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Abstract

There are several qualities of *good* EMDR (eye movement desensitization and reprocessing) therapists that must be examined to understand what clients most value in this specialized treatment. These qualities, as defined by former clients, include therapist personality, an ability to empower clients, flexibility, intuition, a sense of ease and comfort in working with trauma, and a commitment to the small measures of caring that clients identify as helping them feel safer. This article highlights the importance of honoring client safety in EMDR treatment by further exploring a theme from a phenomenological parent study on the use of EMDR with women in addiction continuing care. The parent study offered qualitative evidence showing that there is a place for EMDR as part of a comprehensive women's addiction recovery program when applied properly. In this article, participants' descriptions of their EMDR therapists and how these therapists were able to establish safety are described in greater detail than the parent study article allowed. Implications for emphasis on client-centered factors in the training and formation of EMDR therapists are discussed using the data extrapolated from the clients' experiences, and further directions for researching the client-centered perspective in EMDR are presented.

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Keywords

phenomenology, therapeutic alliance, client safety, client-centered EMDR, EMDR training, EMDR protocols, EMDR therapists

The lived experience of 10 women who participated in eye movement desensitization and reprocessing (EMDR) treatment during addiction continuing care revealed that, when applied properly, there is a place for EMDR as part of a comprehensive addiction recovery program (Marich, 2010). Four major themes emerged from a major study that inform clinicians how to successfully implement EMDR into an addiction recovery program. One theme stressed the importance of ensuring client safety before beginning major EMDR work. The purpose of this article is to go into greater depth than the parent study allowed on the role of the therapeutic alliance in EMDR treatment, especially as a strategy for assuring client safety. When examining the theme in greater depth, there are several qualities of a *good* EMDR therapist, which can be highlighted in order to bolster understanding of what former clients value as important in EMDR treatment. These qualities include therapist personality, ability to empower clients, flexibility (vis-à-vis rigidity to set EMDR protocols), intuition, a sense of ease and comfort in working with trauma, and a commitment to the small measures of caring that former client's identify as helping them feel safer. Emphasizing the importance of these factors within the psychotherapeutic professions predates the discovery of EMDR as an approach to psychotherapy. Most writing on EMDR by professionals, including EMDR founder Francine Shapiro, emphasizes fidelity to set protocols that are unique to EMDR as a major factor in ensuring client safety. Thus, the information derived from this exploratory, client-centered inquiry has the potential to challenge extant knowledge about what elements of EMDR are the most important to those who receive it.

Literature Review

Developed by psychologist Dr. Francine Shapiro in 1987, eye movement desensitization and reprocessing (EMDR) evolved from a simple desensitization technique into a comprehensive, eight-phase therapeutic approach. Desensitization with bilateral stimulation (e.g., eye movements or acceptable alternatives such as alternating tactile motions or audio tones) constitutes only one of the phases (F. Shapiro, 2001). Elements from several major schools of psychotherapeutic thought, including client-centered philosophy and its emphasis on letting the process of therapeutic change organically

unfold, are present in the EMDR approach (Bohart & Greenberg, 2002; Moskovitz, 2001). Many significant clinical bodies (American Psychiatric Association, 2004; Chambless, 1998; Department of Veteran Affairs & Defense, 2004; Foa, Keane, & Friedman, 2000) classified EMDR as an efficacious treatment for posttraumatic stress disorder (PTSD). Moreover, a variety of clinical presentations that do not necessarily merit a formal *Diagnostic and Statistical Manual of Mental Disorders—Text Revision* (American Psychiatric Association, 2000) diagnosis of PTSD but are connected to unresolved, antecedent memories can be successfully addressed with EMDR (Grey, 2011; Korn, 2009; Maxfield, 2007; R. Shapiro, 2005; R. Shapiro, 2009; Zweben & Yeary, 2006).

