Exploring Therapists' Experiences of Applying EMDR Therapy With Clients Experiencing Psychosis

Rebecca Phillips
Pamela McSherry
Cathryn Pinto
Tess Maguire
University of Southampton, Southampton, Hants, England

Little is known of the usability of eye movement desensitization and reprocessing (EMDR) as an intervention for those experiencing psychosis. This study aimed to explore therapists' experience of using EMDR with this population. A qualitative design was employed using an inductive approach and a thematic analysis. Twenty therapists, who had used EMDR with this client group, took part in a semi-structured interview to explore their experiences of the intervention. Key themes were generated from the data: (a) familiarity with psychosis and EMDR, (b) acceptability of EMDR, (c) the importance of systemic factors, and (d) keeping key therapy principles in mind. Findings highlighted the importance of supervision to build therapist confidence, the value of the multidisciplinary team, and the need for a shift in beliefs surrounding the usefulness of EMDR to the wider system. Recommendations for individuals and services are provided.

Keywords: eye movement desensitization and reprocessing (EMDR); psychosis; therapists' experiences; thematic analysis; qualitative

The association between psychosis and trauma is well established (Swan et al., 2017). Traumatic life events are suggested to hold a crucial role in the development and perpetuating nature of psychosis (Hardy, 2017; Longden & Read, 2016). Alarmingly, a notable proportion of this population have been found to experience posttraumatic stress disorder (PTSD), with the prevalence estimated to be as high as 20% (Achim et al., 2011; Hardy et al., 2016). For this reason, it is vital that safe and effective trauma therapies are developed for this client group. However, when evaluating psychotherapies, psychosis is often applied as a criteria for exclusion, due to fear that interventions will exacerbate symptoms (Ronconi et al., 2014). This raises a challenge for therapists, as less knowledge is available outlining how to practice trauma therapies with psychosis. Surprisingly, within research in this area, trauma-focused interventions have been found to be safe, with no adverse consequences reported (Sin & Spain, 2017).

Eye movement desensitization and reprocessing (EMDR) is a trauma therapy that follows an eight-phase protocol informed by the adaptive information processing (AIP) model. This model suggests traumatic incidents can be dysfunctionally processed at the time of event(s). When memories of these events remain unprocessed, this can form the basis of various mental health difficulties, for instance PTSD and other trauma-based disorders (Shapiro, 2001). In recent years, the intervention has been used for comorbid PTSD with clients experiencing psychosis. Promisingly, it has been found to have a positive effect on PTSD symptoms, verbal and auditory hallucinations, delusions, anxiety, depression, and self-esteem (Van den Berg & Van der Gaag, 2012). Adopting this approach is suggested to improve PTSD symptoms

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and quality of life at a lower health care and productivity cost to society than care as usual (De Bont, Van der Vleugel, et al., 2019). In addition, Adams et al. (2020) conducted a systematic review finding that EMDR appears safe and feasible for this population. However, owing to little published research, few robust conclusions could be drawn to determine its effectiveness and acceptability. The majority of studies have also been conducted within the Netherlands; it's therefore unknown whether findings are generalizable to the United Kingdom. Furthermore, the number of sessions within the published studies is generally small, with most forgoing stabilization techniques (De Bont et al., 2013; Van den Berg & Van der Gaag, 2012). It has been explained that as clients have usually received extensive case management and antipsychotic medication, stabilization interventions are not necessary (Van den Berg et al., 2013).

The use of EMDR therapy, although less frequently studied, has extended to varying presentations of psychosis with different objectives. It has been found to be effective for dissociative subtypes of PTSD with clients experiencing psychosis, described as persistent and recurrent depersonalization and/or derealization (Van Minnen et al., 2016). There has also been increasing interest in EMDR focused directly on psychotic symptoms (De Bont, De Jongh, et al., 2019). Kim et al. (2010) examined the efficiency of EMDR in acutely admitted patients with psychosis (PTSD symptoms were not indicated). Individuals were randomly assigned to EMDR, progressive muscle relaxation, or treatment as usual. All groups were found to improve symptoms of psychosis, anxiety, and depression. However, there were no differences in effects between groups. Furthermore, Croes et al. (2014) delivered EMDR therapy as an intervention for psychosis-related imagery and found a reduction in symptoms of depression, anxiety, and psychosis. These early findings indicate that EMDR can be used for those experiencing psychosis with and without comorbid PTSD, with acute phases of psychosis or with clients presenting with greater stability. Nonetheless, more robust research is needed involving randomized control trials with larger samples to achieve firm conclusions about the effectiveness of different approaches.

EMDR in psychosis: Guidelines for conceptualization and treatment have been formed (Van den Berg et al., 2013). These are largely based on clinical experience and theory. This guidance suggests EMDR is indicated for comorbid PTSD, for symptoms of psychosis directly linked to early trauma, when traumatic life events indirectly impact on psychosis, and finally to reprocess distressing psychosis-related imagery. It is reported that in clinical practice EMDR can be used alongside cognitive behavioral therapy (CBT). The authors acknowledged symptoms often intensify when the intervention begins but emphasize that no adversities occurred during their practice. However, there are no data revealing clear indications and specific conditions for when EMDR would be effective. Its proposed therapists judge how to intervene, given their expertise (Van den Berg et al., 2013). Previous investigation into clinicians' experiences using EMDR also found that at least 40% of participants had difficulty integrating the therapy. This was due to workplace difficulties, limitations in the provision of supervision, and other barriers (Dunne & Farrell, 2011). At present, no qualitative literature exists detailing therapists' experiences of providing EMDR to clients experiencing psychosis.

