Training Itself

Greenwald (2006) elaborated on issues pertaining to the training delivery format and warned that trainees who did not use EMDR soon enough after training developed bad habits. This has implications for treatment fidelity because a lack of memory of the protocol is likely to result in modifications, whether intentional or not. Lipke (1995) discussed the discomfort shared by his respondents that necessary skills were lacking and that further consultation was required to increase their confidence in using EMDR. Farrell and Keenan (2013) discussed their primary finding that clinicians in their study were no longer using EMDR because of feeling that the training they undertook did not instill the confidence required to engage in its continued use.

## Clients' Experiences Before and During EMDR Treatment

Becker et al. (2007) found that clients lacked awareness of and familiarity with EMDR. This would suggest the need for the therapist to initiate a discussion of EMDR as a treatment option rather than the client requesting it. With such large numbers of clinicians being trained each year, it is unclear why consumers lack awareness of EMDR (Tarrier et al, 2006).

Many of the studies previously mentioned have discussed the discomfort that can arise on behalf of both the therapist and client during an EMDR session, with Lipke (1995) reporting 31% of clinicians in his study reporting their clients to be more agitated or panicked than those who engage in other therapies. There is a lack of research outlining specific patterns of overall client experiences, but a general theme of fear and discomfort is evident within the findings of Lipke (1995) and Greenwald (2006) and is indicative of this phenomenon in EMDR treatment.

## Posttraining Skill Development

The EMDR International Association (EMDRIA) instituted a posttraining consultation requirement for EMDR basic training in 2008. Prior to that time, many informal study groups were in operation, and there was an apparent need for ongoing support and consultation. Again, Lipke (1995) and Greenwald (2006) discussed the perception of an insufficient training structure because of the large amount of information presented in the weekend training format. Ten hours of consultation are now factored into the training structure, with ongoing consultation and peer support encouraged after that. It remains to be seen how this impacts EMDR retention.

## Socioenvironmental Factors

With many clinicians being trained in EMDR each year, the appeal of EMDR is not disputed. However, from the information distributed by Cook, Biyanova, and Coyne (2009) and Cook, Schnurr, et al., 2009, the vulnerability of the newly trained EMDR therapist is

evident. There are clearly additional influencing factors that render both newly trained and seasoned clinicians vulnerable (Cook, Schnurr, et al., 2009). As described, collegial support, having a resident "champion," and funding for continuing education all affect the likelihood of pursuit or adoption of new techniques.

As can be observed from the earlier information, the literature offers much in the way of therapist pretraining factors, with less data available on the other factors influencing clinician use or discontinuation of EMDR. This study aimed to explore the extraneous factors that remain elusive but are very impactful to the development and continued use of EMDR.

Although EMDR has been shown to be a robust therapeutic treatment (Maxfield & Hyer, 2002), there is likely a level of reduction in its use by practitioners consistent with the research on adoption of other therapeutic modalities (Cook, Schnurr, et al., 2009). EMDR requires a high level of commitment from the clinician because of the extensive training program, and the therapy would be expected to retain therapist adherents well as a result. EMDR is not perceived to be taken on a whim because the requirements for basic training add up to approximately 50 hours of invested time with a significant financial commitment. The reasons for discontinuation are largely unclear. Studies exploring clinician experiences are either dated or focus on a specific clinical setting (Cook, Biyanova, et al. 2009; cf., Farrell & Keenan, 2013; Lipke, 1995).

This investigation aimed to quantify clinician experiences with EMDR and explore the reasons that clinicians choose either to commit to EMDR or return to their previous modality of choice. This will serve as a foundation to expand or refine current training practices or offer validity to existing practices that contribute to retention. Although some clinicians may use EMDR as an adjunct therapy, the focus of this study was to distinguish between those who continued using it as opposed to those who did not adopt the treatment in their practice.

The impetus for conducting this investigation was an original study carried out by Cook, Biyanova, et al. (2009). Clinicians from two U.S. Department of Veterans Affairs treatment sites were interviewed to investigate adoption or rejection of EMDR. In total, 29 clinicians were surveyed. One site had a resident champion of EMDR, thus encouraging its use as a treatment option. At the second site, there was a general lack of support, starting at the management level, with subsequent discontinuation, or avoidance of, EMDR practice. The National Institute of Mental Health (1998) reviewed the difficulties in getting practitioners to use evidence-based psychotherapies, but there is a distinct lack of understanding of the phenomenon (Cook, Biyanova, et al., 2009). The findings presented by Cook, Biyanova, et al. (2009) motivated a quest for a deeper understanding of the unique experiences of clinicians trained in EMDR.

The assertions posited by Lipke (1995) were based on a survey conducted almost 25 years ago with existing EMDR practitioners. Cook, Biyanova, et al. (2009) included a small sample derived from a limited clinical setting. The intention of this study was to dig below the surface by quantitatively and qualitatively investigating the reasons for the occurrence of EMDR clinicians discontinuing their use of such a robust treatment method in a large and varied sample.