Several meta-analytic studies validate the use EMDR in treating PTSD (Bisson & Andrew, 2007; Ironson, Freund, Strauss, & Williams, 2002; Maxfield & Hyer, 2002; Power et al., 2002; Van Etten & Taylor, 1998). Furthermore, the comorbidity between substance use disorders and PTSD has been well established in the literature (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Najavits, Weiss, & Shaw, 1997; Ouimette & Brown, 2002; Peirce, Kindbom, Waesche, Yuscavage, & Brooner, 2008). Since the discovery and clinical dissemination of EMDR, the treatment has been successfully used with clients who have a substance use disorder, justified by the established comorbidity between PTSD and substance use disorders (Brown, 2003; Lipke, 2000; Shapiro, Vogelmann-Sine, & Sine, 1994; F. Shapiro & Forrest, 1997; Zweben & Yeary, 2006).

The parent arm of this study (Marich, 2010) continued an emergent wave of research on successfully implementing EMDR in the treatment of addictions (Abel & O'Brien, 2010; Brown & Gilman, 2007; Cox & Howard, 2006; Hase, Schallmayer, & Sack, 2008; Marich, 2009; Ricci, Clayton, & Shapiro, 2006; Zweben & Yeary, 2006). Marich's (2009) case study was the first on EMDR and addiction to convey a truly phenomenological perspective. Phenomenology rejects the Galilean notion that an individual's worldview can be quantified (Crotty, 1998; Giorgi, 1985). Examining the subjective, human experience is the essence of phenomenological inquiry (Marich, 2010), and it is a perspective historically missing in EMDR writing. Although many case studies and field reports of real-world EMDR clients appear in the literature, the therapist's third-person view serves as the primary voice. Recent pilot research by Stewart-Grey (2008) and qualitative research by Edmond, Sloan, and McCarty (2004) and Ricci and Clayton (2008) began giving direct voice to the client experience by using open-ended, experiential methods.

According to client experience, the quality of therapeutic alliance between client and clinician is an important mechanism in facilitating meaningful change for clients with complex PTSD (Fosha, 2000; Fosha & Slowiaczek, 1997; Pearlman & Courtois, 2005). Since the client is active in that alliance, it is important to obtain their perspectives in assessing the role of the alliance in EMDR treatment. Dworkin (2005) asserted that relational issues between client and clinician often affect whether EMDR results are positive or negative for clients.

Even with her consistent emphasis on fidelity to the protocols of EMDR, Shapiro acknowledges the importance of the therapeutic alliance in EMDR treatment. She described the execution of EMDR as an essential interaction between client, method, and clinician (Dworkin, 2005; F. Shapiro, 2001). In her 2001 text, she indicated that because the potential for disturbance between EMDR sessions is high, the need for a strong therapeutic alliance becomes extremely important. She suggested that having truth-telling agreements in place are key and that the therapist must be able to impart safety, flexibility, and unconditional regard. Several other EMDR authors have made reference to relational issues in their writing (Greenwald, 2007; Leeds, 2009; Lipke, 2000; Luber, 2009; Maiberger, 2009; Parnell, 2007), although elements of technique, protocols, procedures, scripts, and explanatory models seem to take precedence in these works. Of these texts, Greenwald and Parnell most directly acknowledge the synergistic effect of protocols and procedure with a solid therapeutic alliance. Dworkin and Errebo (2010) proposed a process for better training EMDR therapists to repair ruptures in the therapeutic alliance, a task that they identified as overlooked in most EMDR training, but one that is essential to the overall success of EMDR treatment.

In examining literature from the psychotherapeutic professions at large, it can be argued that F. Shapiro's (2001) position of client, method, and clinician interacting equally puts too much emphasis on method (see Wampold, 2001, 2007). Rosenzweig (1936), in response to the numerous philosophies of therapy asserting superiority in his era, published the concept of the four *common factors*. The common factors emphasize the similarities, not the differences, of successful psychotherapies. These common factors are the clients and their extratherapeutic factors (e.g., assets brought to the therapy process and situations out of the control of the clinician), models and techniques that work to engage and inspire the client, the therapeutic relationship/alliance, and therapist factors. In their systematic review of over 60 years of psychotherapy research, Duncan, Miller, Wampold, and Hubble (2009) contend that Rosenzweig's original hypothesis is supported by the literature:

We conclude that what happens (when a client is confronting negative schema, addressing family boundaries, or interpreting transference) is less important than the degree to which any particular activity is consistent with the therapist's beliefs and values (allegiances) while concurrently fostering the client's hope (expectations). Allegiance and expectancy are two sides of the same coin: the faith of both the therapist and the client in the restorative power and credibility of the therapy's rationale and related rituals. Though rarely viewed this way, models and techniques work best when they engage and inspire the participants. (p. 37)

Applying this logic to EMDR, it is insufficient to rely on EMDR method and protocol for the sake of relying on it; rather, EMDR clinicians must be flexible in their application of method so that a client remains engaged. Part of this engagement includes knowing when to deviate from the pure technique of EMDR protocols and to rely more on the humanistic, empathetic responses that are indicative of client-centered approaches. One of the major differences between client-centered therapy and EMDR is that although both rely on the organic flow of a session to facilitate change, EMDR uses eye movements (or other bilateral stimulation), where client-centered therapy makes use of empathetic responses to stimulate this flow of information processing (Bohart & Greenberg, 2002; DiGiorgio, Arnkoff, Glass, Lyhus, & Walter, 2004). Humanistic, client-centered therapists typically integrate the two approaches, knowing when to adjust EMDR protocol if it seems too artificial or contrived for a specific client (DiGiorgio et al., 2004; Marich, 2011).

Using a collection of empirical research studies and chapters from the psychotherapeutic professions, Norcross (2002) demonstrated that a combination of the therapy relationship, together with discrete method, is critical to treatment outcomes. Norcross further concluded that relational skills can be honed by therapists, and that it is the therapist's responsibility to tailor these skills to the needs of individual clients. Collected volumes by Duncan et al. (2009) and Norcross (2002) comprehensively support the significance of relational elements that Carl Rogers (1957) introduced. The classic Rogerian constructs of empathy, genuineness, and unconditional positive regard that constitute the foundation of client-centered therapy still have relevance in the modern era where the influence of the medical model has placed more emphasis on standardization, treatment protocols, and manual-driven therapy (Duncan, et al., 2009; Eugster & Wampold, 1996; Yalom, 2001).

Method

The author used a qualitative, phenomenological design that incorporated semistandardized interviewing as the primary modality of data collection in the parent arm of the study (Marich, 2010). Guided by the work of McCracken (1998) and a qualitative study on the use of EMDR with sex offenders (Ricci & Clayton, 2008) in composing the instrument, further refinement of the instrument occurred following a field-test interview (Marich, 2009). The field test case was not included in the parent study because the case was the author's former client. For the parent study, the author decided to obtain a sample of female clients that she did not treat to ensure a greater degree of objectivity. Participant recruiting was a combined effort between the author and the partnering women's treatment facility.

The research design used a blend of purposive and criterion sampling. Purposive sampling is primarily employed in exploratory research. Cases are selected based on the unique qualities that these cases offer in addressing a research problem (Mertens, 2006; Neuman, 2006). To meet criteria for participation in the study, at least 6 months needed to have passed between engagement in EMDR treatment and the time of the interview. Six months is a time frame established by the author to allow for perspectival reflection. Identification as an *alcoholic* or *addict* was not necessary to participate, but an addiction treatment episode must have occurred (Marich, 2010). A formal diagnosis of PTSD was not necessary to participate since the emphasis of the study was on the recovery experience and because practice evidence indicates that EMDR can be useful in presentations other than PTSD (Maxfield, 2007; F. Shapiro & Forest, 1997; R. Shapiro, 2005, 2009; Stewart-Grey, 2008).

Following institutional review board approval by the author's academic institution, the partnering facility invited several hundred alumnae of its program by mail, phone, and public announcement to participate in the study. All reasonable attempts were made to contact adult (i.e., 18+) alumnae treated at the facility since their initiation of EMDR programming in the mid-1990s. To allow for the possibility of negative case analysis, the author asked that all eligible participants be invited to participate, not just those participants who had good experiences with EMDR. Interested participants contacted the liaison from the partnering treatment facility, who obtained release of information documents. The author conducted a brief telephone screening to determine appropriateness (e.g., 6 months since last EMDR session and acknowledgement of informed consent parameters). The author interviewed the first 10 women to come forward, and others were put on a waiting list. Participants were given a short orientation to the interview process and debriefed about what to

expect. With the written permission of the participants as part of the informed consent process, all the interviews were audio recorded and then transcribed (Marich, 2010).

