Clinicians' Views on Eye Movement Desensitization and Reprocessing Therapy: A Mixed Method Systematic Review

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This mixed methods systematic review aimed to provide insight into the clinicians' views and experiences of eye movement desensitization and reprocessing (EMDR). Seven electronic databases (PsychINFO, Public MEDLINE [PubMed], Cumulated Index to Nursing and Allied Health Literature [CINAHL], Scopus, Web of Science and Excerpta Medica Database [EMBASE], and Applied Social Sciences Index) and grey literature (ProQuest and Google Scholar) were searched systematically from inception to October 2021. Quality was assessed using the Mixed Methods Appraisal Tool and a convergent integrated approach was used to synthesize and integrate the data. In total, 14 studies were included: 7 qualitative, 5 mixed methods, and 2 quantitative, encompassing 1,065 participants. Thematic synthesis generated two overarching themes and seven subthemes. The first theme related to the facilitators and barriers clinicians experience in adopting and implementing EMDR, including the role of organizational support, clinician confidence, primary theoretical orientation, and client suitability and preparedness. The second theme related to the perceived advantages of EMDR, including rapid results and positive outcomes, client empowerment, and getting to the root of the issue. This review provides a helpful insight into the factors that influence the dissemination and implementation of psychological therapeutic approaches.

Keywords: EMDR; eye movement desensitization and reprocessing; systematic review; mixed methods; clinicians

Eye movement desensitization and reprocessing (EMDR) is an integrative psychological therapeutic approach developed in the late 1980s by Francine Shapiro as a treatment for posttraumatic stress disorder (PTSD; Shapiro, 1989). The theoretical underpinning of EMDR is that of the adaptive information processing model, which considers dysfunctionally stored memories as the primary basis of clinical psychopathology that is not otherwise explained by organic disease (Oren & Solomon, 2012). Indeed, according to this model, pathological presentations are believed to be associated with past disturbing experiences, which have been dysfunctionally stored within the memory and thus trigger dysfunctional patterns of emotional, behavioral, and cognitive symptoms (Shapiro, 2018). Thus, EMDR aims to work to process the key traumatic memories within the client's life story that are hypothesized as being connected to the current difficulties and symptoms (Balbo et al., 2019). EMDR follows a standardized protocol consisting of eight phases that utilize the signature component of bilateral stimulation.

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Although initially met with considerable skepticism from the scientific community, EMDR is now recognized as an empirically supported psychotherapy for the treatment of PTSD and is recommended as a treatment of choice for PTSD by the National Institute for Health and Care Excellence (NICE) guidelines (National Institute for Health and Care Excellence [NICE], 2019). Although not currently recommended by NICE guidelines for the treatment of other disorders, the application of EMDR has expanded to the treatment of a wide range of mental health conditions and comorbid presentations to PTSD, including depression (Sepehry et al., 2021), bipolar disorder (Valiente-Gómez et al., 2019), and psychosis (De Bont et al., 2013). Indeed, in recent years, EMDR has attained a significant popularity, with increasing numbers of therapists being trained in the approach and thus a considerable increase in its clinical use.

EMDR is considered as a secondary psychotherapy training model (Farrell & Keenan, 2013), with basic training consisting of a training manual, theory-driven active teaching, experiential learning, and clinical supervision. The basic training structure involves at least 20 hours of didactic teaching and 20 hours of supervised practice from an accredited supervisor. Clinicians can then seek accreditation if basic training has been completed and clinicians have worked with at least 25 clinicians and completed a minimum of 50 sessions (Farrell & Keenan, 2013). It was reported in 2015 that over 100,000 clinicians have attended training in EMDR internationally, but as with other therapeutic approaches, not all clinicians go on to integrate this approach into their clinical practice (Grimmett & Galvin, 2015). According to Farrell and Keenan (2013), within the United Kingdom and Ireland, only 10%–12% of trainees who complete the EMDR basic training had become fully accredited in the therapy approach, though the numbers of clinicians working toward accreditation were not reported.