For this study, the researchers posited four research questions:

1. How do therapists view the experience of applying EMDR with clients experiencing psychosis?
2. What do therapists identify as helpful when using EMDR with this client group?
3. Do therapists perceive any obstacles when using this approach, and how do they overcome these?
4. How do therapists' view the intervention over and above others for this population?'

This study therefore aimed to explored therapists' perceptions of facilitators and barriers when using EMDR with psychosis, their general experiences, and how they find using this approach compared with other therapies.

Methods

Design

A qualitative approach was chosen for this research as it allows analysis of individual experiences of personal clinical practice and for identification of shared experience. We sought to interview therapists with experience of using EMDR with clients experiencing psychosis. We used an inductive approach and a thematic analysis to identify patterns in participants' experiences and views. This was particularly important as this area is under-researched.

Thematic analysis is regarded as a flexible approach that can be used with different epistemologies and theories, as such it allows for a range of viewpoints to be held (Braun & Clarke, 2006, 2013). A critical realist perspective underpinned this research; this unites interpretive epistemology and realist ontology (McEvoy & Richards, 2006). A view is held that

accepts a reality does exist, while acknowledging that our own individual knowledge or truth is constructed from our experiences, and there can be many alternative accounts of reality. Both the researchers' and participants' subjectivity are recognized from this stance and it is assumed that the researchers' personal views will have influenced the way the data were interpreted (Fletcher, 2017).

The Research Team and Reflexivity

Reflexivity explains the process of the researchers reflecting on their own position, experiences, personal beliefs, and how they may influence every stage of the research. This includes data collection, analysis, and interpretation of findings (Parahoo, 2006). The research team consisted of a trainee clinical psychologist (first author), two qualified clinical psychologists, and a PhD research student with expertise in qualitative research. The trainee and qualified clinical psychologists had knowledge of EMDR and had delivered other psychological therapies to/worked with people with psychosis. None of the research team had trained in EMDR, nor used the intervention. The authors understood the value of using trauma-focused interventions which may have influenced both the collection and analysis of data in favor of EMDR. As a way of keeping an account of personal reflections, a trail of decisions made, and to facilitate the process of reporting the research, a reflective journal was kept. This is suggested to provide transparency of the research, improving the trustworthiness of findings (Nowell et al., 2017). The authors also had frequent discussions about different viewpoints, seeking these out and including them, especially during the data collection and data analysis process.

Sampling and Procedure

Convenience sampling was used to recruit therapists (n = 20). Inclusion criteria were that the participant must have: (a) formal training in EMDR therapy; (b) used EMDR with at least one client age 18 years old or above, experiencing psychotic symptoms within the last 5 years; (c) practiced EMDR within the United Kingdom; and (d) been able to speak English sufficiently. Advertisements for the study were posted on social media platforms. Potential participants were also approached via the British Psychological Society specialist network groups and via knowledge of professionals using EMDR with this population. Participants were given the option of entry into a prize draw with the chance to win a £100 or £50 Amazon voucher. Following participation, therapists were debriefed.

Ethics

The study was approved by the University of Southampton Ethics Committee'. Participants gave verbal and signed consent to take part in the study and for anonymized extracts of interviews to be published.

Data Collection

Each participant took part in one semi-structured interview, all of which were conducted by the first author. Following participants' preference, these took place by telephone (n = 7) or via video call (n = 13). Interviews were audio-recorded and lasted between 28 minutes, 3 seconds and 55 minutes, 5 seconds (M = 42 minutes, 21 seconds, SD = 7.83). The interview topic guide was generated based on the research questions' and after considering previous investigations. All members of the research team contributed to the development of the guide, which included 15 open-ended questions (and standard prompts) designed to facilitate conversation surrounding: (a) broad experiences of using EMDR, (b) attitudes to using EMDR with psychosis, (c) views on current guidelines, (d) barriers and facilitators when using EMDR with psychosis, (e) attitudes compared to other interventions, and (f) future considerations. The full interview topic guide is available in Table 1. This guide was adapted according to participants' comments and areas of discussion raised in the interview. In addition to this, participants completed a demographics questionnaire as part of the study. The interviewer also completed field notes after each interview.

Data Analysis

Data collection stopped when the research team felt saturation was reached (Marshall, 1996). Following verbatim transcription of interviews, analysis was guided by the six steps of thematic analysis as described by Braun and Clarke (2006). The first step involved familiarization with the data. The first author read through the transcripts, taking notes, and recording initial ideas. Within the second step, the first author generated initial codes, which were felt to summarize common features across the data. The third step involved grouping the codes into broader, conceptualized themes, providing patterns of shared meaning.