The author conducted the interviews over a 2-month period in early 2009. The 26 questions on the semistandardized interview instrument covered three major areas: demographic information, background questions about life in addiction, the EMDR treatment experience, and EMDR's impact on overall addiction recovery. Only one of the questions on the 26-item interview directly posed, "What role did the EMDR therapist play in your treatment?" (Marich, 2010). Because the parent study focused on the role of EMDR in the overall recovery experience, one question seemed appropriate at the time of instrument construction. The remainder of this article will demonstrate that this one question yielded a wealth of information.

A well-selected data analysis procedure is a critical aspect of a qualitative research design. Data analysis procedures for qualitative data give researchers a step-by-step method to follow for reading, coding, and interpreting information. Otherwise, a qualitative researcher can be easily accused of scouring the data to locate passages that she is looking for to support her own preconceived contentions (Marich, 2010). Giorgi's Descriptive Phenomenological Psychological Method (Giorgi & Giorgi, 2003), a four-step procedure for coding the verbal data, identifying the meaning units within the data, and translating those meaning units into identifiable psychological themes, was selected to analyze the data in the parent study. The Giorgi method was chosen because of its solid basis in phenomenological philosophy and its recognition by an American Psychological Association publication as a viable qualitative research strategy (Camic, Rhodes, & Yardley, 2002). The author's dissertation committee chairwoman listened to all the interviews as an accountability check to ensure that the author, a certified EMDR therapist, was coding with the Giorgi system and not her own beliefs (Marich, 2010).

The study participants ranged in age from 27 to 52 years (mean = 41.7; median = 46.5) at the time of their interviews. Four of the participants identified as African American (or Black), five identified as Caucasian, and one identified as mixed European-Iranian. The time in continuous sobriety reported by each participant ranged from 1 to 6 years (mean = 3.75 years; median = 3.625 years). Various primary addictions of choice were represented, with several of the women considering themselves cross-addicted to multiple substances and maladaptive behaviors (e.g., sex, overeating). The participants reported a variety of religious, educational, and parenting/family experiences. Eight of the participants reported prior addiction treatment episodes, one participant reported no prior treatment, and one participant reported

prior treatment in a correctional facility only. According to the Director of Trauma Services at the partnering facility (personal communication, March 9, 2009), EMDR was incorporated into the treatment plans of each participant based on her respective treatment team's evaluation of her needs and readiness. Thus, the time of EMDR implementation varied (from 1 month of observed sobriety to 2 years among the sample) because of the facility's individualized treatment plan philosophy (Marich, 2010). All the participants in the study worked with a primary counselor (non-EMDR), several different group counselors, case managers, and their EMDR therapists.

Results

Four major thematic areas emerged from the interview data in the parent study:

1. The existence of safety as an essential crucible of the EMDR experience
2. The importance of accessing the emotional core as vital to the recovery experience
3. The role of perspective shift in lifestyle change
4. Using a combination of factors for successful treatment

All 10 women, to some degree, credited EMDR treatment as a crucial component of their addiction continuing care, especially in helping with emotional core access and perspective shift (Marich, 2010).

Thematic Area 1, the existence of safety as an essential crucible of the EMDR experience, offers valuable, client-centered insight into how EMDR can be best implemented into addiction treatment programs. Four subthemes demonstrate the various ways that safety was established and assured for the participants: the treatment setting itself, quelling initial skepticisms about EMDR, the role of the EMDR therapist, and features of the EMDR approach. Even though just one of the subthemes directly addresses the characteristics of EMDR therapists, the EMDR therapist was responsible for executing all four functions identified by the former clients as being important, often using client-centered therapeutic techniques that are not unique to EMDR. These elements will be expanded on in each subthematic area.

