EMDR for Survivors of Sexual and Intimate Partner Violence at a Nonprofit Counseling Agency

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Trauma related to sexual violence and intimate partner violence (IPV) affects millions of women, resulting in detrimental impacts to economic, physical, and mental health. Survivors are often subjected to repeated acts of violence or abuse, compounding the trauma and its effects. Participants in this mixed-methods research study included 41 women who experienced trauma related to sexual violence or IPV and were seeking counseling services at a nonprofit community agency. Quantitative assessment of depression, anxiety, and posttraumatic stress disorder (PTSD) through validated measures showed statistically significant improvement in all areas after eight sessions of eye movement desensitization and reprocessing (EMDR). Qualitative analysis through semi-structured individual interviews revealed improvements in assertiveness, self-control, functionality, and self-acceptance. Increasing access to EMDR across underserved communities, which are disproportionately affected by trauma, is discussed.

Keywords: sexual violence; intimate partner violence; EMDR; nonprofit counseling

While 8 million adults in the United States experience posttraumatic stress disorder (PTSD) in a given year, women are 50% more likely to have PTSD in their lifetimes than men (Tolin & Foa, 2006). The most common cause of trauma for women is sexual assault or child sexual abuse (Tolin & Foa, 2006), and approximately 25% of women have experienced physical violence, contact sexual violence, and/or stalking by an intimate partner (Smith et al., 2018). The impact of violence against women has accelerated during the COVID-19 pandemic, with reports from across the United States showing significant increases in 911 calls and arrests related to domestic violence (Boserup et al., 2020). Despite this increase in violence, there have been fewer victims receiving treatment services (Gosangi et al., 2020). The financial consequences of the COVID-19 pandemic disproportionately affect lower-income adults (Horowitz et al., 2021), making affordable resources for underserved individuals even more crucial. Eye movement desensitization and reprocessing (EMDR) can be a more cost-effective treatment for trauma survivors than other recommended treatments, such as trauma-focused cognitive behavioral therapy (TF-CBT; Mavranezouli et al., 2020); however, many frontline practitioners at rape crisis centers are not aware of the strong evidence base for EMDR in treating survivors of sexual trauma who are experiencing PTSD (Edmond et al., 2016).

Monetary Costs of Trauma to Survivors and Society

Trauma caused by sexual and domestic violence comes at an enormous cost to society, as UN Women (2016) reported that the annual financial cost of violence against women globally is $1.5 trillion and $5.8 billion in the United States. For individuals surviving intimate partner violence (IPV), there is a lifetime cost of $103,767 per female survivor and $23,414 per male

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survivor, leading to a national economic burden of $3.6 trillion (Peterson et al., 2018). Sexual violence is even more financially burdensome, costing rape survivors $122,461 over their lifetime and totaling $3.1 trillion for the United States across 25 million adults who have been raped (Peterson et al., 2017).

Overall healthcare costs are three times higher for individuals with PTSD than those without PTSD, equaling approximately $35,000 more over a 5-year period, and making affordable and efficient treatment options critically important (Bothe et al., 2020). Productivity losses for individuals from marginalized communities are significantly greater, with IPV affecting 8.1% times as many black women, 2.5% as many Latinx women, and 10.4% as many Native American and Alaska Natives (Stockman et al., 2015). The impacts of PTSD on marginalized groups are compounded by other inequities in education, income, and healthcare, resulting in intersecting issues that intensify negative effects (Goodman et al., 2009).

Physical Costs of Trauma to Survivors

In addition to financial burdens, survivors with PTSD can also suffer physical effects such as increased rates of chronic pain, gastrointestinal disorders, and cardiovascular and neurological issues (Stockman et al., 2015). Mental and emotional impacts including stress, sleep disturbance, depression, and anxiety can be particularly salient for women who have experienced IPV (Chandan et al., 2020; Lagdon et al., 2014). Neuroimaging studies show that PTSD impacts brain responses (Bremner, 2002), with one study of adult women who survived severe childhood sexual abuse seeing a 5% reduction in left hippocampal volume (Stein et al., 1997). Women who have experienced PTSD as a result of IPV may deal with altered perceived threats, modified visual processing, and difficulty with regulation of their emotions (Neumeister et al., 2017).

EMDR as a Treatment Option

EMDR is a therapeutic modality developed by Francine Sharpiro in the late 1980s (Shapiro, 2018). Research has shown EMDR and TF-CBT to be the most effective interventions in reducing the severity of PTSD symptoms and have been identified as first-choice treatments to combat PTSD by the World Health Organization (WHO, 2013) National Institute for Health and Care Excellence (NICE, 2018) and International Society for Traumatic Stress Studies (ISTSS, 2019). EMDR seeks to free a client from their past trauma by unblocking dysfunctionally stored material and helping the client to adaptively assimilate memories. The goal, as Shapiro states it, is for us to be "informed by our memories, not controlled by them" (2018, p. 3). EMDR is built upon the adaptive information processing (AIP) model, which views the primary source of pathology as determined by early disturbing life experiences. Because we learn how to respond to disturbing scenarios based on past experiences, we repeat those responses, including in the case of our more recent trauma. EMDR therapy uses bilateral stimulation of the brain, typically using eye movements but also the use of auditory tones or physical hand taps, which activates the information-processing system. An EMDR clinician will work with the client to define the central source of the trauma, and use bilateral stimulation to decrease the intensity of negative cognitions, images, and affect, and increase the power of positive cognitions, images, and affect. In essence, the EMDR clinician helps the client activate the self-healing capabilities of their own brain (Shapiro, 2018).