The decision to employ a particular therapeutic approach appears to be influenced by a range of factors, including clinician-related factors, client-related factors, the training itself, post-training skill development, and socioenvironmental influence (Becker et al., 2007; Grimmett & Galvin, 2015). A study conducted by Cook and colleagues (2009) employed a web-based survey to investigate influences on psychotherapists' adoption and sustained use of new therapies in the United States and Canada. The most endorsed factors influencing current practice were significant mentors, information gathered from books, and training received during graduate school. The least endorsed factors influencing current practice included training videos, treatment manuals, and electronic listservs. In terms of factors influencing willingness to learn a new therapeutic approach, the most endorsed were that it could be integrated with the therapists' current approach, it is endorsed by respected therapists and has training opportunities available. The least endorsed factors included positive findings on the therapy reported in a research journal, endorsement by a professional organization as being evidence based, and clients' testimonials regarding the therapy's effectiveness. In terms of continued use of a new therapy, psychotherapists reported that the most influential factors were their ability to conduct the therapy successfully and help clients, their own enjoyment using the therapy, and clients liking the therapy and reporting good effects.

Clinicians are therefore in a position to provide helpful insight into the facilitators and challenges in terms of training in and implementing particular therapeutic approaches in clinical practice, which can inform both the development of new approaches and the process of dissemination of therapies, including clinician training, implementation needs, and supervision needs. As proposed by Becker and colleagues (2004), it is important for the research to be carried out with those who are directly involved in the implementation of a therapy approach in order to identify factors affecting clinical use or barriers within routine clinical practice.

Aims and Objectives

No systematic review has previously been conducted exploring the views of clinicians using EMDR. Thus, the aim of this review is to provide insight and understanding, through the summary and synthesis of findings from studies that report on clinicians' views and experiences of EMDR therapy. The secondary objectives to be addressed are:

1. What are clinicians' experiences of the integration of EMDR into clinical practice?
2. What barriers/difficulties might be experienced when integrating EMDR into their practice?

Methodology

Protocol Registration

The protocol for this systematic review was registered on The International Prospective Register

of Systematic Reviews (PROSPERO) (registration number: CRD42021277333).

Search Strategy

The following databases were searched from the inception of the database to October 2021: PsychINFO, PUBMED, CINAHL, SCOPUS, Web of Science, EMBASE, Applied Social Sciences Index, and ProQuest. The search strategy included the following keywords: [("Eye Movement Desensitization Therapy" OR EMDR OR "eye movement desensitization") AND (clinician* OR professional* OR practitioner* OR psychologist* OR therapist* OR psychotherapist* OR psychoanalyst* OR counsellor* OR counselor* OR analyst* OR staff OR personnel OR training) AND (view* OR opinion* OR perception* OR perspective* OR belie* OR attitude* OR experience* OR qualitative OR viewpoint* OR standpoint* OR encounter* OR reaction* OR use* OR utility OR evaluation* OR account* OR narrativ* OR impression*)], with medical subject headings adapted and included for each database (see Appendix A). In order to assist in identifying relevant papers, the first 30 pages of Google Scholar were also searched and forward and backward citation chaining was conducted on included studies, whereby articles that cited the included studies were screened and reference sections of included studies were screened.

The inclusion criteria encompassed the following: qualitative, mixed methods, and quantitative studies, written in the English language, that focused on mental health clinicians' personal views or experiences of EMDR in terms of training or delivery of the approach. Doctoral theses and nonpeer-reviewed studies were also included in order to reduce the risk of publication bias. Studies were excluded based on the following criteria: the population was not mental health clinicians eligible or using EMDR; case studies, editorials, opinion pieces, books, reviews, and papers not reporting primary research findings; studies whereby clinicians' views and experiences of EMDR are not represented or analyzed separately within mixed sample studies; studies reporting on their experience of a specifically adapted form of EMDR; studies that use "EMDR clinicians" as a sampling strategy but are investigating another phenomenon of interest that is the not the focus of this article; and mixed outcome studies whereby clinicians are reflecting on their experience of both EMDR and other therapeutic approaches within the same survey/interview and results are mixed.