TABLE 1. Interview Topic Guide

1. Could you tell me a little about your experience of using the EMDR intervention?
2. Can you tell me a little about your experiences of using EMDR with clients experiencing psychosis?
3. How often would you say you use this approach with this population?
4. What are your thoughts about using EMDR with psychosis?
5. Can you tell me about your thoughts about any guidelines for using EMDR with psychosis that you have come across?
6. Is there anything that makes it difficult to use EMDR with this population?
7. Are there things that make it difficult to engage clients when using this approach?
8. What sorts of things do clients with psychosis tend to find difficult when using this intervention, from your perspective?
9. What sorts of things seem to be helpful when you are using EMDR with this client group?
10. When you see clients doing well using this approach, is there anything in particular about EMDR you think has been helpful?
11. Compared with other approaches, how have you found using EMDR with clients experiencing psychosis?
12. Can you tell me about times where you have integrated EMDR with other approaches as an intervention for this population?
13. Is there anything you think could help therapists when using EMDR in the future with this client group?
14. Are there any other things you think therapists should consider when supporting clients with psychosis when using this approach?
15. Is there anything else you would like to tell me that we've perhaps not talked about, that might be important for me to know?

The codes and themes were discussed regularly with the research team. Step four involved generating mind maps to explore links between themes; the research team collated themes that were then checked against the coded extracts and original transcripts to ensure they were compatible. Within the fifth step, all authors further refined themes to ensure as much as possible they were reflective of the data collected, linked to the research aims and questions, yet different enough that they were distinct conceptually. In addition to this, themes were defined and given names. Finally, during the sixth step, the results were written up. A thematic map was formed (see Figure 1), themes were organized into a coherent story which was representative of the data, and direct quotes were also selected to illustrate each theme. This process was facilitated using Nvivo version 12 software (QSR International Pty. Ltd., 2018).

Throughout the analysis the authors reflected together on the influence of their assumptions and biases, including their perspectives of EMDR and their understanding of psychosis.

Results

Participant Characteristics

Twenty (5 male, 15 female) therapists took part in the study. Participants estimated they had worked with between one and 32 clients experiencing psychosis using EMDR ($M = 10.10$, $SD = 9.83$). The length of time practicing this intervention with this client group ranged from 1 to 10 years ($M = 2.78$ years, $SD = 2.26$ years). Participants worked in a variety of outpatient settings, including, Early Intervention Psychosis Services ($n = 8$), Adult Community Mental Health Teams ($n = 4$), Traumatic Stress Services ($n = 4$), and Psychosis Community Services ($n = 3$), and Private Practice ($n = 3$). See Table 2 for participant characteristics.

Key Themes

Four themes and 11 subthemes, distinct yet related to one another, were generated. Main themes were familiarity with psychosis and EMDR, keeping key therapy principles in mind, the importance of systemic factors, and acceptability of EMDR. Emphasis was placed on facilitators and barriers to using EMDR with people experiencing psychosis. These were explored within themes, as were how therapists view EMDR, compared to other interventions. The interrelationships between the themes are presented within a thematic map (see Figure 1).

This diagram shows how the main overarching themes (depicted in grey boxes) are related to subthemes through the use of arrows to demonstrate

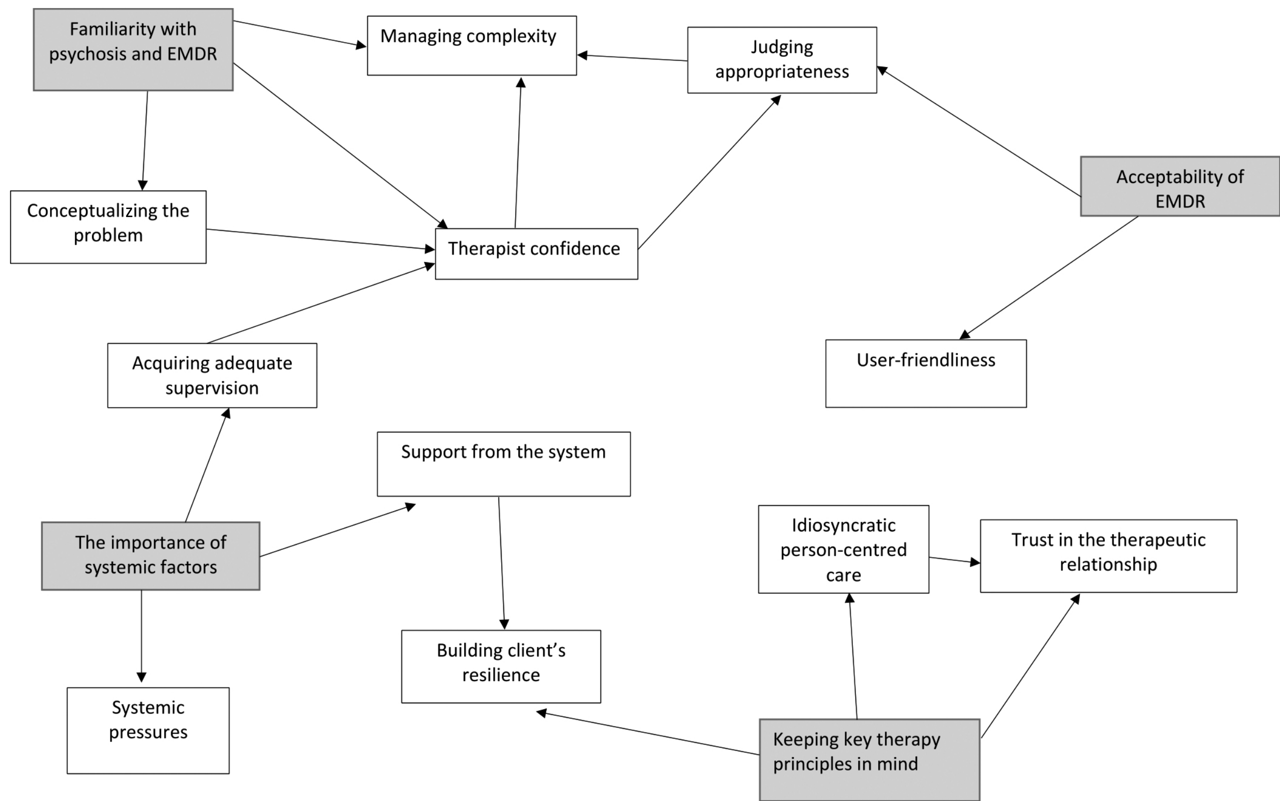

Figure 1. Thematic map.