Over 70 randomized control trials have established EMDR as an effective treatment for PTSD (Maxfield, 2019) across numerous populations, including disaster-bereaved individuals (Lenferink et al., 2017), individuals with bipolar disorder (Moreno-Alcázar et al., 2017), and survivors of sexual violence (Allon, 2015; Edmond et al., 1999; Rothbaum et al., 2005), domestic violence (Ehring et al., 2014; Jaberghaderi et al., 2019), and IPV (Mosquera & Knipe, 2017). Other therapies that have shown effective results in addressing PTSD among survivors of sexual violence, domestic violence, and IPV include prolonged exposure (Rothbaum et al., 2005), cognitive processing theory (Chard, 2005; Krupnick, 2009), STAIR/Exposure (Cloitre et al., 2010), STAIR-NST (Cloitre et al., 2012), and CBT (McDonagh et al., 2005). According to the NICE PTSD treatment recommendations, each of these therapies can be categorized as a form of TF-CBT (2018). Additionally, group interpersonal therapy was assessed specifically in the context of low-income female participants with PTSD related to interpersonal trauma (Krupnick et al., 2008). In comparing EMDR with TF-CBT, EMDR has shown similar impact to TF-CBT on PTSD symptoms, and similar or greater impact than TF-CBT with comorbid disorders, such as depression and anxiety (Maxfield, 2019). However, each treatment does not come at an equal cost of time to survivors, with EMDR requiring less treatment time and a lower mean cost than TF-CBT to effectively treat PTSD among adults (Mavranezouli et al., 2020).

Qualitative assessments of EMDR have highlighted the way participants experience symptom

reduction. In a recent systemic review of 13 qualitative studies assessing participant experiences with EMDR, a number of identified themes addressed the intrapsychic experience of EMDR (Shipley et al., 2021). The results of the 13 studies showed the following results: six studies demonstrated participants' increased understanding of the origin of their trauma; eight studies showed added perspective in which participants had a new view of the past; four studies identified getting at the core of the trauma rather than simply touching upon symptoms; and four studies identified transformative improvements in participant mental health (Shipley et al., 2021). Edmond and Rubin (2004) similarly found EMDR healing at the core, providing stronger trauma resolution than routine therapy at 18 months posttreatment. Six of the 14 adult female survivors of child sexual abuse who received EMDR treatment in their study obtained subsequent treatment, but only one did so focusing on the same target issue (Edmond & Rubin, 2004). A qualitative examination of EMDR addressing grief, compared with CBT, showed that both therapies led to increased insight, more positive emotions, and stronger self-confidence (Cotter et al., 2017). Uniquely, EMDR participants experienced distressing memories less clearly and vividly, and CBT participants experienced adoption of emotional regulation tools (Cotter et al., 2017). Multiple additional case studies demonstrate EMDR improving cognitive functioning, particularly related to participant's attention profile (Camacho-Conde, 2020; Aranda et al., 2015). In reviewing existing qualitative research, Marich et al. (2020) identified that a number of qualitative assessments specifically followed quantitative ones, reflecting a more quantitative orientation in EMDR research. They call for additional qualitative research that starts from a qualitative perspective, rather than a follow-up to quantitative findings.

The influence of the care setting has had limited exploration in existing literature. Many EMDR studies, which identified the setting of EMDR administration, were conducted in primary care (Marsden, 2016) or private practice outpatient settings (Naccarato, 2008; Wise & Marich, 2016). Of 13 qualitative studies of EMDR examined by Shipley et al. (2021) in a systemic review, the only study conducted at a nonprofit counseling agency was a pilot study conducted by the lead author of this article, which centered on the use of EMDR in treating survivors of sexual and domestic violence (Schwarz et al., 2020). In the current study, we sought to explore the effectiveness of EMDR with survivors of sexual violence and IPV in a nonprofit community agency, as there is limited evidence for the most appropriate and cost-effective treatments for PTSD in nonprofit counseling settings, particularly in low-resourced communities.

Purpose of Study

Considering the prevalence and effects of trauma due to sexual violence and IPV, which disproportionately affects women and underserved populations, it is essential that research is conducted to identify the most effective treatments to support survivors in their healing, particularly in communities which are historically under-researched and underserved. EMDR is an established treatment for PTSD in various populations, but there is a need for research focused on evaluating the effectiveness of EMDR with sexual and domestic violence survivors in nonprofit settings, particularly in lower-resourced communities. The purpose of this study is to expand the research in this area by examining the effectiveness of this modality with sexual and domestic violence survivors receiving counseling in a nonprofit setting. This study was conducted in a low-income community at a nonprofit counseling agency, where clients receive low or no cost services, in an effort to gain insight and information around the experiences of underserved populations with EMDR, a modality to which none of the participants previously had access. A mixed-methods approach was employed to capture both quantitative changes in symptoms and to qualitatively assess the meaning underlying those changes and their impact on participants' lives. The quantitative assessment was designed to objectively assess changes in anxiety, depression, and PTSD for participants after receiving EMDR, and the purpose of the qualitative assessment was, as Levitt et al. (2018) described, "to give a voice to historically disenfranchised populations whose experiences may not be well-represented in the research literature" (p. 28).

Methods

Procedure

Forty-one women who had experienced sexual violence and/or domestic violence were enrolled in the study at a nonprofit counseling agency in New Jersey. They received eight EMDR treatment sessions. Quantitative measures were completed immediately prior to and after treatment for all 41 clients. Fifteen

clients and all six counselors engaged in a posttreatment semi-structured interview, with data collected for qualitative analysis.

In this study, the first author served as the lead researcher who developed the research design and protocol, conducted all of the interviews and the focus group, and served as the liaison with the agency. The study received IRB approval from the researcher's college and approved informed consent paperwork was provided and explained to each participant. Only those who voluntarily agreed and completed the paperwork were included in the study. The lead researcher trained the director of counseling at the agency in administering the assessments, which she administered uniformly to each client–participant prior to their first EMDR session and immediately following their eighth session. To preserve the client's anonymity, the director assigned each client–participant a number, which was included on each assessment rather than their name. The second author/co-researcher assisted in scoring the assessments and analyzing the quantitative data. All participants were given the opportunity to participate in the qualitative interviews and 15 client–participants and all six counselor–participants elected to do so. The third author/co-researcher participated in transcribing interviews and analyzing the qualitative data.

Treatment

All counselor-participants were trained in standard EMDR protocol by the same EMDR instructor and completed the training in its entirety prior to the start of the study. None of the counselors had experience with practicing EMDR prior to working with the client–participants in the study. To assure fidelity to the model, counselors received ongoing consultation with an EMDR consultant throughout their administration of the modality during the study. The number of preparation, grounding, and trauma-processing sessions varied based on the needs of each individual client.