Following the search, all identified citations were collated and uploaded to the reference management software Zotero (Center for History and New Media, 2021) and duplicates were removed. The primary author (MH) first screened all citations for eligibility based on the title and abstracts. Articles that were clearly not relevant to the research question were excluded at this stage. The second reviewer (AG) screened 10% of all citations based on the title and abstracts as a quality control measure to ensure the accuracy and consistency of the selection process and to ensure that the primary author (MH) was correctly applying the inclusion and exclusion criteria. The remaining full texts of potentially relevant articles were then reviewed by the primary author (MH) and the second reviewer (AG). Where the full text was not available, the authors were directly contacted or articles were requested through the university. Full texts were excluded at this stage if they did not meet the eligibility criteria and any discrepancies that arose between the reviewers were resolved through discussion. If a discrepancy could not be resolved, a third reviewer (CR) was contacted to assist with the decision.

Quality Assurance

Eligible studies were subjected to a critical appraisal of methodological quality using the Mixed Methods Appraisal Tool (MMAT), version 2018 (Hong et al., 2018). The MMAT is a tool designed to allow for concurrent quality appraisal of qualitative, quantitative, and mixed methods research studies. This tool was chosen as it provides a standardized approach for screening a range of research designs and thus allows comparisons to be made across studies of differing methodological designs (Crowe & Sheppard, 2011). Each study was assigned a quality score, using asterisks to signify the quality appraisal. Quantitative and qualitative studies were appraised based on five criteria, with possible scores ranging from (*) when one criterion is met to (*****) when all criteria are met (Hong et al., 2018). The most recent guidelines (Hong et al., 2018) recommend that one overall score should not be calculated from the ratings, and instead a more detailed presentation of the quality ratings should be provided to better inform the quality of the included studies. Thus, the quality appraisal is provided in Appendix C. Furthermore, as per Hong et al. (2018), studies of lower quality will not be excluded, but their potential impact on data synthesis will be discussed.

Data Extraction

A data extraction form was created and the primary author identified all data to be extracted from the chosen articles for inclusion. Data extracted included: author, study location, research aim, study design, participant characteristics, sample, data, analysis, and an overview of findings.

Data Synthesis

Data synthesis was conducted in accordance with the guidelines published by the Joanna Briggs Institute (JBI) Mixed Methods Review Methodology Group (Lizarondo et al., 2020). As per the JBI guidelines (Stern et al., 2020), this review employed a convergent integrated approach given that the review question could be addressed by both quantitative and qualitative research designs. Consistently with this approach, quantitative data was "qualitized," whereby data were extracted from quantitative studies and converted into textual descriptions to allow integration with qualitative data (Stern et al., 2020). Thematic synthesis was then employed as a means of synthesizing the data in accordance with the steps outlined by Thomas and Harden (2008), which involves the coding of text "line-by-line," the development of "descriptive themes." and the generation of "analytical themes."

Results

A total of 6,526 studies were identified through database searching. Following the removal of duplicates, 5,546 studies remained for title and abstract screening. The first author (MH) independently screened all titles and abstracts, while the third author (AG) independently screened 10% of all title and abstracts (n = 554). There was 98% agreement between reviewers at this stage of the screening (Cohen's Kappa = .82). Fifty full texts were assessed for eligibility. Thirty-three articles were excluded as they did not meet the inclusion criteria (for further reasons please see Figure 1: Preferred Reporting Items for Systematic Reviews and Meta-Analyses [PRISMA] diagram). Three articles were excluded as no full texts were available to review. Fourteen articles (as outlined in Table 1) were identified as eligible for inclusion in this systematic review: seven qualitative studies (Brendler, 2017; Cook et al., 2009; DiGiorgio et al., 2004; DiNardo & Marotta-Walters, 2019; Hasandedic-Dapo, 2021; Jones-Smith, 2018; Phillips et al., 2021), five mixed methods studies (Dunne & Farrell, 2011; Farrell & Keenan, 2013; Farrell et al., 2013; Hasanović et al., 2021; Vuong, 2019), and two quantitative studies (Edmond et al., 2016; Grimmett & Galvin, 2015). The included articles represented studies from the United States (57%), the United Kingdom (29%), Turkey (7%), and Bosnia (7%). In total, 1,065 participants were included across studies. Gender was reported in 9 of the 14 studies, with 70 males and 198 females included within these studies.