TABLE 2. Participant Characteristics

Participant number	Gender	Current job title	Length of time practicing EMDR with clients experiencing psychosis
P1	Female	Clinical Psychologist	1yr 6 m
P2	Female	Clinical Psychologist	5yrs
P3	Female	Clinical Psychologist	1yr 6 m
P4	Female	Senior Clinical Psychologist	2yrs 6 m
P5	Female	Clinical Psychologist	1yr 5 m
P6	Female	Clinical Psychologist	4yrs
P7	Male	Integrative Psychotherapist	1yr
P8	Female	Clinical Psychologist	1yr
P9	Male	Clinical Psychologist	2yrs
P10	Female	Senior Cognitive Behavioral Psychotherapist	1yr 3 m
P11	Male	Cognitive Behavioral Psychotherapist	4yrs
P12	Female	Clinical Psychologist	6 m
P13	Female	Senior Clinical Psychologist	1yr 6 m
P14	Male	Senior Clinical Psychologist	3yrs
P15	Female	Principal Clinical Psychologist	1yr 6 m
P16	Female	Systemic Psychotherapist	1yr

(continued)

TABLE 2. Participant Characteristics *(continued)*

Participant number	Gender	Current job title	Length of time practicing EMDR with clients experiencing psychosis
P17	Female	Senior Cognitive Behavioral Psychotherapist & EMDR Consultant	6yrs
P18	Female	Principal Counseling Psychologist	5yrs
P19	Female	Clinical Psychologist	2yrs
P20	Male	Senior Cognitive Behavioral Psychotherapist & EMDR Consultant	10yrs

the direction of this connection. Some subthemes were also linked to other subthemes, which demonstrates how different themes become interrelated with one another. For example, from the overarching theme "Familiarity with psychosis and EMDR" emanates "managing complexity;" this in turn impacts on "acquiring adequate supervision," which stems from the overarching theme "The importance of systemic factors," therefore linking the two main themes together.

Theme 1: Familiarity With Psychosis and EMDR. Therapists expressed the importance of having experience working with individuals experiencing psychosis, reporting that this helped when formulating and provided a greater understanding of how EMDR could be relevant. This population often presents with greater complexity, and experience of how to manage commonly arising difficulties was thought to facilitate the intervention. Some participants suggested that this complexity, combined with a newer intervention, can lead therapists to feel less confident about its use.

Therapist Confidence. Concerns were expressed that EMDR could inadvertently exacerbate clients' difficulties, leading to significant consequences involving risk to self:

> *I have been a bit hesitant about doing it because of people's stability, thinking is this going to destabilize them, because invariably our clients often self-harm or are high risk of various things. (P3, Clinical Psychologist)*

Some participants described not fully understanding the mechanisms underpinning EMDR. Currently there is not a well-developed evidence base for EMDR and psychosis, which led to concerns over its safety relative to other interventions:

> *What happens if EMDR goes wrong? What would wrong look like? There's a lot more unknowns. Whereas if someone suddenly destabilises in another form of therapy, oh that's because of X and Y. (P13, Senior Clinical Psychologist)*

Confidence was related to both having experience in working with psychosis and the intervention. More experience with psychosis led to greater confidence in EMDR:

> *I think those practitioners, yeah, terrified of people with psychosis having a relapse. We are much more casual about it because our client's relapse, it happens all the time. If we weren't going to do anything because we're scared of somebody relapsing, we would never do anything. (P4, Senior Clinical Psychologist)*

Less confidence with the population was a barrier to EMDR being implemented. Some participants viewed this as problematic because they believed the intervention might be of use in helping clients, with concerns over risk and safety being misplaced:

> *The reluctance to go over this is with professionals involved in their care because of again previously misunderstood risk. (P20, EMDR Consultant & CBT Therapist)*

Conceptualizing the Problem. Therapists indicated their understanding and knowledge helped when conceptualizing individuals' presenting problems. This enabled them to see the relevance of EMDR,

providing confidence that the intervention would be of use. Interestingly, some felt that the wider therapist community might be unaware of the applicability of EMDR for this population:

> *On my first day of training in EMDR, they were asking what do people think will be blocks in using EMDR and people were saying maybe learning disabilities or autism, and somebody said psychosis . . . People obviously think it is not for people with psychosis, whereas having worked in it for a little while, wow, trauma is a massive issue in psychosis, for me they are indistinguishable almost. (P15, Principal Clinical Psychologist)*

Multiple therapists expressed that understanding trauma and its relationship to psychosis is highly important. They explained that it could be beneficial to communicate aspects of the formulation to both colleagues and service users in order to demonstrate the usefulness of EMDR:

> *Understanding of trauma as being very key in many people's experience is really important, that understanding and narrative is shared with people in our service. For the service users themselves, that general formulation of trauma in psychosis being related is very helpful. (P18, Principal Counseling Psychologist)*

Therapists often said they would draw on knowledge and understanding of trauma, dissociation, and psychosis when building a formulation of the individuals presenting difficulties and this informed the relevance of EMDR:

> *We know about the incidents of trauma people with psychosis experience, the higher rates of sexual abuse etc. You have to draw quite widely on the literature on dissociation. (P2, Clinical Psychologist)*

Managing Complexity. Therapists said that clients are more likely to present with greater complexity, including dissociation and positive symptoms of psychosis. They shared the importance of having an awareness of common difficulties and possessing skills to manage these. Optimistically, therapists described that this was achievable. This appeared to relate to therapist confidence and how appropriate they deemed EMDR. Among therapists, dissociation was perceived to be the main presenting complexity:

> *There's really, really high levels of dissociation in my population. A lot of the basic training doesn't really talk about how to manage people with really high levels of dissociation and people who've never really allowed themselves to feel. (P13, Senior Clinical Psychologist)*

Complexities encountered were not necessarily viewed as criteria for exclusion. Therapists thought carefully at each phase of EMDR to identify how to best support clients with their individual needs:

> *Just a potential for distraction if you've got active voice hearing at the same time. It's about having conversations within your stabilisation phase of work with people around coping with that and ensuring that they've got their strategies to keep them in their window of tolerance. (P2, Clinical Psychologist)*

Participants viewed those experiencing psychosis as likely to encounter difficulties in their home environment, for example, social difficulties, financial difficulties, and substance misuse. It was suggested that individuals might require support with these problems in order to safely engage in EMDR:

> *Do they have permanent shelter and housing? What is their level of risk like, are they using drugs and alcohol to manage their symptoms? All of those things can affect other client groups as well, but I think particularly with people with psychosis. They might be more likely to experience marginalisation and isolation which then makes them more likely or more vulnerable to using substances, so that's always something you have always got to be ready to manage. (P5, Clinical Psychologist)*

Theme 2: The Importance of Systemic Factors. Having a supportive system surrounding the therapist and client facilitated the implementation of EMDR. Therapists highlighted challenges in obtaining supervision from an experienced supervisor, explaining it is an essential requirement for safe clinical practice. Some participants mentioned that supervision boosted confidence in using the intervention. Support from the multidisciplinary team (MDT) and

the client's personal network of support was also emphasized as key to facilitating the intervention. Further to this, systemic pressures were sometimes viewed as a barrier to implementing EMDR.

Acquiring Adequate Supervision. Those with expertise supervising in this area were not easily identifiable. It often took therapists time to secure appropriate supervision. Many therapists explained the importance of the supervisor having experience of working with psychosis and EMDR:

> *None of the EMDR supervisors would take us on because they were saying that they didn't have experience in psychosis. Nobody would take us on and then eventually [an experienced supervisor] took us on. (P4, Senior Clinical Psychologist)*

Therapists said it was not always possible to access a supervisor with experience in working with psychosis; that being so, it felt helpful if the supervisor had at least some knowledge of this client group. Supervision was also viewed important in building confidence:

> *Supervisors may not have come from a psychosis background, so having knowledge of the evidence-base around psychosis, or the theoretical basis for using EMDR with psychosis would be good. There's a confidence that is necessary and as a new therapist that won't necessarily be yours, but supervisors can help you to develop it. (P18, Clinical Psychologist)*

The usefulness of peer supervision was also expressed, particularly when challenges occurred procuring specialist supervision:

> *It's important to be able to at least do some good peer supervision and try and link in and share resources and support one another, because the work is quite draining and tough. It can lead to quite a lot of therapist stress. (P14, Senior Clinical Psychologist)*

Systemic Pressures. A barrier to using EMDR therapy was pressure from the system. As EMDR is not currently a routinely employed intervention for this population, therapists felt less confident using it, due to fears that it may be potentially harmful:

> *From an EMDR community perspective, you don't have to travel back too far to see a general reluctance to use EMDR with psychosis. Back then it was probably for good reason, because what we don't want to do is do more harm. I think the more that we understand psychosis and experience of psychosis, the more that we understand EMDR, the more confidence we can get using the approach with service users that traditionally would be excluded from this approach. (P20, Senior Cognitive Behavioral Therapist & EMDR Consultant)*

Several therapists expressed that their service placed emphasis on other interventions with a stronger evidence base; this deterred therapists from employing EMDR. Interestingly, some therapists believed that despite this, colleagues had noticed benefits of the intervention:

> *CBT or family work gets noticed and recorded for audits, but my EMDR work doesn't go anywhere, so my service doesn't recognise or notice it. On the ground I know my team value it because they can see what's happening with people. (P18, Principal Counseling Psychologist)*

Some therapists explained that they experienced resistance from other colleagues when attempting to use EMDR. Conflicting views about the conceptualization of psychosis among colleagues is suggested to have led the intervention to be perceived as less useful:

> *It was a [colleague] who said, no that's a delusion, it's not a trauma memory, and for me, the difference. I struggle to understand the kind of differentiation and actually at that point it it was suggested that I didn't proceed. (P2, Clinical Psychologist)*