Subtheme 1: The Treatment Setting

The participants needed to feel that they were not going to be attacked or belittled. This assurance was crucial for them to "open up" in the meaningful

way that EMDR fosters. The collective experience of the participants revealed that there were three major ways in which the treatment setting created a safe environment. Being surrounded by women with similar histories was one component; however, the other two components related to staff members (especially therapists) who operated the facility: the trauma-informed nature of the program and optimistic reception by facility staff and therapists.

One of the most significant examples of how the treatment program created safety is from Fadalia's experience. Fadalia (pseudonym), an Iranian American treated approximately 25 times prior, the most of any of the participants, shared: "The people that I worked with here communicated to me somehow that they believed that I could really stay clean. I never really experienced that before." Fadalia believed that if she was greeted cynically like she had been at other treatment centers, she would not have gotten sober and well. The staff at these other centers doubted her ability to get sober, which reinforced her inner sense of shame. Fadalia needed empowerment, and the staff provided that. She expressed that she would not have felt safe to open herself up for EMDR had she been received with cynicism, and other participants related to this experience (Marich, 2010).

Subtheme 2: Quelling Initial Skepticisms About EMDR

Nine of the 10 participants initially experienced some level of skepticism about EMDR. This skepticism ranged from mild hesitation to blatant fear that the treatment facility was out to control them. There were several factors that ultimately allowed the women to feel comfortable with the EMDR approach (e.g., simple education from counselor, mustering internal willingness, hearing positive experiences about EMDR from other members in the therapeutic community, an existent trusting relationship with a reliable counselor). For the purposes of this article, it is important to note that two of those four factors directly involved therapist action and/or presence. Denise (pseudonym), a marijuana addict with bipolar disorder and a history of molestation, shared that she originally harbored a great deal of skepticism about EMDR, and as a result, it did not seem to work. In her interview, Denise shared that as she developed trust in the EMDR therapist, the more confident she felt about the therapy and the more it seemed to work for her. The majority of the participants described similar experiences. For several other participants, the therapist's willingness to provide them with information about the therapy helped them feel more assured about proceeding with EMDR. This simple, educational process lessened some existent fears that the counselors, and the facility itself, were trying to "control" or "manipulate" them, legitimate fears for survivors of trauma.

Table 1. Adjectives Used to Describe EMDR Therapists

Positive Experiences	Negative Experiences
Caring	Rigid
Trustworthy	Scripted
Intuitive	Detached
Natural	Anxious
Connected	Unclear
Comfortable with trauma work	Uncomfortable with trauma
Skilled	
Accommodating	
Magical	
Wonderful	
Commonsensical	
Validating	
Gentle	
Nurturing	
Facilitating	
Smart	
Consoling	
"The bomb"	

Subtheme 3: The Role of the EMDR Therapist

In summary, feeling that they were in capable hands with their EMDR therapists facilitated fulfilling EMDR experiences for the women (Marich, 2010). Eight of the 10 participants described their EMDR therapists in positive terms, and these adjectives appear on Table 1. This table showcases little, if any, emphasis on the therapist's technical competence; instead, the table showcases adjectives that are indicative of client-centered approaches to therapy predominate. An interesting aspect of the parent study is that 7 of the 10 participants had the opportunity to work with two or more EMDR therapists during their time in the treatment program. Two of the participants, Cindy and JoElle, indicated that they needed to switch EMDR therapists before they were able to experience good results from the treatment.

Cindy (pseudonym), a recovering heroin addict with multiple mental health issues (PTSD, bipolar disorder, borderline personality disorder), believes that she experienced virtually no progress with her first EMDR therapist, who she

described as rigid, scripted, and not comfortable with trauma work. Cindy, a Caucasian lesbian in her 30s, shared that her first therapist seemed overly concerned with getting scale readings throughout the session (e.g., subjective units of distress on a 1-10 scale) that inhibited forging a connection. Cindy revealed that she was able “to really process and get stuff done” when she switched to another EMDR therapist. Looking back on her experience, Cindy views EMDR as “something that’s very personal and very involved and I think it takes a special kind of counselor to pull stuff out of you.” Cindy described the therapist who she ultimately connected with as intuitive, natural, and very comfortable with trauma work. For Cindy, this was significant because her good therapist:

Played a very significant part in knowing exactly what she needed to say to me to either bring stuff out or to move onto something else or to focus on this. And I think it was huge, actually, in making that connection that was so important.