Quality Appraisal

Overall, MMAT quality scores ranged from two stars (i.e., 40%) to five stars (i.e., 100%). Qualitative studies scored the highest for quality (6 of the 7 studies scoring 100%), followed by quantitative studies (ranging from 60%–80%), and mixed methods studies (ranging from 40%–80%). One study by Vuong (2019) failed to pass the screening questions as a clear research question was not provided and there was insufficient data presented and thus further appraisal was deemed not feasible or appropriate as per the MMAT scoring guidelines. See Appendix D for a breakdown of the quality scores.

Thematic Synthesis

Thematic synthesis generated two overall themes, with seven subthemes. See Figure 2 for an outline of findings.

Theme 1: Adopting and Implementing EMDR—Facilitators and Barriers. The theme "adopting and implementing EMDR" discussed the range of facilitators and barriers clinicians identified as influencing their experience of adopting EMDR as a therapeutic approach to train in and subsequently implementing it into their clinical practice. This theme included four main subthemes: "organizational support," "clinician confidence," "primary therapeutic orientation," and "client suitability and preparedness."

Organizational Support. Clinicians across nine studies discussed the role of organizational support as both a facilitator and barrier to the adoption and implementation of EMDR in clinical practice (Brendler, 2017; Cook et al., 2009; Dunne & Farrell, 2011; Farrell & Keenan, 2013; Farrell et al., 2013; Grimmett & Galvin, 2015; Hasandedic-Dapo, 2021; Hasanović et al., 2021; Phillips et al., 2021). Organizational factors that supported clinicians to adopt the approach included the provision of on-site annual funded trainings, a felt expectation within the service to practice EMDR, and suggestions to