Support From the System. Connected with building client resilience, gaining support from the wider MDT when providing EMDR appeared to be valued by therapists. The MDT was seen as adding an extra layer of scaffolding to ensure the clients were resilient enough to engage in therapy. This allowed participants to feel more confident using intervention. Some therapists mentioned they would not feel as comfortable using EMDR without this support:

> *I would be hesitant to offer it to someone who didn't feel well engaged with the team more widely, their care co-ordinator etc. Also, thinking about risk generally, and particularly in the face of reprocessing, when that starts it can lead to a brief period*

of things potentially getting worse. (P12, Clinical Psychologist)

Participants said support from the wider team was perhaps central to delivering EMDR therapy. Interestingly, this was perceived as a facilitator for success with those experiencing psychosis outside of the United Kingdom:

People that we're working with currently have care co-ordinators but in my other job we haven't got care coordinators. People haven't got those things and I think a lot of where the current research is coming from is Holland, most of its coming from where they work. They work in more inpatient and settings or they've got these wonderful intensive clinics. (P10, Senior Cognitive Behavioral Therapist & EMDR therapist)

Taking time to support the client in building a support system was also highlighted as important; this often consisted of support worker, friend, or family member. This was seen as crucial due to potentially challenging personal circumstances that may need addressing before therapy can safely commence:

It's very helpful if there is a friend or another professional, a social worker or somebody that's also holding the client in some way so that you can focus on the therapeutic work, because otherwise it's difficult and understandably gets derailed with many social difficulties, finance difficulties. (P6, Clinical Psychologist)

Theme 3: Keeping Key Therapy Principles in Mind. Therapists explained elements of therapy related to use of EMDR and psychosis are not dissimilar to when working with other client groups. Therapists explained the importance of a strong therapeutic alliance and building clients' resilience before embarking on trauma therapy.

Idiosyncratic Person-Centered Care. Some therapists spoke about tailoring EMDR to suit individuals' idiosyncratic needs, rather than adapting the standard protocol simply because the client experiences psychosis:

Everybody that I get through this door is a different individual. They've got their own different quirks and their own different thoughts and feelings and difficulties. It's very important, the module, the history taking and building resources, but can be very different. (P17 Senior Cognitive Behavioral Psychotherapist & EMDR Consultant)

Several therapists spoke about the importance of being responsive to the client, listening, and taking time to understand difficulties. Being attentive to the individuals' idiosyncratic needs also guided the intervention:

Within the first couple of sessions you will get a sense of the person and then collaboratively working with them, they'll tell you whether they're feeling overwhelmed and aren't able to manage. (P14 Senior Clinical Psychologist)

It was mentioned that it is important to adhere to standard EMDR protocol; however it should not be applied inflexibly:

Problems come when you try and use a manualised approach with psychosis; it should be used as a guide. (P7, Integrative Psychotherapist)

Trust in the Therapeutic Relationship. Spending more time on building a trusting therapeutic relationship was considered necessary before embarking on processing when using EMDR with this population:

You take your time to engage a psychosis client, whether you're doing CBT for psychosis or whatever, you take your time to build a relationship, to get them feeling comfortable and safe and trusting. (P19, Clinical Psychologist)

Paranoia can occur when working with those with psychosis. For this reason, therapists spent more time building a trusting relationship:

They might have had a lot of awful experiences in the past where they've been let down or . . . So, sometimes you do find that paranoia can be a bit of a problem, so developing that relationship can take a little bit longer. (P17, Senior Cognitive Behavioral Psychotherapist & EMDR Consultant)

Therapists described providing a rationale to explain the benefits of EMDR, using simplistic and relatable language. Validating adverse previous

experiences was said to foster the therapeutic relationship and facilitate engagement:

> *If I start talking to my client about the prefrontal cortex or amygdala then it's just going to lose them straight away. You need a really good working-class explanation for your work. Just normalising our clients, validating that experience is so important. (P11, Cognitive Behavioral Psychotherapist)*

Building Client Resilience. Therapists said that client resilience is attended to when using EMDR, particularly during the preparatory phase when stabilization techniques are introduced. This phase of therapy was viewed as helping to ensure that clients felt safe enough to engage in processing, while preventing symptoms from worsening. Building clients' resilience through stabilization techniques was also linked with managing the complexity of dissociation:

> *Underpinning psychosis is somehow a feeling of not being safe, a feeling of being under threat. Perhaps in psychosis it would be especially prudent to not rush the stabilisation stage and get some good grounding skills in there. (P1, Clinical Psychologist)*

Therapists discussed previous research where stabilization strategies were not used. There was confusion and uncertainty around whether this would suffice based on their own experience. Some therapists explained this has led to differences in practise:

> *There seems to be a bit of a split within the field at the moment of those that are looking to boost the resourcing and do a lot of safety work, grounding and resourcing and those that seem to be just diving straight into the heart of it and kind of trying to get people to process. I've even seen clinicians locally who I work with who kind of vary in that way that they work. It seems to be a little worrying that there is quite a difference in perspective about how much preparatory work and resourcing you do. (P14, Senior Clinical Psychologist)*

The majority of therapists were concerned that it could be detrimental to any client if stabilization techniques were left out:

> *In the UK, we need to make sure that the person is stable and has sufficient resources to start processing, whether it's psychosis, or something else. (P9, Clinical Psychologist)*

Some therapists explained that stabilization techniques were helpful, yet they would not necessarily spend additional time on the preparatory phase. These therapists explained that any changes to standard protocol were tailored to the client's idiosyncratic needs:

> *I wouldn't say that I do more stabilization because it's psychosis. There are quite a few where we just get going almost immediately, but certainly if somebody had particular issues around current safety, or inability to attend. (P18, Principal Counseling Psychologist)*

Theme 4: Acceptability of EMDR. Beliefs surrounding the acceptability of EMDR for clients experiencing psychosis varied in terms of how and when therapists deemed the intervention appropriate. Promisingly, all therapists observed benefits to clients during clinical practice, regarding its user-friendliness and the reduction in frequency of clients' symptoms. Therapists also described enjoying the ease of use comparative to other interventions.