Highlighting Cindy’s experience is very significant to this inquiry because Cindy is one of the few participants from the study who directly credited her current sobriety specifically to EMDR treatment and not a combination of factors. At the time of the interview, Cindy was working on her bachelor’s degree in substance abuse counseling, with the goal of going on to be an EMDR therapist herself.

JoElle (pseudonym), a biracial woman who identifies as Black, shared similar experiences when it came to switching EMDR therapists. JoElle developed a heroin addiction in her late 30s following 23 years of abstinence from marijuana. Both Cindy and JoElle were heroin addicts with multiple prior treatments, and both grew up in homes where rigid religious beliefs reinforced shame-based identities. For JoElle, a connection with her EMDR therapist was an important component of her perceived progress. JoElle shared that her first EMDR therapist, the same one that Cindy had a problem with, made her feel uncomfortable. JoElle revealed, “She didn’t make it really clear to me that I could just do nothing, so I felt uncomfortable.” In essence, this therapist did not emphasize the nonjudgmental, organic flow that can make EMDR sessions inherently client-centered. JoElle further indicated that the therapist seemed overly anxious after each set about seeing some kind of effect, and when nothing out-of-the ordinary happened, JoElle felt like she was doing something wrong. Like Cindy, JoElle began to experience immediate results with EMDR when she switched to the same, “natural” therapist that Cindy also experienced as positive. JoElle expressed:

She was a natural for this job. I could think something and she would say it. She was just amazing and she knew so much . . . she just knew a lot about me and she was really easy to talk to. She used, to me, a lot of common sense along with counseling. That's not always done. She was the greatest.

Like Cindy, JoElle also indicated that the new counselor seemed to have a solid understanding of trauma that enhanced JoElle's overall comfort level. Moreover, the new counselor had a way of making JoElle feel empowered. "With her," JoElle shared, "I did not seem like just a number." The adjectives that Cindy and JoElle both used to describe the inferior EMDR therapist also appear on Table 1.

Subtheme 4: Features of the EMDR Approach

Many participants credited certain features of the EMDR approach, such as preparation, orientation, and session closure, because these strategies enhanced their personal safety. EMDR preparation, orientation, and session closure are covered by F. Shapiro (2001) in her basic text and readdressed in other guides for EMDR therapists (Greenwald, 2007; Leeds, 2009; Lipke, 2000; Luber, 2009; Maiberger, 2009; Parnell, 2007). These are the only three features of the EMDR approach to psychotherapy that the participants directly recognized as being important during the interviews. From the perspective of the participants, these elements were not simply procedures but an extension of their EMDR therapists' humanistic care and concern.

Mae (pseudonym), an African American recovering alcoholic with 6½ years of sobriety at the time of the interview (the longest in the sample), shared an example of this concern. Mae noted that her EMDR therapist always ensured that she "would never go out of this office messed up." The therapist achieved this by simply talking to Mae in regular conversation at the end of their EMDR sessions about what happened during the session, and assuring Mae that she could call the program's crisis counselor at night "if anything else kicked up." For Mae, taking the time to review this safety plan was very important, because the issues that she processed in the EMDR session (e.g., childhood abuse, her mother's abandonment, and having her own children removed from her custody) were the issues that she previously "drank over."

The majority of the participants indicated that the therapist's willingness to carefully prepare and orient them before major EMDR trauma processing commenced helped build trust. Mae indicated that it was important not to be

rushed into such major trauma work. Fadalia revealed that it was critical that she had the skills not to come “unglued” before she began addressing her traumas. For participants like Nya (pseudonym) and Denise, having their questions about EMDR answered in a scientific manner helped quell their skepticism about EMDR. Although addressing such questions is a simple function of orientation, for these participants, the careful execution of this function by the therapist was critical to their EMDR success. Linda’s (pseudonym) EMDR therapist was able to arrange a very direct form of EMDR orientation: Linda observing her minor son’s EMDR sessions. For Linda, one session of observation erased her doubts, identified as a major reason she allowed the EMDR to work for her.