Participants

There were 41 client–participants and six counselor-participants.

Client–Participants. Participants included 41 adult female clients receiving services at a nonprofit counseling agency for survivors of sexual and domestic violence. Counselors identified both new and existing clients who would be appropriate to receive EMDR treatment and invited them to participate in the study. Participation in the research study was voluntary and did not affect access to treatment (i.e. there were clients who chose not to participate in the study, but still received EMDR treatment). Criteria for participation included (a) aged 18 or older; (b) a client at the agency; (c) identified as a woman; (d) experience of sexual and/or domestic violence as a primary reason for seeking counseling; (e) English or Spanish speaking. Forty-five clients met the criteria and agreed to participate in the study, and 41 client–participants completed the eight sessions of EMDR and the pre- and postassessments. The participants ranged in age from 18 to 60 and self-identified as African American ($n = 7$), Asian ($n = 1$), Biracial ($n = 1$), White ($n = 22$), and Latina ($n = 10$).

Counselor–Participants. The six counselors who administered EMDR treatment were all licensed mental health professionals (i.e., licensed professional counselors or licensed clinical social workers) working as full-time counselors at a nonprofit counseling agency for survivors of sexual and domestic violence. All of the counselors were women, ranging in age from 25 to 65 and self-identifying as Indian ($n = 1$), Latina ($n = 3$), and White ($n = 2$). Prior to the start of the study they completed EMDR training in its entirety. All counselors were trained by the same EMDR instructor and continued with consultation as they administered EMDR with client–participants. Based on their training, they offered EMDR to those clients whom they deemed appropriate to receive the treatment and invited them to participate in the study. All counselors participated in a semi-structured individual interview and focus group at the completion of the study, where they shared their perspectives on how EMDR had impacted their clients.

Quantitative Assessment

The following measures were administered to participants prior to the start of the first session and at the conclusion of the eighth session of EMDR: (a) Beck Depression Inventory (BDI-II); (b) Generalized Anxiety Disorder 7-item Scale (GAD-7); and (c) Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5). Spanish-language versions of each assessment were provided to clients whose primary language was Spanish ($n = 4$). The assessments were all conducted by the director of counseling services for the agency, who worked in conjunction with the lead researcher to assure uniformity in administration. Each client–participant was assigned a number

that was noted on the top of each assessment in lieu of their name to help protect their anonymity. The researchers scored all of the assessments and reported the data back to the agency in aggregate.

Beck Depression Inventory-II (BDI-II). The Beck Depression Inventory-II (BDI-II) is a 21-question self-report assessment that measures participants' depression severity. The measure has been shown to have a high degree of internal consistency with α ranging from .73 to .92, $M = .86$, and strong test–retest reliability ($\alpha = .93$; Yuan-Pang & Gorenstein, 2013). It also shows strong convergent validity with the BDI-I (r =.82–.94) and relatively high construct validity ($r = .66$–.86; Yuan-Pang & Gorenstein, 2013)

Generalized Anxiety Disorder Questionnaire (GAD-7). The GAD-7 is a research-supported, seven-item, self-report questionnaire that measures a participant's level of anxiety (Kertz et al., 2013). It has strong internal consistency ($\alpha = .91$) and convergent validity with other normed assessments for anxiety (Kertz et al., 2013). The GAD-7 can be used for measuring specific anxiety disorders such as social anxiety disorder, PTSD, and panic disorder (Lowe et al., 2008).

The Posttraumatic Stress Disorder Checklist (PCL-5). The PTSD Checklist (PCL-5) was used to measure participant symptoms of PTSD. The PCL-5 is a 20-question, self-report measure and is considered a valid measure for assessing the level of existing PTSD symptoms (Weathers et al., 2013). It has been shown to have strong internal consistency ($\alpha = .93$), convergent validity ($r = .82$), and divergent validity ($r = .64$; Ashbaugh et al., 2016).

Semi-Structured Interview

Development of Semi-Structured Interview. The semi-structured interview questions were developed by the lead researcher to facilitate discussion with participants around their experiences with EMDR. The development was informed by previous pilot studies at the agency and the protocol was used in a previous published study (Schwarz et al., 2020). The questions were all open-ended to allow for freedom of response without leading, and individualized follow-up questions were asked based on participant responses. All client–participants were asked the following: (a) What are your overall impressions of EMDR?; (b) What did you like and dislike about it?; (c) How was EMDR different from or similar to other counseling you have received?; (d) What was most beneficial to you?; (e) What changes, if any, did you notice in yourself?; (f) Is there anything else you want to share?

Counselor–participants were interviewed individually and in a focus group. They were asked the following questions: (a) What were your overall impressions of EMDR?; (b) What was it like for you as a counselor to administer this treatment approach?; (c) What did you learn?; (d) How did EMDR differ from traditional sessions with your clients?; (e) Do you think EMDR benefitted your clients? If so, how?; (f) What specific changes, if any, did you observe?; (g) Please comment on your clients' learning or growth.; (h) What haven't I asked you about that you would like to share?

Interviewers. All interviews were conducted by the lead researcher and first author of this article (J.S.), who has a PhD in counseling and is a professor at a public college in the same county as the nonprofit agency. The researcher had served as a research consultant for the agency in the past, and the agency director asked the lead researcher to conduct a study to help them assess the effectiveness of a new modality (EMDR) in which their counselors would be trained. Other researchers and coauthors were graduate students in the counseling master's program in which the lead researcher teaches. One of the coauthors (D.B.) participated in several of the interviews. Another coauthor (E.G.) participated in transcription and coding.

Provision of Semi-Structured Interview. Qualitative data was collected following the completion of all eight sessions of EMDR through semi-structured individual interviews with 15 client–participants and the six counselors who provided them with EMDR. The interviews were all conducted by the lead researcher (J.S.). All interviews were audio recorded and transcribed verbatim. During interviews, researchers utilized follow-up questions and interviewees were given opportunities to clarify their responses and ask questions. After transcription, interviews were analyzed for recurring themes using open coding and the constant comparative method. Through triangulation with four different researchers, along with reflexive journaling, audit trails, and member checking, researchers established trustworthiness and confirmability.