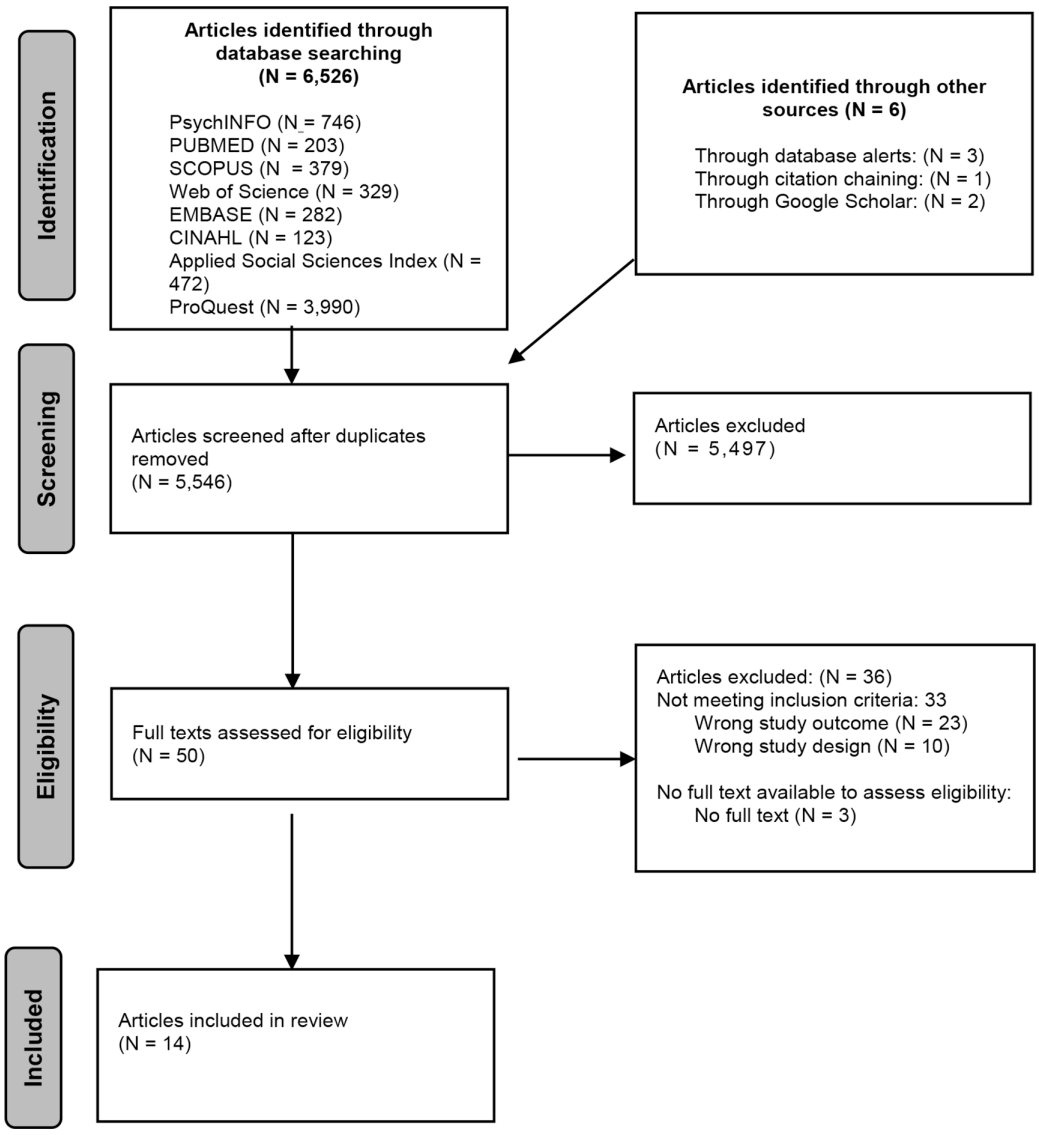

Figure 1. PRISMA flow diagram.

use the approach from colleagues and supervisors (Cook et al., 2009; Grimmett & Galvin, 2015). Reflecting how EMDR was a part of the organizational culture within the service, one clinician in the study conducted by Cook et al. (2009) stated:

> This is the first setting that I've worked in where EMDR, is considered to be the treatment of choice … where it's almost an expectation that you be trained in or versed in it. I mean it comes (up) in interviews, colleagues ask you do you do this, patients will ask are you going to be trained in EMDR; whereas in other settings where I've worked that's never been a part of the culture or climate. (Cook et al., 2009, p. 6)

Furthermore, the provision of supervision within the workplace was discussed as an important facilitator to the use of EMDR in clinical practice, providing clinicians with both emotional and practical support (Farrell et al., 2013; Grimmett & Galvin, 2015; Hasanović et al., 2021; Phillips et al., 2021). Supervision was described by clinicians as an important support in supporting them in "consolidating the teaching and learning of EMDR" (Farrell et al., 2013). Clinicians spoke about the benefit of receiving information and advice from their supervisor and other peers within their supervision group, obtaining advice from others when challenges arise, learning from other clinicians' cases, and being reminded of the frameworks and protocols