The purpose of this study was to determine if a clear pattern would emerge to illuminate the reasons for EMDR-trained clinicians continuing to use the therapy or not. As such, several questions regarding use surfaced and were used as a means to guide the objectives of the survey instrument and subsequent interpretation of data. For each factor, scores on various items were compared for use or discontinuation of EMDR:

1. Pretraining factors:
   a. Differences in use when examining the respondents' original theoretical orientation
2. Training factors:
   a. Comparing level of training (e.g., basic training vs. certified EMDR therapist)
   b. Comparing those trained by the EMDR Institute and those trained by other EMDRIA-approved trainers
   c. Comparing those who felt adequately trained versus those who did not feel adequately trained in EMDR and their subsequent levels of use
3. Clients' experiences factors:
   a. Clients' previous experiences with EMDR
   b. Negative in-session experiences with EMDR and whether this affected continued use
4. Posttraining skill development factors:
   a. Continuation levels when comparing how much each respondent endorsed personalizing/altering the EMDR protocol
   b. Participation in EMDR support activities (consultation, conferences, etc.)
5. Socioenvironmental factors:
   a. The difference between respondents from private practice settings and agency outpatient settings with respect to participation in EMDR support activities

Additional analyses were conducted to examine the relationships between various factors—for example, if

employment setting influenced participation in post-training consultation.

## Method

### Procedure

A SurveyMonkey request was sent via electronic mail (e-mail) to 250 randomly selected clinicians from the geographical states with the highest number of EMDR-trained clinicians; these were New York, California, Massachusetts, Colorado, and Washington. To ensure that an adequate number of participants were selected, estimates based on population size were taken from SurveyMonkey. A sample size of 8% was chosen to allow for plus or minus 5% error margin. This equated to a sample of 400 participants from a population of approximately 5,000 EMDR-trained clinicians across the selected states. There were no limitations or restrictions related to demographic features that would exclude a clinician from the study.

Snowball sampling was used to help recruit a sufficient number of clinicians who no longer use EMDR despite completing the training process. The clinician completing the survey was requested to forward the e-mail to any clinician he or she was aware of who was trained in EMDR but was no longer using it. It was anticipated that more clinicians still using EMDR would complete the initial round of surveys and that clinicians no longer using EMDR would be more difficult to trace; therefore, snowball sampling would allow for a more accurate view of who was not using EMDR and why. A follow-up e-mail was sent 1 week after the initial e-mail solicitation to increase exposure to the survey and encourage clinicians to respond. A final request was sent via e-mail 3 weeks after the initial solicitation.

Because of a low response rate, additional methods of contact were initiated. The same e-mail was posted on the EMDR Institute's LISTSERV with the permission of the list moderator. Regional coordinators for the five states initially targeted also received the e-mail and were requested to forward it to their members. Finally, the author approached trainees at an advanced EMDR training and obtained e-mail address for those in attendance. Again, they received the same e-mail solicitation and were similarly requested to complete the survey and forward it to their colleagues.

### Participants

Any clinician trained in EMDR was eligible to participate in the online survey. Therefore, participants had all met the EMDR Institute's requirement of having completed postgraduate education or being currently enrolled in pursuit of at least a licensable master's degree. Recruitment included contacting clinicians listed on the EMDR Institute's website (EMDR Institute, 2011) as any therapist who had completed Part 1 or Part 2 training through the EMDR Institute is maintained in their database.

***Type of Setting.*** In total, 239 respondents completed the survey. Not all participants completed the survey in its entirety because some elected to skip some questions. Of the 228 who responded to the question of workplace setting, most participants (78%) worked in private practice, with 17.5% citing employment in an outpatient agency setting. The remaining respondents endorsed working in an inpatient setting or educational capacity.

***Geographic Location.*** Although the survey was initially distributed to residents of the aforementioned states, international respondents were represented. In total, all but two respondents provided information about where they practiced. Approximately half of the respondents originated from the targeted five states, with Colorado and California being most heavily represented. In total, clinicians from 37 states participated in the survey. The solicitation also reached clinicians from Argentina, Mexico, Canada, New Zealand, Asia, Australia, Great Britain, Zimbabwe, Israel, Italy, Ecuador, Brazil, and South Africa, representing a noteworthy portion of the responses (10%).

### Apparatus

As previously stated, this research was motivated by the study completed by Cook, Biyanova, et al. (2009). This study expanded the measure used by those authors. The revised survey used in this study was a 23-item questionnaire yielding mostly numerical data (see Table 1 for survey questions). There was also the opportunity for respondents to provide qualitative responses to elaborate on a subset of questions asking for quantitative data.