Discussion and Implications

The results illustrate how a group of former clients describe a good EMDR therapist and how an EMDR therapist can competently provide a safe context for the therapeutic experience. Many of the qualities described by the participants parallel what Rogers (1957) and Yalom (2001) posited about the nature and the importance of the therapeutic relationship (see Table 1). For instance, the women in the study used Rogerian terms such as *caring*, *accommodating*, *connected*, *gentle*, *nurturing*, *trustworthy*, and *consoling* to describe their EMDR therapists. The participants also cited *common sense* and being *natural*, therapist traits that Yalom esteemed. Adjectives such as skilled and smart hopefully evidence some manifestation of therapeutic training.

These conclusions may seem obvious because the psychotherapeutic professions have long embraced the importance of the therapeutic relationship. However, it is of great significance to reiterate such findings in the modern era in studying specialized treatment approaches like EMDR. The teaching and dissemination of specialized approaches often places excessive emphasis on theory and technique as being the prime variables that ensure client safety, and the literature demonstrates that this trend clearly applies to EMDR. This exploratory inquiry indicates that it is the humanistic, client-centered functions that are likely yielding the greatest benefit in ensuring client safety and success in EMDR. Therapists who practice these principles, even if that means adapting prescribed protocols to better suit the needs of a client, make the best EMDR therapists.

Comfort with trauma work was an admirable therapist trait that many participants directly identified as essential to their safety. This positive trait report has direct implications for informing the way that EMDR therapists are trained. Greenwald (2006, 2007), Parnell (2007), and Curran (2009) all

contended that clinicians who have a solid understanding of trauma and its impact on human behavior seem to learn and to implement EMDR more easily than those clinicians who do not. Greenwald et al. (2008) presented preliminary evidence, which shows that teaching trauma-related insight to a group of paraprofessionals and mental health professional led to increased empathy with challenging clients and increased comfort/confidence in their work as helpers. Additionally, comfort with addressing client trauma can arguably be a function of a therapist's willingness to work on his or her own trauma issues (Parnell, 2007). The exploratory findings of this study suggest that understanding trauma and being comfortable with trauma affects therapist efficacy in using EMDR with clients.

The data from this exploratory study support Dworkin's (2005) contention that relational issues between client and clinician can effect whether EMDR results are positive or negative for clients. Cindy and JoElle's disclosures reveal that changing from an EMDR therapist who both experienced as ineffective to a therapist who both experienced as dynamic in multiple domains can have an impact on outcome. With EMDR's founder placing so much recent emphasis on fidelity to EMDR protocols and procedures as primary factors in successful EMDR outcomes (Luber & Shapiro, 2009), Cindy and JoElle's experiences suggest that method may be the least important element. Both noticed that the same, ineffective therapist presented as too scripted, rigid, and eager to see an effect of the eye movements. These are qualities indicative of a therapist who is not comfortable with trauma work, reading directly from a scripted protocol.

The EMDR community, currently led by the EMDR International Association, needs to investigate if the positive qualities articulated by clients (such as the ones in this exploratory study) are the result of EMDR training or other factors. These other factors can include personality, an ability to empower clients, flexibility, clinical intuition, personal experience with trauma, prior work with trauma in clinical settings, and commitment to client safety, which includes practicing the small measures of caring and concern that are inherent in humanistic approaches. The experiences shared by the participants in this study clearly demonstrate that what allowed EMDR to work for them in a way that honored their safety and dignity is not unique to the EMDR approach to psychotherapy. Rather, time-honored, client-centered principles that happen to be included in the EMDR approach are of utmost importance. A good EMDR therapist, as described by the findings of this exploratory inquiry, will likely emphasize these principles over those of protocol, procedure, and method.