TABLE 1. Characteristics of Included Studies

No.	Reference	Country	Research aim	Study design	Participants	Sample	Data	Analysis	Quality rating	Overview of key findings
1.	Brendler, (2017)	United States	How do experienced EMDR practitioners help their clients to develop resources required to tolerate EMDR desensitization?	Qualitative	Age range: 40–65 years Gender: 1 male, 4 females EMDR Training Level: Part 2 (n = 5) Highest Level of Education: Master's (n = 4), Doctorate (n = 1) Years practicing EMDR: At least 3	5 clinicians	Semi-structured interviews	Integrative Phenomenological Analysis (IPA)	*****	Themes identified: Therapist experience of working with their clients; Trauma conceptualization; Stabilization; All these tools used to resource clients.
2.	Cook et al. (2009)	United States	To provide an in-depth comparative case study of two attempts at diffusion of EMDR	Comparative Case Study	Age range: 30–62 Gender: 14 male, 15 female Ethnicity: White (n = 25), African American (n = 1), American Indian (n = 1), Mixed Ethnicity (n = 2). Qualification: Majority (n = 23) were doctoral-level psychologists. Setting: Department of Veterans Affairs (VA) treatment setting	29 clinicians (n = 10) at first site, (n = 19 at second site).	Semi-structured interviews	Explanation building (Yin, 2003)	*****	Themes identified: EMDR adopted or thwarted based on influential staff members; It's (not) what we do here; Proof of value: experiencing is believing; Mechanism of therapeutic change; Perceived characteristics of EMDR; Different lens, different criteria; Esthetics and comfort level using EMDR.
3.	DiGiorgio et al. (2004)	United States	This study examined how 3 therapists from differing theoretical orientations (psychodynamic, humanistic, and cognitive–behavioral) EMDR into their work with clients.	Qualitative	Age range: 57–71 years Gender: 3 males Theoretical orientation: Psychodynamic (n = 1), Humanistic (n-1), Cognitive-behavioral (n = 1)	3 therapists	Semi-structured interviews	Consensual Qualitative Research (CQR) method	****	All therapists deviated from standard protocol to some degree, influenced by their primary theoretical orientation and clients.
4.	DiNardo & Marotta-Walters (2019)	United States	To explore the question of how a sample of EMDR clinicians integrated the role of culture in EMDR therapy	Qualitative	Age range: 27–79 Years practicing EMDR: 1–27	56 clinicians	Online survey	Interpretive and discourse analysis	*****	Themes identified: Reflections on universality, reflections on cultural influences on treatment, individual differences in cultural identity, clinician identity interacting with treatment, EMDR process, and implicit cultural aspects of treatment.
5.	Dunne & Farrell (2011)	United Kingdom	To explore if therapists from different theoretical backgrounds	Mixed-methods	Study Part 1 Age range: 32–78	Part 1 74 clinicians	Part 1 Survey with one open ended	Part 1 Descriptive statistics, ANOVAs and thematic	***	Part 1 30 participants (41%) reported experiencing difficulties in incorporating EMDR into

(*Continued*)

TABLE 1. Characteristics of Included Studies (*Continued*)

No.	Reference	Country	Research aim	Study design	Participants	Sample	Data	Analysis	Quality rating	Overview of key findings
			experience difficulties in incorporating EMDR into their clinical practice.		Gender: 31 male, 43 female Years practicing EMDR: 2–18 Highest level education: Diploma ($n = 10$), Primary degree ($n = 10$), Masters ($n = 38$), Doctorate ($n = 16$) EMDR training level: Part 1 ($n = 1$), Part 2 ($n = 22$), Part 3 ($n = 51$) Therapeutic orientation: Integrative ($n = 26$), Cognitive/behavioral ($n = 25$), Humanistic/experiential ($n = 10$), Analytic ($n = 8$), Other ($n = 5$) Study Part 2 Age range: 36–68 Gender: 6 male, 3 female Therapist years range: 6–28 EMDR years range: 2–16 Highest level education: Diploma ($n = 1$), Primary degree ($n = 0$), Masters ($n = 5$), Doctorate ($n = 3$) EMDR training level: Part 1 ($n = 0$), Part 2 ($n = 3$), Part 3 ($n = 6$) Therapeutic orientation: Integrative ($n = 3$, Cognitive/behavioral ($n = 3$), Humanistic/experiential ($n = 2$), Analytic ($n = 2$), Other ($n = 0$)	Part 2 9 clinicians	question Part 2 Semi-structured interviews	analysis Part 2 Content analysis		clinical practice. Five distinct themes emerged in relation to challenges in integrating EMDR into clinical practice: Time constraints; Anxiety/confidence, Workplace issues, Changes in EMDR therapists practice or theories, Client characteristics. Part 2 Themes identified: Reported difficulties incorporating EMDR into practice; Specific changes in EMDR therapists practice or theories.
6.	Edmond et al. (2016)	United States	This study sought to determine the extent to which rape crisis centers use EMDR therapy, practitioners' perceptions of EMDR, and the provider	Quantitative, cross-sectional, web-based survey	Age range: 23–65 Gender ($n = 75$): 4 male, 71 female Years of experience: 0–28 Ethnicity: White ($n = 50$), Latino ($n = 17$), Black ($n = 3$), Mixed-	76 practitioners working within 47 rape crisis centers	Web-based survey	Descriptive statistics, χ analyzes and t tests.	****	There is a low-use rate of EMDR (8%) in this setting. Perceptions of EMDR were predominately marked by uncertainty, reflecting a lack of familiarity with the model. More than half of the practitioners indicated that they