The additional questions for the survey were developed by exploring the current literature for views on EMDR (Davidson & Parker, 2001; Perkins & Rouanzoin, 2002). Examination of anecdotal experiences of clinicians using or dropping EMDR from their practice provided guidance for pertinent issues to include in the survey. For example, reviewing posts on the EMDR Institute's LISTSERV and observing discussions at local EMDR trainings yielded direction for questions. Additionally, research that declared opposition to EMDR assisted in formatting questions to identify possible areas for

**TABLE 1. Survey Questions Sent to Participants**

| No. | Question |
|---|---|
| 1. | In what type of setting do you primarily practice? |
| 2. | In which geographical state do you practice? |
| 3. | Indicate the highest level of EMDR training completed. |
| 4. | What year did you complete your EMDR training? |
| 5. | Who provided your EMDR training? |
| 6. | Why did you initially pursue training in EMDR? |
| 7. | What was your original theoretical orientation? |
| 8. | Participation in consultation groups or other support activities? |
| 9. | Number of times participated in support activities? |
| 10. | To what extent have you personalized the EMDR protocol to suit your practice? |
| 11. | Have you seen clients who have previously had EMDR? |
| 12. | If yes, what did they say about their experience with it? |
| 13. | With approximately how many clients have you used EMDR? |
| 14. | Did EMDR training adequately prepare you to use the method effectively? |
| 15. | If no, please describe. |
| 16. | How have your colleagues reacted to your use of EMDR? |
| 17. | What percentage of your clients have responded: positively, negatively, or no change? |
| 18. | How often do you use EMDR in your practice (daily, monthly, etc.)? |
| 19. | Please rank order your experiences with EMDR (ineffective, disappointed, other, etc.). |
| 20. | If you answered "other," please describe your experience. |
| 21. | If you stopped using EMDR, indicate which experiences contributed to your decision. |
| 22. | If you are using EMDR, in spite of negative experiences, please indicate how EMDR has enhanced your practice. |
| 23. | What recommendations do you have for making EMDR more user-friendly to newly trained clinicians? |

*Note*. EMDR = eye movement desensitization and reprocessing.

exploration caused by potential resistance or bias (Devilly, 2005; McNally, 1999). Supplemental studies looking at resistance to other techniques and methods in current use also influenced the development of the measure (Cook, Schnurr, et al., 2009).

### Analysis

To determine if the factor assessed in an item contributed to continued use, either one-way analysis of variances (ANOVAs) or chi-square analyses were run for each of the quantitative research questions outlined earlier; EMDR usage was a between-subjects variable. Responses to open-ended items were interpreted by the researcher and categorized as yes or no, in addition to being coded for qualitative data. The number and percentage of respondents endorsing particular items were calculated, allowing for identification of emerging themes, particularly with rank order questions.

## Results

Responses provided by the 239 clinicians who completed the survey were analyzed to reveal patterns differentiating those clinicians still using EMDR from those no longer using it and to identify the factors contributing to its continued use. As previously stated, not all respondents answered all questions, and percentages reflect the number of analyzable responses obtained. The survey was initially sent to clinicians in five states in the United States. The momentum of the participants expanded the scope to include 37 states and 14 countries, with most respondents being private practitioners (78%).

Thirty-three percent of the sample had used EMDR with their clients on more than 100 occasions. A further 15% had used it on zero to nine clients. Of the clinicians surveyed, 37.5% were using EMDR daily, 35% weekly, 12.5% monthly, and 15% too infrequently to track. In the sample as a whole, only 12% had stopped using EMDR. Preferring other methods, needing more consultation, and not feeling prepared were prevalent reasons provided for discontinuing use.

### Pretraining Factors

There was no statistical significance when comparing original theoretical orientation and levels of EMDR use. The most common reason cited for pursuing training in EMDR was having heard about its positive results from colleagues. See Table 2 for a list of factors contributing to seeking training in EMDR, ranked in order, from most endorsed to least endorsed items.

EMDR drew interest from practitioners of numerous treatment modalities, with cognitive behavioral, psychodynamic, and humanistic therapies being most widely represented.

Concerning original theoretical orientation and use of EMDR, 10% of cognitive behavioral therapy (CBT) clinicians and psychodynamic practitioners were no longer using EMDR. Sixteen percent of humanistic

**TABLE 2. Ranked Reasons for Initially Pursuing EMDR**

| Rank | Reason |
|---|---|
| 1 | Heard of positive results |
| 2 | Curiosity |
| 3 | Suggested by colleague |
| 4 | Personal experience with it |
| 5 | Suggested by supervisor |
| 6 | Paid for by employer |
| 7 | Mail/Internet solicitation |
| 8 | Skeptical and wanted to prove it did not work |

*Note.* Number 1 = most prevalent, number 8 = least prevalent reason. EMDR = eye movement desensitization and reprocessing.

therapists were no longer using it. The reasons for each modality differed, with CBT clinicians stating client refusal or client lack of interest in EMDR. Psychodynamic therapists tended to prefer other modalities unrelated to their original orientation, and humanistic therapists stated not using EMDR enough and finding it too expensive as a reason for discontinuing using it. Gestalt therapists were small in number (seven), but 57% of them had stopped using EMDR. Responses provided indicated a lack of emotional connection and depth in therapy as being the deterrents to using EMDR as well as client refusal (see Table 3).