Judging Appropriateness. Differences were present in therapists' descriptions of when EMDR felt acceptable to use. Closely linked to having less confidence, some therapists expressed that when a client was actively experiencing positive symptoms of psychosis, for example, hallucinations or delusions, their condition would not be stable enough to engage in EMDR:

> *I might be a bit more cautious if anomalous experiences, or beliefs were present for them. (P2, Clinical Psychologist)*

Some therapists expressed concern that some of symptoms of psychosis, for example, voice hearing, may interfere with the therapy creating a barrier to engaging in the processing stage of therapy:

> *You could get the voice interfering with the processing, that would be my worry. (P8, Clinical Psychologist)*

Concern was raised about the appropriateness of using EMDR with those acutely unwell, with therapists explaining difficulties may occur when forming a robust therapeutic relationship. Interestingly,

therapists that expressed feeling hesitant about using the intervention when positive symptoms manifested, stated their beliefs were based on conjecture not knowledge:

> *They have not been actively psychotic whilst we have been doing therapy, so they have been in quite a stable condition while we embarked on therapy. I do know there has increasingly been some research around doing brief EMDR in acute settings. I think it's too early to tell, and there are some questions and queries about how effective that might be in terms of been able to establish, realistically a strong enough relationship particularly if someone has been acutely unwell recently. (P5, Clinical Psychologist)*

There was variation in therapists' thresholds for what they considered stable enough to engage in EMDR. Most worked with individuals experiencing positive symptoms at the time of the intervention. In some cases, this led to a reduction in the frequency of these symptoms:

> *People have presented with active voice hearing, which had very clear links with past traumas, so that was more of an obvious direct view. You treat with the EMDR and the voices went away. (P2, Clinical Psychologist)*

Some therapists shared their surprise at the success they had in using EMDR with clients experiencing voice hearing whilst using the intervention:

> *It just moved on to something else and the voices went away again. So, we just accepted that the voice hearing was part of the stuff that was coming up as part of processing the trauma that we were working on. It was quite a revelation for me that you could do that and the voices would come in and out. (P9, Clinical Psychologist)*

User-Friendliness. All therapists identified benefits to themselves and clients when providing EMDR therapy. They described the ease of use regarding the intervention, which was enjoyable for therapists to use, while leading to positive outcomes for clients. The blind therapist protocol was repeatedly described as a benefit of this approach. This protocol allows clients to engage in EMDR without verbalizing the content of their traumatic experiences. Therapists said that this felt kinder to the clients if they found their experiences distressing to repeat, or did not wish to share their experiences due to shame:

> *You can be really upfront from the beginning that we can do the blind therapist protocol, you don't actually have to tell me any of the details of your experience. As long as I know that there's some kind of change going on, so the person doesn't have to go over and over again, telling me about the worst things that ever happened to them. (P13, Senior Clinical Psychologist)*

The blind therapist protocol was thought to provide less opportunity for vicarious trauma to occur from listening to a client's experiences. EMDR was also deemed less demanding for clients due to the lack of homework that is common with CBT:

> *There's no homework, there's less, I don't know, it just doesn't seem to be so much hard work for the clients, and maybe for the clinician too. (P3, Clinical Psychologist)*

Therapists explained that EMDR can be implemented more flexibly with trauma memories. This benefit of EMDR was recognized as attractive, sometimes making it the preferential intervention:

> *With trauma Focused CBT, often it will be a specific, with the reliving you have to focus on a specific event. With EMDR you start with a specific event, but sometimes it ends up going into other things. So, I think it feels like it is going to be a bit more generalisable and it allows them to make sense of other things so I quite like that. I think that would probably be my preferred model. (P8, Clinical Psychologist)*

Therapists shared that clients are able to take more control in guiding the therapy comparatively to other interventions. Encouragingly, therapists described being enthusiastic about EMDR and spoke of witnessing promising outcomes. However, therapists were clear in highlighting that the intervention does not completely eliminate distress for all clients:

> *For some people it's maybe not that much of a dramatic improvement, but they have found it okay and quite like it. They really like that they have got a lot of control over the process and it's not me*

> *interfering, it's less of the talking. (P9, Clinical Psychologist)*

Therapists also explained that the fast pace of processing led to quick reductions in distress in some cases:

> *When it works, it works really well; what struck me with EMDR is, helping people to process the traumatic memories quickly, quicker than some other ways. (P16, Systemic Psychotherapist)*

Discussion

Confidence in using the intervention was variable and related to familiarity with the population and EMDR. Those with less confidence consistently cited concerns of symptoms escalating during therapy. Previous research has also found therapists hold concern that trauma therapies will intensify symptoms of psychosis (Frueh et al., 2006). Furthermore, it has been suggested that those unfamiliar with psychosis assume clients will not be able to manage during EMDR (Van den Berg et al., 2013). Participants described that their conceptualization of the problem provided them with confidence of the interventions' relevance.