Quantitative Results

Pre- and posttest scores for all 41 participants were calculated, and a series of dependent t-tests were conducted to measure change in participants' depression, anxiety and PTSD symptoms. Results were analyzed using IBM SPSS v. 23. Because results from three assessments were analyzed, we corrected for the additional Type I error with a Bonferroni adjustment

TABLE 1. Paired Samples Mean Analysis With Effect Sizes

Assessment	*M* Pre-	*M* Post-	*t*	*df*	*p* (two-tailed)	ES	ES 95% CI
Combined results ($n = 41$)							
GAD-7	13.85	8.63	6.353	40	< .0001[a]	1.00	[.541, 1.459]
BDI-II	28.05	15.04	8.037	40	< .0001[b]	1.16	[.689, 1.625]
PCL-5	43.83	27.76	6.626	40	< .0001[c]	1.02	[.558, 1.478]

[a]$p = .000000151$; [b]$p = .000000001$; [c]$p = .0000000625$.

whereby the critical p value was set at 0.017. Effect sizes with 95% confidence intervals (CIs) were calculated using Cohen's d for within sample designs (Borenstein, 2009). Clinical significance was determined by the levels defined as significant by the criteria published for each of the three assessments. A change in participant score that resulted in a change in their category of depression or anxiety was deemed clinically significant, for example, a drop from "Severe" to "Moderate." For PTSD a change in score of more than 10 points was considered clinically significant. Details of the assessments and analyses are included below. Refer to Table 1 for a summary of all statistical analyses for the three assessments.

Depression

Statistical significance. BDI-II pre- and posttreatment assessments were scored according to the following criteria:. 0–10 "None;" 11–16 "Mild" Mood Disturbance; 17–20 "Borderline" Clinical Depression; 21–30 "Moderate" Depression; 31–40 "Severe" Depression; >40 "Extreme" Depression. Pretest scores ($M = 28.05$, $SD = 11.865$) were in the moderate depression range. After EMDR, posttreatment scores were in the mild range ($M = 15.04$, $SD = 10.448$), indicating statistically significant improvement in client symptoms ($t(40) = 8.037$, $p < .0001$). The effect size was large ($d = 1.16$). See Figure 1.

Clinical Significance. Overall, 78% of participants achieved clinically significant symptom improvement after eight sessions of EMDR. The mean score dropped by over 13 points. Nearly 20% of all participants who started with extreme or severe levels of depression reported mild or no depressive symptoms after EMDR. These results indicate a strong improvement in mood for many participants. Three women reported having severe symptoms of depression after the eight sessions of EMDR, indicating the need for further treatment.

Anxiety

Statistical significance. Statistical significance GAD-7 pre- and posttest results were scored according to the following criteria: ≤ 4 "None;" 5–9 "Mild" Anxiety; 10-14 "Moderate" Anxiety; ≥ 15 "Severe" Anxiety. Pretest levels of anxiety ($M = 13.85$, $SD = 4.720$) were in the moderate range. After EMDR, the mean score was in the mild range, below clinical levels ($M = 8.63$, $SD = 5.607$). These changes were statistically significant ($t(40) = 6.353$, $p < .0001$) with a large effect size ($d = 1.00$). See Figure 2.

Clinical Significance. There was marked improvement in participant anxiety levels after completing EMDR. For all participants, the mean score decreased by over 5 points. Approximately 63% of participants saw clinically significant improvement and 44% fell below clinical levels of GAD. Twelve clients, or nearly 30% of the 41 participants, reported a decline from "Severe" anxiety to "Mild" or "None," and 11 (26.8%) participants who began the study with some amount of anxiety reported none after EMDR. Nine women still reported severe symptoms of GAD after eight sessions of EMDR, indicating the need to consider further treatment.

Posttraumatic Stress Disorder

Statistical significance. The PCL-5 was scored according to the following criteria**:** A score of 32 and below is considered "Not Significant," while a score of 33 and above is "Significant" and indicates a need for treatment or referral. It is notable that the mean client score dropped from well above the threshold score of 33, indicating clinically significant PTSD ($M = 43.83$, $SD = 15.269$), to below the threshold after EMDR treatment ($M = 27.76$, $SD = 16.255$). The drop in mean scores was statistically significant ($t(40) = 6.626$, $p < .0001$) and the effect size was large ($d = 1.02$). See Figure 3.

Clinical Significance. From pre- to postassessment, mean scores decreased by over 16 points. Of the 41 participants, 61% experienced clinically significant symptom relief. It is important to note that nine women started the study without significant symptoms of PTSD. When accounting for those who started the study without significant PTSD symptoms and those who saw clinically significant improvement, after eight sessions of EMDR, approximately 38% of the participants still met the criteria for referral for

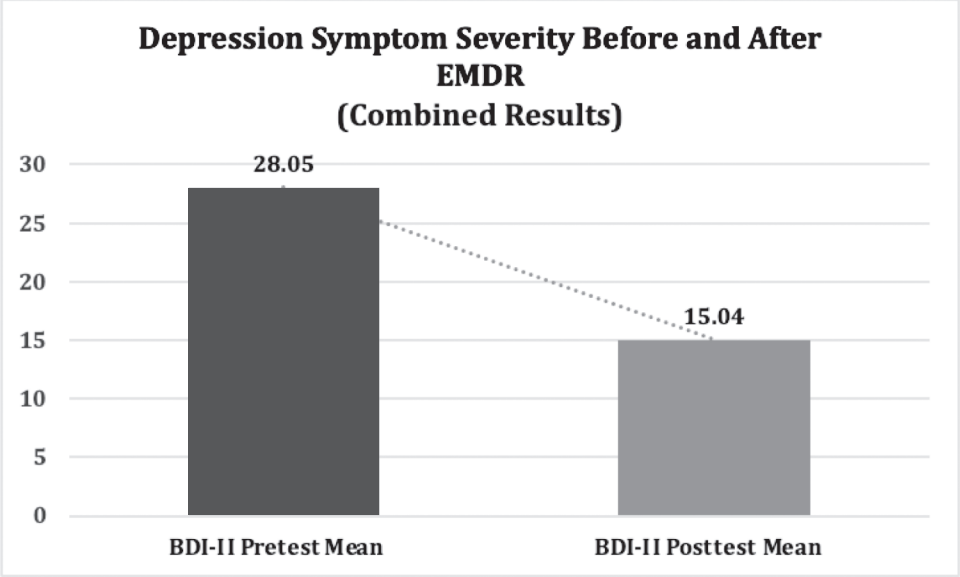

Figure 1. Symptom severity before and after EMDR. This figure depicts the decrease in average symptoms of depression for all 41 clients (dark grey bar represent pretest mean scores, and light grey bar represent posttest mean scores).