## Training Factors

Most of the respondents were at least Part 2–trained, with 5% only having completed Part 1 of the basic training (earlier called Level 1 and Level 2; see Table 4).

**TABLE 3. Rates of Clinician Use/Discontinuation by Original Theoretical Orientation**

| Theoretical Orientation | Discontinued Use of EMDR | | Continued EMDR Use | |
|---|---|---|---|---|
| | *N* | % | *N* | % |
| Psychodynamic | 6 | 10.00 | 54 | 90.00 |
| Humanistic | 6 | 15.79 | 32 | 84.21 |
| Cognitive behavioral therapy (CBT) | 8 | 10.00 | 72 | 90.00 |
| Gestalt | 4 | 57.14 | 3 | 42.86 |
| Other orientations | 4 | 8.51 | 43 | 91.49 |
| Total | 28 | 12.07 | 204 | 87.93 |

*Note.* EMDR = eye movement desensitization and reprocessing.

**TABLE 4. Respondents' Level of Training in EMDR**

| Highest Level of Training | *N* | % |
|---|---|---|
| Part/Level 1 | 13 | 5.46 |
| Part/Level 2 | 124 | 52.10 |
| Certified | 54 | 22.69 |
| Approved consultant | 15 | 6.30 |
| Facilitator | 18 | 7.56 |
| Trainer | 10 | 4.20 |
| Trainer of trainers | 4 | 1.68 |

*Note.* EMDR = eye movement desensitization and reprocessing.

The results of a chi-square analysis indicated there was no significant difference, suggesting that level of training and levels of continued use are generally unrelated ($\chi^2(6) = 6.87, p = 0.33$).

The EMDR Institute had provided 65% of the training, with other EMDRIA approved trainers accounting for the remaining 35% of those surveyed. Statistical analysis indicated there was no significant difference between training providers with respect to levels of EMDR use ($\chi^2(1) = 1.59, p = 0.21$).

In total, 76% of respondents felt EMDR training had adequately prepared them. For those feeling unprepared (24%), ongoing training and consultation were presented as necessary for competence, as was more practice during the trainings. A chi-square analysis indicated there was no significant difference when looking at whether clinicians felt adequately trained in EMDR, suggesting that feeling adequately trained in EMDR and levels of continued use are generally unrelated ($\chi^2(1) = 3.44, p = 0.56$). Too much information in too little time was the general theme that emerged for those feeling the trainings were lacking.

## Clients' Experiences Factors

Most clients (74%) seen by the respondents had had previous EMDR therapy. In their own treatment practice, 80% of respondents reported positive treatment responses from their clients, with 7% reporting negative outcomes.

## Posttraining Skill Development Factors

Support services (e.g., consultation groups) offered by the EMDR community were being used with frequency above and beyond the training requirements set by EMDRIA. Both paid and unpaid services were endorsed as being attended with similar frequency (see Table 5).

**TABLE 5. Frequency of Attendance in EMDR Support Activities**

| Participation in EMDR-Related Activities | *N* | % | Average Number of Times |
|---|---|---|---|
| EMDR regional study group | 82 | 38.50 | 11 |
| EMDR consultation group | 138 | 64.79 | 20 |
| EMDR individual consultation | 131 | 61.50 | 24 |
| EMDR LISTSERV | 123 | 57.75 | 300 |
| EMDR conference | 117 | 54.93 | 4 |

*Note*. EMDR = eye movement desensitization and reprocessing.

The participants considered themselves to adhere to reasonable treatment fidelity, with 50% stating they had minimally personalized or altered the protocol. Nine percent of the sample stated they had mostly personalized it, with great variation in how EMDR had been modified. Using EMDR with other methods, such as Brainspotting (Grand, 2013), slowing down bilateral stimulation, or adapting the protocol because of the age of the client, were explained as personalization. Whether or not respondents altered the protocol was not found to have any statistical significance when looking at levels of continued use via chi-square analysis ($\chi^2(3) = 2.70$, $p = 0.44$).

As far as recommendations for newly trained clinicians, ongoing consultation was most heavily endorsed, with 40% of respondents ranking its importance high on their lists. Having a buddy or peer support and undergoing personal EMDR were also suggested. New clinicians were encouraged to practice EMDR as soon as possible after the training, a sentiment conveyed at EMDR trainings. Needing more practice in trainings, normalizing anxiety, having realistic expectations, and requiring that the clinician have basic therapy skills prior to training were also mentioned.

## Socioenvironmental Factors

Most respondents (88%) reported positive reactions from colleagues regarding their EMDR use. Two percent stated they had negative reactions from colleagues. A pattern emerged dist inguishing private practitioners from agency personnel. Those in private practice were twice as likely to attend regional EMDR trainings and group consultation, 3 times more likely to attend individual consultation, and 5 times more active in the EMDR LISTSERV.