Keeping therapy principles in mind was perceived as important; this was related to managing the complexity that can arise when working with this population. Therapists expressed stabilization techniques are necessary to support clients in building resilience to safely engage in therapy. Adams et al. (2020) also questioned the appropriateness of the lack of stabilization techniques in studies predominately conducted within the Netherlands, particularly as symptoms of psychosis have been found to escalate at the beginning of therapy (Kratzer et al., 2017). Such differences in practice and perspectives may be explained by mental health care systems differing across countries, or perhaps different cultural needs. Further research is required to provide therapists with guidelines and tested protocols within the United Kingdom; more specifically, studies evaluating the importance of stabilization strategies within the preparatory phase of the intervention.

Spending time focusing on forming a strong therapeutic relationship was regularly mentioned. Previous research has found that essential to working with those experiencing psychosis is developing a therapeutic alliance where the person feels safe, and failure to do so may lead to disengagement (Leonhardt et al., 2015). Earlier studies also state that building the relationship takes more time for this population (Frank & Gunderson, 1990). Further to this, clients with psychosis have emphasized the importance of trust in clinicians (Allard et al., 2018).

One limitation facing many therapists was procuring an experienced supervisor. Supervision held a pivotal role in facilitating therapist confidence in providing EMDR, as has been reported elsewhere in studies investigating CBT and psychosis (Shafran et al., 2009). The importance of the system surrounding the therapist and client is consistent with previous findings. Wood et al. (2019), for example, explored psychologists' perspectives of therapy with those experiencing psychosis, finding that personal social networks and mental health teams are essential to facilitating psychological interventions. Adams et al. (2020) also highlighted the need of support from the MDT when using EMDR with this population.

An overarching theme was that therapists viewed the EMDR intervention as acceptable, with all witnessing benefits. This finding supports previous research stating EMDR therapy is feasible for service users experiencing psychosis (Adams et al., 2020). In some cases, therapists reported that the intervention led to a reduction in distress and positive symptoms. However, there are contrasting views regarding when it is appropriate to use, which appears closely linked with confidence. Concerns were raised that positive symptoms of psychosis might interfere with therapy, or that the client would not be stable enough to engage, a narrative consistent with that reported elsewhere (Prytys et al., 2011). This is likely not an EMDR-specific problem; Hazell et al. (2018), for example, investigated CBT for psychosis and found that many therapists held ambivalent attitudes toward psychotic experiences and were not confident in their ability to manage difficult emotions and beliefs. Despite these concerns, the intervention was viewed as preferential in many cases, compared to other interventions.

Strengths, Limitations, and Future Research

To the best of our knowledge, this was the first peer-reviewed UK qualitative study exploring the use of EMDR with psychosis. We examined the views of therapists from a range of core professions, generating novel insight into the views of those applying EMDR with this population.

However, therapists self-selected to participate and felt that EMDR was an important, feasible intervention. Those with less positive views and experiences may not be represented. Moreover, no therapists working within inpatient settings participated, perhaps reflecting that the intervention is seldom used within acute care. However, as previously stated, research within inpatient settings with those experiencing psychosis, although limited, supports its use within this context (Kim et al., 2010; Kratzer et al., 2017). Further research is needed to investigate whether differences exist regarding the use of EMDR therapy for clients experiencing acute phases of psychosis.

Implications for Clinical Practice

- EMDR appears a feasible intervention to use with clients experiencing psychosis and has been highlighted as user-friendly for therapists.
- Familiarity with psychosis and EMDR can foster confidence in its use and managing complexity.
- Accessing specialist training in working with psychosis and EMDR for those less experienced may be useful. Therapists could also benefit from special interest groups to share information and expertise, while providing a space for peer support.
- Supervision from an expert, preferably who has experience in working with EMDR and psychosis, is important; this can help to bolster therapist confidence.
- Support and understanding of the therapy's relevance from the wider MDT is essential. Educating staff on the link between trauma and psychosis should be considered key to increasing the intervention's value for this client group.
- It remains crucial to keep key therapy principles in mind; this is particularly important when deviating from standard protocols. This also appears necessary until more evidence is available on the optimum level of stabilization techniques necessary when using EMDR with this population.

Conclusion

This study explored therapists' experiences of using EMDR with clients experiencing psychosis. Key themes related to the topic were generated: familiarity with psychosis and EMDR, acceptability of the intervention, the importance of systemic factors, and keeping key therapy principles in mind. Insight was provided regarding benefits of the intervention in terms of its user friendliness. Adequate supervision was perceived crucial to building therapist confidence when working with psychosis using EMDR. Further clarity is still required regarding the need for stabilization techniques and when the intervention is contraindicated. The findings contribute to the ongoing paradigm shift that those experiencing psychosis need not automatically be excluded from trauma therapy.

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Correspondence regarding this article should be directed to Rebecca Phillips, Trainee Clinical Psychologist, Shackleton Building (Building 44), University of Southampton, Faculty of Environmental and Life Sciences, Highfield Campus, Southampton, Hants, England SO17 1BJ. E-mail: rep1u18@soton.ac.uk