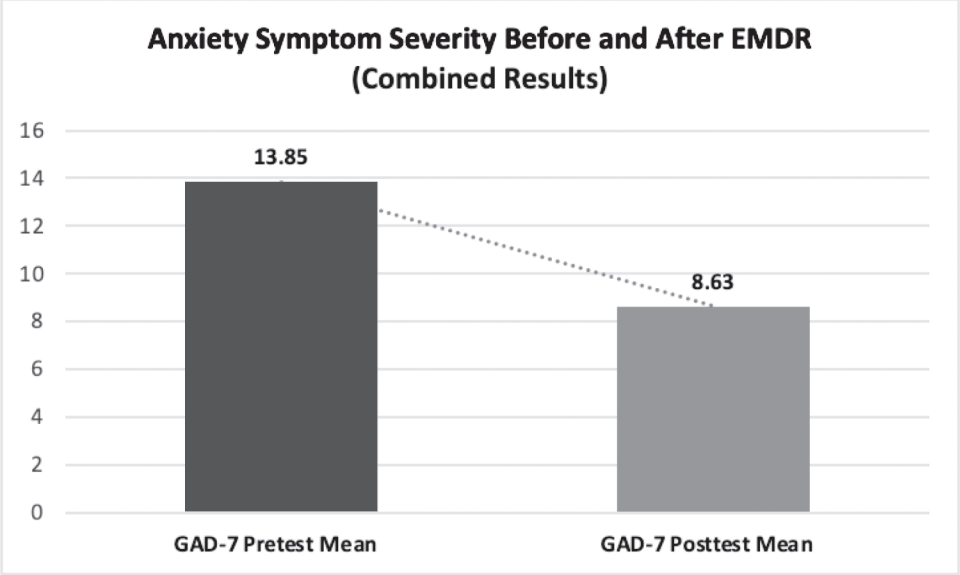

Figure 2. Symptom severity before and after EMDR. This figure depicts the decrease in average symptoms of anxiety for all 41 clients (dark grey bar represent pretest mean scores, and light grey bar represent posttest mean scores).

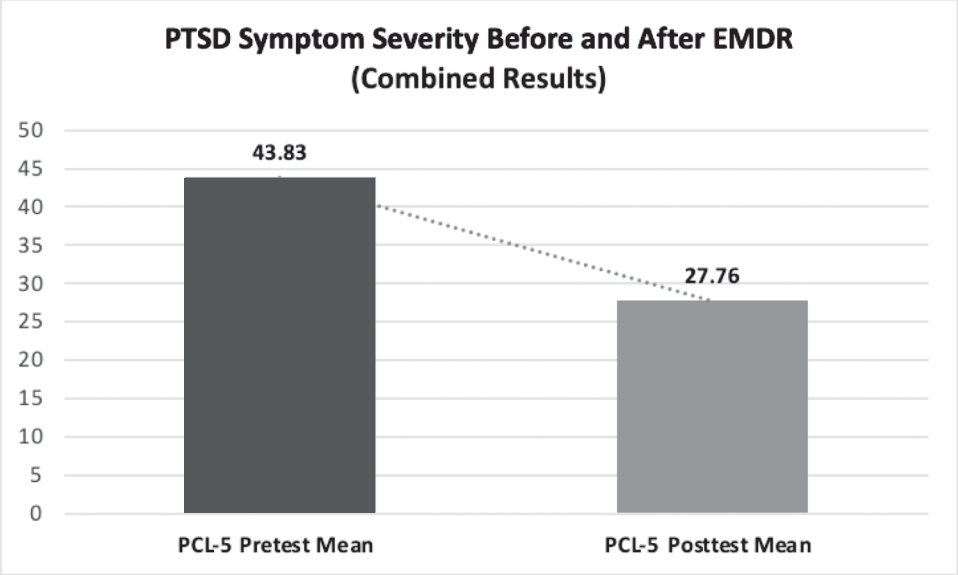

Figure 3. Symptom severity before and after EMDR. This figure depicts the decrease in average symptoms of PTSD for all 41 clients (dark grey bar represent pretest mean scores, and light grey represent posttest mean scores).

additional treatment. For these participants, this may indicate a need for additional EMDR sessions or other trauma-focused therapy.

Qualitative Results

Themes

In this section we detail the most prominent themes identified throughout client–participant and counselor–participant interviews. These themes are interconnected and provide a more complete and accurate understanding of the client–participants' experiences and counselor–participants' perceptions of EMDR. Overall, participants described being able to find their voices and assert themselves, thus enacting more control over their internal and external lives. The most notable themes included increased assertiveness, enhanced sense of control and self-regulation, improved functionality and cognitive capacity, and self-acceptance.

Increased Assertiveness. Every participant interviewed spoke about a newfound ability to assert themselves across a variety of settings and relationships. Participants described an increased ability to advocate for themselves, express painful emotions, and set and uphold boundaries in their relationships after EMDR. One participant described a longtime friendship in which she was now able to assert her needs. The participant shared:

> *I have a very good friend, and it was more of an "I gave" and "she took" relationship. So, I told her "look, I love you dearly, I'd do anything for you, but I can't any longer do this where you call me up and expect me to drop what I'm doing and just run in and help you and then you don't speak to me for six months." So I've never had that before . . . that ability to say to someone . . . "It's gotta be a two-way street."*

After years of not asserting themselves, participants stated that they could now express needs and confront others. As one participant explained, "I tend to let people walk all over me and not stand up for myself or say anything, but . . . I'm kind of done. I won't do that anymore and will actually say what's bothering me." Another participant also expressed that EMDR "has allowed me to stand up for myself more."