Of the 182 private practitioners surveyed, only 10 (5%) stated they were no longer using EMDR. Of the 41 agency personnel, 9 (22%) were no longer using it. To test the hypothesis that practice setting and participation in EMDR support activities were unrelated, five different one-way ANOVAs were conducted (one for each measure of support activity). Only one of those analyses showed significant findings. Private practitioners reported vsignificantly more hours ($M = 21.22$, $s = 31.3$) of individual consultation than those in agency outpatient settings ($M = 5.29$, $s = 7.91$), $F(1, 87) = 5.28$, $p = 0.02$; as shown in Table 6.

**TABLE 6. Hours of Attendance in EMDR Support Activities by Practice Setting**

| Support Activity | Private Practice *M* (*SD*) | Agency Outpatient Setting *M* (*SD* | *F* value |
|---|---|---|---|
| Group consultation | 16.43 (22.97) | 11.71 (15.79) | 0.77 |
| Individual consultation | 21.22 (31.36) | 5.29 (7.91) | 5.28* |
| LISTSERV participation | 215.53 (574.08) | 4.33 (12.89) | 2.01 |
| Conference attendance | 3.63 (4.41) | 1.75 (3.43) | 2.53 |
| Regional study group attendance | 9.51 (22.95) | 4.95 (13.45) | 0.75 |

*Note*. EMDR = eye movement desensitization and reprocessing.
*$p < .05$.

## Reasons for Discontinued and Continued Use of EMDR

In summary, there were no statistically significant relationships between the factors investigated. However, the primary reasons that emerged for not using EMDR were preferring a previous modality (no treatment surfaced as generally preferred), not feeling competent, client refusal, and discomfort suggesting it. Of those clinicians still using EMDR, 25% stated rapid results as the primary reason. Other reasons for retaining EMDR were feeling more effective as a clinician and an increase in referrals because of using EMDR. Five respondents stated their practice was enhanced either because their clients experienced less distress, were able to do deeper work, achieved their treatment goals, or because the therapist experienced more success in treating patients with PTSD. Table 7 includes a tabulation of negative experiences, both from clinicians still using EMDR and those who were no longer using it.

## Discussion

In applying these findings to the literature previously presented, several conclusions can be made that complement existing research. The primary (most endorsed) reason given for discontinuing use of EMDR in this study was preferring another modality (pretraining factor); either the one previously used or a new one that the participant considered to be more efficacious. Needing increased training to feel more comfortable using EMDR (training and posttraining skill development), client rejection (client factor), and a lack of supervision (posttraining skill development) all featured prominently in this study despite the gains that have been made in improving the basic training over the last two decades. Farrell and Keenan (2013) noted similar findings, with lack of funding being the primary reason provided in their study for not completing EMDR training, followed by lack of EMDR clinical supervision and lack of confidence using EMDR.

**TABLE 7. Ranked Negative Experiences Using EMDR**

| Rank | Negative Experience |
|---|---|
| 1 | Prefer other modality |
| 2 | Did not feel competent |
| 3 | Client refusal |
| 4 | Uncomfortable "pitching" it |
| 5 | Ineffective |
| 6 | Uncomfortable exposing client to distress |
| 7 | Don't understand how it works |
| 8 | Did not like client abreactions |
| 9 | Lack of support from colleagues |
| 10 | Disappointed with results |
| 11 | Resistance from employer |

*Note.* 1 = most important, 11 = least important. EMDR = eye movement desensitization and reprocessing.

### Pretraining Factors

The importance of pretraining factors was advocated by Greenwald (2006). He highlighted the issue of an inadequate fund of knowledge pertaining to trauma treatment in general and a subsequent lack of confidence in applying EMDR. Preferring a previous modality was the most commonly endorsed reason for not continuing to EMDR. This finding converges with prior literature on the effects of pretraining factors (Cook, Schnurr, et al., 2009; Lipke, 1995). No particular loyalty was noted toward an alternative orientation; in contrast, the responses indicated that it was more about finding something that works and with which the clinician is already comfortable. Of interest, even though the sample size was very small, clinicians practicing from a Gestalt orientation were more explicit about the personal connection in therapy and focused on the importance of depth of the clinical relationship, suggesting there may be some treatment loyalties that are difficult to integrate with EMDR. Intriguingly, none of the therapists using an integrated approach to treatment had stopped using EMDR, indicating they are perhaps indeed better able to assimilate new approaches than therapists loyal to one approach. Of interest, Farrell and Keenan (2013) discussed how EMDR training can be regarded as a secondary psychotherapeutic training because of the stringent eligibility criteria for receiving EMDR training: one must be an established mental health professional (or a supervised graduate student). Farrell and Keenan (2013) also speculated that CBT being taught at the academic level raises its credibility with practitioners. It is interesting to consider what impact there would be, if any, to the practice of EMDR, if it were taught as an initial therapeutic orientation rather than as adjunctive to a method in which one has previously been trained.