Limitations

Exploratory inquiry extrapolated from a larger, phenomenological study is not intended to be used as a basis for large-scale conclusions. The hope is that these client-centered, exploratory findings from a group of 10 women can be used to launch broader study on issues of therapeutic alliance, defining what constitutes excellence in EMDR therapists, and EMDR therapist training/formation. The primary limitation of the study is that only women who had a positive experience with EMDR responded to the recruiting, leaving information about predominantly neutral or negative experiences with EMDR largely unaddressed (Marich, 2010). Another limitation is that the author, a certified EMDR therapist, conducted the interviews herself. The credibility of the study could have been further enhanced if someone with a neutral opinion about EMDR conducted the interviews. This limitation was mitigated by the author's academic dissertation committee diligently confronting any bias in her coding or interpretation.

The all-female sample described in this article represents a reasonable diversity of socioeconomic, racial, educational, religious, and sexual backgrounds. However, because the parent study was designed to examine the role of EMDR in gender-specific addiction treatment presents a major limitation in this specialty article. It is important to note that the experiences of male clients and clients without addiction issues are not represented in the discussion points made in this article.

Recommendations for Further Research

Future research on the role of the EMDR therapist in EMDR treatment will need to include the experiences and perspectives of men, children, adolescents, and nonaddicts. Each of the discussion points made in this article represents an area of future research that will add to the depth of knowledge on how to most effectively implement EMDR into clinical settings. The first point of discussion looked at the positive qualities that a group of previously treated clients used to describe their EMDR therapists. More data can be gathered in this area by duplicating the semistandardized interview used in this parent study with a larger, more diverse sample and then coded with grounded theory strategies. Quantitative measures can also be introduced to correlate treatment outcomes with characteristics of EMDR therapists (and the EMDR therapeutic alliance) identified by former clients.

A major conundrum still exists on how to best research if (or how) current EMDR training methods influence the development of these positive qualities. At this point, with the relative dearth of research on EMDR training outcomes, any research has the potential to offer a valuable contribution. The most obvious, simple continuation of this study (as it relates to therapist formation issues) would be to interview the therapist who participants Cindy and JoElle credited with facilitating a positive, impacting EMDR experience for them following their negative experiences with another therapist. Case studies of treated clients constitute a significant portion of the literature on EMDR, but a meaningful case study on the training and formation of a therapist who actual clients identify as successful is missing.

A major discussion point in this article is that a solid understanding of trauma and its impact on human behavior can influence how effectively a clinician learns and implements EMDR into their practice settings. Research is needed to determine if the current teaching of the adaptive information processing model in EMDR training programs constitutes sufficient education in principles of trauma. The exploratory findings in this study preliminarily suggest that a clinician's ease with trauma work could be more important than their strict adherence to the traditional Shapiro protocol, an idea that Parnell (2007) previously proposed.

Grounded theory research, the goal of which is to develop an explanatory theory of basic social processes (Starks & Brown-Trinidad, 2007) by interviewing participants who have experienced the phenomenon under many conditions, can be implemented to answer some of these questions posed in the discussion. This strategy could be achieved by interviewing more former clients about their experiences with EMDR therapists/therapy and also interviewing the EMDR therapists who treated them regarding their experience with EMDR training and implementation. Open-ended questions would need to be written that specifically correspond with the purpose of the inquiry. Since grounded theory sampling is typically larger than phenomenological sampling so that broader conclusions can be drawn, such a study would constitute a major effort of time and resources. Nonetheless, such a design may be most reflective of what happens in usual care settings.

Quantitative measures can also be implemented by using the Barrett-Lennard Relationship Inventory, the California Psychotherapy Alliance Scale, the Empathy Assessment Index, or the Working Alliance Inventory with clients and comparing those measures with outcomes in EMDR treatment. Such a study could also incorporate a comparison with a therapist's degree of fidelity to the original Shapiro protocol as measured by an

independent rater. Although trauma competence and therapist ease with trauma are somewhat more difficult to measure than therapeutic alliance and client satisfaction with a therapist, correlational survey research on trauma competence and experience of implementing EMDR following training can be a solid starting point. Taking it a step further, these survey data can then be compared with a therapist's EMDR outcomes over an established period of time.

Author's Note

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