Portions of EMDR are dedicated to accessing emotions while processing negative stimuli. In advocating for themselves, participants shared they were able to express previously suppressed emotions and gain new strengths, as exemplified by one client who noticed a major change in herself:

> *I've always had issues expressing my emotions, so I think it really helped me deal with that and . . . it was like "this is what I'm feeling, this is what I've dealt with, this is what happened." You can't argue*

that because that's the way I feel.' . . . so I think it kinda emboldens me a little bit with sharing those things.

Another participant explained that EMDR helped her to more effectively communicate and assert her feelings with her mother. She recounted:

I was able to go and talk to my mom about how I was feeling as a little girl and the impact that her decisions had on me. I was never able to really get to the core of how that decision impacted me and literally was part of changing my being because of what I had to experience . . . and so hearing it this time, I was able to express it in a way that she understood.

This client and others stated that EMDR helped them to productively articulate their emotions to others in a way that promoted mutual understanding.

While EMDR appeared to help participants become more vocal, it also seemed to help them discover their internal voice. One participant explained, "You know, I have a voice and I can use it. When I use it appropriately . . . , it can be heard." Another client reported that EMDR helped her rediscover and redefine her voice: "I have my voice back in a different way, with a lot of perspective." Participants reported that this new perspective helped them prioritize their physical and emotional needs. One participant recognized the importance of allowing herself time to physically recover after experiencing an injury. Another participant recognized the need to observe her own emotional needs:

I need to do for myself first what is the best thing for me . . . and if I do that it will spread into other people. If you are constantly putting yourself on the bottom of the pile . . . , the most important relationship you have is with yourself.

In addition to reporting a greater awareness of their emotional and physical condition, participants reported an increased ability to assert their needs. One participant described her ability to "set boundaries"with her abuser as unprecedented:

I still see him, but I'm able to say "no." I'm able to place some boundaries on it that I was never able to before. That has to do with EMDR. . . . I don't feel bad when I say "no." I do what I want to do as opposed to constantly running and trying to do the right thing by him and trying to fix this and fix that. I have boundaries now.

Participants spoke about how EMDR increased their ability and willingness to say "no" with their abusers. The counselors noticed these changes in their clients as well. One counselor spoke of a client, saying, "She was able to face the abuser various times," whereas before the participant had deemed that impossible. Another counselor explained that a client–participant was able to set explicit boundaries and was surprised to learn her client had requested a restraining order against her abuser. She explained that after EMDR, "Something that they have struggled with . . . , that seemed impossible to them, has been accomplished."

Another participant described the difference as, "I'm recognizing that I want certain boundaries, and I'm recognizing that when people don't accept my boundaries that I can get enraged, when prior to that I might have just held it in." This participant reported an ability to set and reinforce boundaries when overstepped by others. She continued, "In general I'm just like no nonsense at this point." Another participant described her ability to speak out, even in new, unestablished relationships. She explained:

I have been talking to this guy and he made this joke about rape and I literally was just like, "we're done here." To me that's not funny because it's happened to me. And that's not okay. . . . So, in the past I would've just laughed it off, but . . . I told him I was done with it . . . and . . . I understand you don't know my boundaries, but a joke like that isn't funny. So I haven't talked to him since, which is okay by me.

She reported an ability to set and defend firm boundaries against others who did not understand their significance. Ultimately, she expressed an ability to identify and eliminate someone from her life who did not respect the boundaries she asserted. Overall, participants expressed feeling empowered to assert themselves. This reported, newly developed strength may have contributed to another prominent theme in clients' lives: their feeling of enhanced control and increased ability to self-regulate their emotions.

Enhanced Sense of Control and Self-Regulation. Fourteen of the 15 client–participants spoke of a new sense of control that emerged after EMDR treatment. They expressed an ability to settle their mind, react calmly to triggering situations, self-regulate spiraling emotions, and find an internal locus of control. They reported that EMDR helped them learn tools to exert control over both their external and internal lives. One participant explained, "I'm

taking control of my life and not letting things just happen." Another expressed, "It [EMDR] has given me a sense of control." Participants reported feeling "not defeated, not helpless" and gaining the ability to stop risky behaviors, reduce their reliance on anxiety medication, and actively make strides toward switching jobs in search of more fulfilling careers.

EMDR appeared to equip participants with tools to monitor themselves amid emotional and situational chaos, mirroring the fifth phase of EMDR in which traumatic or negative events are targeted and desensitized. One participant described her ability to use the resourcing she learned to "hold onto the joy" longer and longer after each session of EMDR:

> *As soon as something bad happens . . . I usually tumble right back down. [Now] I'm able to remember . . . that by hugging myself, and breathing, and thinking about it, and working with it. Yeah, I can hold onto it.*

This participant was able to control and maintain her joy by implementing grounding techniques learned in the preparation phase of EMDR. Another participant expressed that EMDR allowed her to manage everyday stressors with "breathing and tapping and visualizing" techniques.

Others expressed how EMDR created an internal place of refuge in moments of distress. During the second phase of EMDR, participants identify and visualize a real or imagined "safe place" that they return to throughout sessions when reprocessing trauma and moments of negative arousal. Each client's space provided a soothing environment individualized to their needs, as evidenced by their unique phraseology: for some a "safe place," for others a "calm place," and still others a "happy place." One client reported that her "happy place" helped her control her thoughts: "It [the trauma] kept coming back. So now being able to think about something else . . . , it reminded me how much I love to travel and things that I do like to do." Another participant explained that her "safe place" allowed her to cope with her everyday life:

> *I use it [the safe place] all the time. I use it . . . outside of here . . . when I'm struggling or I'm at work and I need to not deal with the things in my personal life. I can go to my safe place, center myself, and kinda get a handle on things again. . . . I know that everything is still crazy around me and I can't control that, but I can control . . . trying to protect myself from it.*

She expressed that EMDR helped her identify what she could not control and exert power over what she could.