It is important to keep in mind that in general not all trained clinicians continue to practice newly acquired techniques (Cook, Schnurr, et al., 2009).

Returning to what feels comfortable to the clinician may hold more weight than loyalty to a specific modality, as suggested by the lack of endorsement of a particular theory in this study.

## Training Factors

In this study, level of training or training provider did not surface as statistically significant with regard to continued use. There was also no significant difference when looking at whether clinicians felt adequately trained in EMDR, suggesting that feeling adequately trained in EMDR and levels of continued use are generally unrelated. With 24% of respondents feeling unprepared after their EMDR training, there are general elements of the training that would likely benefit from review.

## Client Experiences

Fourteen respondents indicated that clients' previous negative experiences with EMDR were primarily caused by perceived treatment fidelity drift (as reported on the personalization of the protocol item). Becker et al. (2007) reported a lack of awareness and familiarity with EMDR from the perspective of the client, bringing attention to client factors that influence EMDR use. As previously mentioned, this puts the responsibility in the therapist's hands to initiate a discussion of EMDR as a treatment option rather than wait for the client to request it. Interestingly, several respondents mentioned lack of interest or client refusal as a reason for not using EMDR as well as feeling uncomfortable suggesting EMDR to their clients. This supports the findings of Lipke (1995) and appears to present a dilemma for the EMDR clinician; if she is uncomfortable suggesting it and the client lacks awareness to request it, EMDR is likely to be underused. Considering client factors, although many respondents cited negative experiences with EMDR, the respondents did not convey that client abreaction was a primary factor in their choice to use EMDR or not. In fact, the responses provided did not lend support to discontinued use of EMDR being the result of EMDR experiences or attributable to subsequent disappointing results in general. Of note, some clinicians reported having had negative experiences with EMDR but still using it anyway, presumably because the results outweighed the discomfort (EMDR therapy not being effective was ranked as reason number 5 on a list of 10 factors of negative experiences); this supports that the focus may be on the progress of the client, instead of the discomfort of the therapist.

## Posttraining/Skill Development Factors

Lipke's (1995) speculation that private practitioners may be more willing to "investigate innovative treatment" (p. 378) appears to be upheld by this study, as evidenced by the larger number of private practitioners recruited, and their subsequent involvement in extracurricular EMDR activities when compared to their agency-employed peers. However, it was beyond the scope of the study to investigate the factors contributing to this phenomenon, and therefore, it was not possible to rule out lack of access (e.g., funding, agency support) in addition to other factors such as motivation. Nonetheless, this speaks to investment of time and money in posttraining support, although engagement in such activities did not reliably increase retention of the therapy.

Because it was found that many respondents said they personalized or altered the protocol to suit their practices, conjecture as to the frequency with which the general population of EMDR clinicians engages in this behavior can be made. For example, respondents referred to not using the subject units of disturbance (SUD) scale (a required part of the EMDR protocol) based on the practices of their trainer or an expert in the field. This draws attention to the issue of training fidelity, as well as treatment fidelity, with respect to the protocol; these issues are relevant to the areas of training, clients' experiences, and posttraining skill development. Further research is needed to explore the ramifications. However, it is easy to speculate how differences in training of the protocol can result in differences in practice. Maxfield and Hyer (2002) found that deviating from the protocol resulted in poorer outcomes, emphasizing the importance of developing a highly trained culture of proficient EMDR clinicians who are comfortable using the prescribed methods. It is important to note, however, that in this study, personalization of the protocol was not of statistical significance when looking at levels of continued use. To the contrary, some of the clinicians most pleased with EMDR endorsed personalizing the protocol based on their needs. Further investigation is required to establish specifically how those clinicians are altering the protocol and if said personalization enhances treatment outcome. Such exploration may in fact offer suggestions to enhance the EMDR protocol, as it currently exists.

## Socioenvironmental Factors

Cook, Biyanova, et al. (2009) found a need for a champion in order for EMDR to be sustained in an agency/organizational practice. In this study, individual

experience with EMDR and comfort with other modalities were more predictive of continued use or rejection of EMDR practice. However, the relatively large number of private practitioners in this study makes a direct comparison difficult. Level of investment (consultation and other support activities) in EMDR also was not related to increase in retention. This point was illustrated by the number of private practitioners who no longer used EMDR despite numerous additional hours of consultation and participation in EMDR support activities. Indeed, some therapists who had achieved certification status had discontinued use. As such, it appears EMDR will not retain a therapist who believes he or she gets better results from another modality. Future research may yield information on as yet unidentified socioenvironmental factors instrumental in the continued use or discontinued use of EMDR.

Given that neither EMDR treatment effectiveness, as perceived by the clinician, nor level of investment in the treatment (as measured by consultation hours) appeared to drive continued use of the therapy, it becomes apparent that the reasons clinicians retain or discontinue use of EMDR are complex. On the negative experiences ranking scale, therapists rated their noneffective experiences with EMDR as less important than other factors such as preferring another treatment modality and lacking confidence in using EMDR. Therefore, clinicians are putting other factors ahead of effectiveness when making a treatment choice consistent with the results of Becker et al. (2007) and Tarrier et al. (2006), who discussed the preconceptions on behalf of both the therapist and client as well as therapists' reluctance to expose their clients to distress. However, it will be important to investigate the reasons for the 20% who were disappointed with treatment results and whether the importance of treatment fidelity is influential.

Lipke (1995) solicited information from his survey participants to uncover reasons for decreased EMDR use. It is important to note that his participants were trained in EMDR prior to the current day requirements for consultation during the training process and prior to much of the efficacy research that has since been conducted. The primary reason given was a change in client load or work situation. Other reasons were "preference of other procedures owing to their success or EMDR failure, need for more training to feel comfortable using EMDR, client rejection of the procedure, and lack of supervision" (p. 384). The results of this study, although not statistically significant, support these findings but with different levels of emphasis on each.

## Limitations

The primary limitation of this study was that clinicians who no longer using EMDR were underrepresented. As a result, the obtained results may not be fully representative of the population sampled. Although there was convergence of results with prior research conducted in the field, questions arise regarding the representativeness of the sample caused by a lack of random sampling in the methodology. The second limitation of this study was sample composition. Although 239 people completed the survey, which did allow for meaningful interpretation of the results, there was an overrepresentation of private practitioners compared to agency clinicians. As such, it would have been preferable to increase the sample size and obtain greater representation of agency clinicians.

A further limitation of the study was not having a random sample of participants, thus limiting the extent to which the results are generalizable. Given the scope of the study, participants were recruited purposefully, and the original five states were selected because of the volume of EMDR clinicians in those geographical areas. Participation in the survey was entirely voluntary and relied on the willingness of clinicians to respond to solicitations. This may have created a response bias in the sample, thus not being an accurate representation of the population at large. As previously stated, however, the results of this study did converge with previous research findings, and although restraint should be exercised when generalizing the findings of this study, it is presumed to be representative to the greatest extent possible.

A further limitation associated with using an online survey pertains to missing data. As previously reported, not all respondents answered all questions. The survey format allowed for respondents to answer those questions that were pertinent to them. Some respondents also skipped questions that did pertain to them, creating a gap in the data that may have yielded more useful information.

## Training Recommendations

Not having a background in trauma treatment (pretraining factor), not using EMDR soon enough after training, and a subsequent lack of confidence (posttraining skill development factors) arose as prominent issues pertaining to discontinued use of EMDR. These factors likely considerably influence the clinician's ability to suggest the treatment to the patient or to work proficiently with client refusal (client experiences/training factor).

Proposing EMDR to a client came up across various questions as being an issue for clinicians. This highlights the need for trainers to be more aware of this issue and perhaps to incorporate a structured discussion during the trainings (training factor). If a clinician is unaware of how EMDR works, he or she is not going to feel comfortable explaining it to a client. Advances have been made in identifying some neurophysiological processes that EMDR impacts. Incorporating this information may help train new therapists in presenting EMDR to potential clients. Setting standards for applicants' study of EMDR—prior to and after basic training—would probably also help with therapists' comfort in presenting the method to clients.

When addressing discomfort with proposing EMDR as a treatment option, or a general lack of confidence in using the treatment, a natural connection between this issue and the idea of receiving consultation and ongoing support after completion of training arises (training and posttraining skill development factors). Although the introduction of the consultation requirement was not driven by research, most respondents felt it was a crucial element to success and ongoing use of EMDR. This gives support to the training changes that occurred in 2008. This speaks to the complex nature of the therapy and also highlights some potential inconsistencies in training delivery (training factor). Consultation beyond the initial training requirement is elective and cost-prohibitive to many, especially private practitioners, who are responsible for paying for their own posttraining support.

With 40% of respondents reporting that basic training was inadequate (training factor) and that they had sought posttraining supervision and skill development, it is interesting to observe that consultation was made a training requirement in 2008. Participants in this study suggested that trainers emphasize that Parts 1 and 2 constitute only a basic training, and advanced trainings are required for addressing specific disorders and situations. Opinions pertaining to normalizing anxiety and having realistic expectations were prevalent, suggesting that current trainings overlook these aspects. Remarkably, some practitioners stopped using EMDR despite having had from 24 to 40 hours of EMDR consultation. Those clinicians nevertheless reported finding EMDR to be ineffective, not knowing how it works, and not being comfortable with client abreaction. A recommendation is that all such topics should be addressed during the course of consultation. Such may imply a need to structure basic training consultation more uniformly, at least initially, to address each of these factors early on in the training process.