Participants credited EMDR with helping them recognize and productively respond to emotions and triggers. One participant explained she had a better grip on her anxiety and an increased sense of self-awareness that allowed her to take control of the decision-making process for the better. She further explained that EMDR helped her recognize and accept negative emotions, without emotionally flooding. She described:

> *Instead [of] staying in a negative place, I can get myself out of it a lot more quickly. So that I can move on with the day. And that for me, that's pretty huge. . . . Because it changes my day and then by changing my day . . . it changes my quality of life. It [a trigger] will bring up the thing, the feeling of trauma . . . , it could spiral down to like a negative place, but now I'm just like, okay, this didn't go the way I wanted it to but I'm not gonna stay here. I'm not gonna let this ruin my day.*

Another participant noted the impact that EMDR has had on her ability to respond to emotional triggers:

> *Well, I definitely think it [EMDR] had an effect because I had some things come up that ordinarily would trigger a strong response, but I had more of an indifferent response, which I found I was so grateful for. . . . When I received this letter [from my ex-boyfriend] . . . it would have really set me down a bad path, but it didn't trigger a hardcore response. . . . Ordinarily, getting that letter from my ex's lawyer with these ridiculous things would have just been soul-crushing. But I was like, whatever, of course. Yeah this bothers me, but I'm not crushed. And so that was just so markedly different.*

The participants' counselors noticed these changes in their participants as well. As one counselor described, "I saw a drastic shift in just how they were reacting to different situations." Participants reported no longer needing to rely on others to manage their lives; rather, EMDR appeared to give them the tools to self-regulate. For example, one client–participant explained that she was able to self-soothe in moments of emotional difficulty:

> *These are ways you can self-soothe yourself. You can sort of seek out ways for other people to soothe you, but when you're able to self-soothe and you're in a*

moment of emotional difficulty, you can't always reach out to that person. You can't always find someone who's just going to give you a hug.

Participants reported that EMDR helped them find emotional comfort within themselves and gain independence. As a counselor–participant explained, "they can resource themselves now to hold on to it [a positive belief]." The tools and techniques acquired during EMDR seemed to help participants to self-regulate, in turn allowing them to process the trauma and PTSD in a way that increased cognitive capacity and functionality in everyday life.

Improved Functionality and Cognitive Capacity. Participants discussed how EMDR enabled them to more productively function in daily life tasks, which was seemingly connected to their increased cognitive capacity. Most notable among participant experiences was one participant's improvement in cognitive functioning. Prior to her experience with EMDR, she reported losing acuity, mathematical ability, memory, and reading ability after too much shock therapy. She explained that EMDR made a significant impact on her life:

I can read longer and faster than I [did] before. That was a surprise for me. And a very positive one. [I have] adult-onset attention deficit disorder so that's been a challenge to adjust to and . . . there's definitely a great focus there, which I've appreciated.

After receiving EMDR, this participant reported resuming reading at a level that had been significantly compromised for three years prior. Another participant described the ability to manage monetary responsibilities associated with her business that were previously too overwhelming. The participant was able to shift her focus and begin engaging in more entrepreneurial work, pursuing additional options that she felt were previously beyond her capacity. She explained, "It [EMDR] freed up space to handle my financial needs." This additional space allowed her to more effectively manage her career. Still another participant reported being able to shower on her own for the first time, after years of experiencing panic attacks following a domestic violence incident in the shower.

Another participant explained that after EMDR she had more energy to be productive with life tasks. Before receiving EMDR, she depleted her energy on anxiety and emotional stress. She discussed her prior experience as, "You're taking a lot of energy from yourself which you know later on in the day you could have stored up and spared there for something else that you need to do." Another echoed these sentiments, saying, "It [EMDR] cleared my mind" and:

I always felt so heavy, like I had so much on my mind and could constantly only think of one event that happened to me and . . . I felt lighter after a few weeks [of EMDR]. I just felt like it [the intrusive trauma] wasn't there anymore. I wasn't only thinking about that.

Still others discussed how EMDR freed up cognitive space for more emotions and gave them a will to live. One participant expressed, "My brain's allowing me to feel this and so that's a sign of not just being dead inside." The counselors noticed these changes as well. One counselor stated, "These tools really do help because if you can decrease the anxiety, they're freer to think in a more rational mind rather than emotional mind. Their head is cleared out." It seems that participants were finally able to remove the trauma and PTSD from the forefront of their minds. This additional cognitive space allowed them to function throughout everyday life without the obstruction of their past trauma.

Self-Acceptance. One step of EMDR focuses on the establishment of a positive internal belief. Counselors facilitate the implementation of their clients' positive core beliefs, while helping them to reduce and eliminate their negative core beliefs. The installation of a new, positive internal belief may contribute to clients' increased self-worth and self-acceptance. During counselor interviews, all six counselors talked about how they witnessed EMDR help participants institute positive core beliefs. As one counselor explained:

You're using that negative core belief to guide them and looking at all their experiences in life in which they felt that exact same way. And then . . . you get a touchstone. So any experience in their life is lined up . . . to kind of lay out their life and how this negative belief has developed over time.

By accessing the negative core belief and repeatedly reinforcing a positive cognition, participants surrender the negative belief in favor of a true, positive self-concept. EMDR uses resourcing, bilateral stimulation, and visualization to achieve this goal. Another counselor described, "sometimes the resourcing becomes the most effective because the more you can shift the brain to more positive, it kind of subdues the traumatic part." The techniques of EMDR allowed

participants to develop a more positive and stable self-image. As one participant explained, "I have to say to myself, even though other people in my life might not think I am worthy of whatever, I feel that I am. And if I feel like I am, then I can be okay."As another counselor explained, "the positive belief sticks and the negative belief that they had is just no longer there." One client–participant explained this transformation in detail:

> *This [EMDR] has helped me because when we started doing this program—what started first was that feeling of, "You are okay and you are allowed to be okay . . . You are valuable. You have reason. . . . You have joy. You have happiness." And those things—no matter what my husband says—he can't take them away from me. So when we started . . . I held onto those no matter what he said. And now . . . they have become my shields. We've reinforced them, and we've expressed them. And by doing that . . . and giving me tools to hug myself . . . I can feel her tapping. I can feel that connection, that this is me. This is who I am and I'm certainly higher than those comments.*

Throughout EMDR, participants reinforce their positive belief until they have internalized it, in an effort to permanently improve their self-worth. As one counselor said of one of her clients, "She felt empowered. She felt the strength. She didn't have the negative belief anymore."