Because EMDR addresses trauma, and the most severe trauma disorder, PTSD, is highly comorbid, clinicians lacking certain skills will often have difficulty applying EMDR (pretraining and training factors). Having the ability to integrate EMDR with other modalities to optimize treatment for the patient is crucial when EMDR alone is not sufficient in reaching treatment goals (pretraining and training factors).

## Implications for Practice

Some respondents stated they were no longer using EMDR because of either lack of client interest or client refusal (training and client factors). This is an intriguing response that suggests the responsibility of treatment choice lies with the client. This pattern would require a very informed consumer be able to ask for what he or she needs. As Becker et al. (2007) discussed, the client is initially generally unaware of or unfamiliar with EMDR. As professionals, the change in focus to bearing the burden of informing the client regarding what is available may reduce this scenario significantly. Mental health practitioners may be in the minority with this expectation when considering how treatment is offered in parallel professions. Placing the responsibility of being informed of treatment options on the patient reflects a lack of effort on the clinician who will contribute to the resistance with which the EMDR community has already been faced.

The fact that EMDR works has been established (Foa, Keane, Friedman, & Cohen, 2009; Schubert & Lee, 2009). Its efficacy is strongly supported by those respondents who continued to endorse using EMDR despite negative experiences with it. Given the support that EMDR receives from those who firmly believe in it, it is unclear why others lack such enthusiasm (socioenvironmental contributors). It has gone from being a treatment for PTSD to being a comprehensive treatment. Perhaps some enthusiasm has distorted the views of those being trained, as they approach the training expecting miraculous outcomes. Much of EMDR success was driven by the results of single incident trauma. Complex PTSD requires far more clinical skill and judgment than a single incident trauma. The question of for whom it works best remains. Maybe managing these expectations differently (training and socioenvironmental factors) will offer a more realistic expectation for the new EMDR clinician and encourage him or her to persevere when the results require more arduous EMDR work than might have been expected.

## Recommendations for Future Research

It would be helpful to know how long since completion of their degree that each clinician was trained in EMDR. Such information may shed more light on therapist attrition with regard to being set in their ways and having developed significant loyalty for another modality and should be included in any follow-up study.

## Summary

This study yielded findings related to the previously outlined themes. With regard to pretraining factors, not having general clinical skills or knowledge of trauma treatment were provided as reasons for discontinued use. Similarly, possessing unrealistic expectations was offered as a reason contributing to discontinuing the use of EMDR. Continued use of the method was seen as a result of ability to integrate therapies and participate in EMDR support activities, as indicated by a large but nonsignificant number of respondents.

Training factors indicative of discontinued use were feeling that training was inadequate, not conforming to treatment fidelity, difficulty understanding EMDR well enough to suggest it posttraining, and lack of ability to integrate new concepts with previously learned modalities. A factor contributing to continued use was seeking additional training and increased comfort in suggesting EMDR to a prospective or current client.

Negative client experiences before and during EMDR included lack of awareness of the treatment, outright refusal to participate in the EMDR treatment, and poor EMDR outcomes probably as a result of fidelity drift on behalf of the clinician all offered as reasons clinicians were less likely to continue using EMDR. Continued use was more likely when the client had not had a previous negative experience with EMDR and, therefore, did not refuse it.

Posttraining factors lending themselves to discontinuing use were needing more training, consultation, and/or supervision, not using the method enough following training, and not engaging in EMDR support activities in general. Although not statistically significant, continued use was reported to be enhanced by ongoing support, including individual and/or group consultation and/or participation in the EMDR LISTSERV.

Finally, few general socioenvironmental factors were identified. Needing a champion was not endorsed as necessary, although the sample consisted primarily of private practitioners, an environment in which having a champion is irrelevant. However, many respondents reported positive collegial experiences, including their peers using EMDR, which resulted in positive outcomes for those clinicians. Maintaining unrealistic expectations following training and closing one's practice because of life circumstances were the most commonly featured explanations pertaining to this factor.

Consequently, this study appears to lend support to the following: Continuing to use EMDR in clinical practice would be enhanced by having a strong clinical background to tolerate the additional demand of treating trauma (pretraining factor); more attention to developing comfort with the treatment to allow for comfort in proposing EMDR to clients, sufficient practice, and exiting training with realistic expectations (training factors); and an increase in consultation (posttraining skill development). It may be beneficial for trainers to consider the structure of their trainings to ensure adequate practice is attained upon completion of their Part 1 training and in the time between trainings in order to ensure readiness to proceed with more in-depth instruction and advanced practice in Part 2. Reasons for discontinued use by clinicians in agency settings should be further explored to identify if it is a general avoidance of risk (as Lipke [1995] asserted), a lack of support in their vocational setting (as suggested by Cook, Biyanova, et al. (2009), or other factors yet to be determined.

Refinements in training will likely result in a more confident clinician and, subsequently, a more informed client. This will ultimately help with continuing to promote EMDR as an empirically validated and efficacious therapy.

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