Participants echoed this increase in self-worth and reduction in negative core beliefs. One participant described this shift, saying, "I never saw any goodness in me [pauses], and I do now." Another powerfully stated, "I'm glad I'm able to now say, 'I count.'" Still another participant explained, "I've made some decisions that I'm pretty proud of myself for making."

Participants also spoke about being able to fully accept themselves. EMDR helped them to validate their own feelings and experiences. One participant finally perceived her childhood self in a positive light; she explained, "As a result of one of the sessions . . . I was able to feel compassion for the little girl." Client–participants reported that their newly ingrained positive beliefs allowed them to accept themselves and internalize their worth.

Discussion

Overall, after receiving eight sessions of EMDR participants experienced statistically significant decreases in levels of anxiety, depression, and PTSD, with large effect sizes. Qualitative interviews amplified these results, in which participants expressed feeling more empowered to assert and accept themselves and an increased functionality and control over their lives. These results may stem from participants working throughout EMDR treatment to reprocess memories and trauma associated with sexual or IPV, which was previously harmfully encoded or inadequately stored. These results not only support the effectiveness of EMDR in reducing PTSD symptoms, reinforcing the recommendations by the WHO (2013), NICE (2018), and International Society for Traumatic Stress Studies (ISTSS, 2019); but also provide initial support for EMDR as an effective treatment option for sexual or IPV trauma survivors in marginalized and underserved communities receiving counseling in nonprofit community-agency settings.

Similar to previous research, participants in this study initially presented with clinically significant depression and anxiety symptoms alongside PTSD, which were substantially reduced after participating in EMDR (Chandan et al., 2020; Lagdon et al., 2014; Schwarz et al., 2020). Given that this study resulted in significant change for the majority of participants after only eight sessions, it also supports the assertion that EMDR comes at a reduced cost to survivors, requiring less treatment time than competing recommended treatment TF-CBT to reduce PTSD symptoms (Mavranezouli et al., 2020). This is of particular importance due to the increased costs survivors already incur as detailed at the beginning of this article (Bothe et al., 2020), as well as the prevalence of the intersection of complex trauma with poverty and under-resourced populations (Goodman et al., 2009).

Simultaneously assessing the qualitative impact of EMDR on participants, alongside quantitative data collection, addressed the recommendation identified by Marich et al. (2020), that qualitative assessments should not primarily follow or come after quantitative ones, as most existing ones had. In terms of clients' personal experiences of EMDR, qualitative findings of this study echo prior findings that EMDR treatment decreases vividness of traumatic memories (Cotter et al., 2017), increases insight about the past (Shipley et al., 2021), strengthens self-confidence (Cotter et al., 2017), increases positive emotions (Cotter et al., 2017), drives transformative change (Shipley et al., 2021), and improves cognitive functioning (Aranda et al., 2015; Camacho-Conde, 2020). Transformative change and improved cognitive functioning are expected changes related to the AIP model, which addresses treatment at the source of pathology, targeting insufficiently processed information from a disturbing event early

in life (Shapiro, 2018). An increase in cognitive functioning may be linked to participants' exchange of maladaptive neural pathways, for properly processed adaptive pathways.

A prevalent finding in our qualitative assessment was that participants gained an enhanced sense of control and self-regulation. This echoes Phase Two of the EMDR protocol, Preparation, in which participants are taught relaxation and safety procedures to establish self-regulation throughout EMDR treatment (Shapiro, 2018). In a study of participants presenting with grief, Cotter et al. (2017) indicated that unlike EMDR participants, TF-CBT participants felt more in control of consciously regulating their emotions, including grief, across their lives. In other studies of EMDR, including one focused on individuals presenting with addiction, participants felt a better ability to self-regulate (Marich, 2010); and in another study of EMDR as a treatment for obsessive-compulsive disorder, participants found the safety exercises to establish a safety net (Marsden et al., 2018). It is possible that, despite receiving relaxation and safety training as part of the standard EMDR protocol, participants in Cotter et al. (2017) did not experience the same increase in self-regulation tools due to their presentation with grief rather than other clinical presentations.

This study was conducted at a nonprofit agency in an under-resourced community, where counseling services were offered for free or a nominal sliding scale cost, and many clients remarked that they were surprised and pleased to have access to a modality like EMDR, which they thought would only be available in private practice settings. This underscores the importance of expanding access to EMDR treatment across all communities and counseling settings, so that it can benefit those disproportionately affected by trauma and the compounding effects of poverty and PTSD (Stockman et al., 2015). Due to the marked improvements in relatively short periods of time for a lower mean cost (Mavranezouli et al., 2020), this could be a choice form of therapy made available to underserved populations navigating the effects of trauma.

This study was limited by a relatively small number of participants. Future studies could seek to increase the number and diversity of participants, which could offer more evidence as to the effectiveness of EMDR in treating complex trauma. Although Spanish-speaking participants were included in this study, the number of participants ($n = 4$) was too low to make statistical comparisons. Only female participants were included in this study, so the results cannot be generalized to male survivors.

Another limitation is the lack of follow-up with participants to assess the maintenance of the effects. Our next study (currently in process) will address both of these limitations, as we are studying a larger sample across multiple domestic and sexual violence agencies across the state and incorporating a longitudinal assessment, following up and administering assessments to participants at 6 and 12 months posttreatment. Future research could also use qualitative findings to inform the selection of quantitative assessments, measuring constructs such as assertiveness and self-regulation.

This research was conducted at a nonprofit agency where many clients are experiencing crisis situations and need to receive the most effective treatment immediately. The administration of this nonprofit agency did not approve a delayed treatment waitlist or comparative evidence-based treatment design, which could be employed in future research to create a comparative study with a control group that could provide even stronger evidence, strengthening the confidence of the results. It is of note that many women in the research study expressed how the research process itself added to their growth and confidence as they were able to see measurable effects, discuss their experience through interviews, and know that they were contributing to the field through sharing their experiences, underscoring the importance of including all voices (especially those which are under-represented) in future research endeavors.

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