(*Continued*)

TABLE 1. Characteristics of Included Studies (*Continued*)

No.	Reference	Country	Research aim	Study design	Participants	Sample	Data	Analysis	Quality rating	Overview of key findings
			characteristics that might support or hinder implementation of EMDR in this setting.		Race (n = 3), American Indian (n = 1), Native Hawaiian (n = 1). Highest Level of Education: No Bachelor's degree (n = 18), Bachelor's degree (n = 17), Advanced degree (n = 41) Setting: Urban (n = 45), Rural (n = 31)					did not have a good understanding of the procedures and techniques involved in EMDR therapy (55.0%), and another 18.3% were uncertain about their understanding. There is strong interest in receiving training, particularly for those working in urban areas and those with advanced degrees.
7.	Farrell & Keenan (2013)	United Kingdom	To explore EMDR training participants' application of EMDR within their current clinical practice.	Mixed methods survey	Age: Not reported Gender: Not reported Core Profession: Psychology (n = 161), Psychotherapy (n = 95), Counseling (n = 83), Mental Health Nursing (n = 71), Psychiatry (n = 36), Social Work (n = 14), Other (n = 13), Medicine (n = 12). Main Psychotherapeutic Orientation: CBT (n = 211), Integrationist (n = 127), Psychodynamic (n = 60), Other (n = 50), Humanistic (n = 37).	485 clinicians	Postal survey	Descriptive statistics, ANOVA, qualitative analysis (type not reported)	**	Fewer than 10% of clinicians did not complete the full EMDR basic training for diverse range of reasons, including lack of funding, lack of EMDR clinical supervision and lack of confidence using EMDR. Most commonly cited reason for not using EMDR clinically was feeling that the training they received was insufficient in enabling them to feel suitably equipped and confident in using EMDR. 39.5% of overall clinicians had no supervision in place. EMDR is being used with a wide range of mental health problems, other than PTSD.
8.	Farrell et al., (2013)	United Kingdom	This article is an evaluation of eye movement desensitization and reprocessing (EMDR) Europe Humanitarian Assistance Program (HAP) facilitators' training in Pakistan based on a project set up in the aftermath of the 2005 earthquake	Q-methodology	Age range: Not reported Gender: 4 male, 2 female Job title: Psychiatrists (n = 5), GP / Psychologist (n = 1).	6 clinicians	Q-methodology	Factor analysis	****	Two Factors: Theory Practice Integration and Scientific Inquiry; Therapeutic Relationship and Cultural Context.

(*Continued*)

TABLE 1. Characteristics of Included Studies (*Continued*)

No.	Reference	Country	Research aim	Study design	Participants	Sample	Data	Analysis	Quality rating	Overview of key findings
9.	Grimmett & Galvin (2015)	United States	This study investigated factors contributing to clinicians' use or discontinued use of EMDR as well as obtaining information pertaining to training experiences.	Quantitative, cross-sectional, web-based survey	Age range: Not reported Gender: Not reported EMDR training level (n = 238): Part 1 (n = 13), Part 2 (n = 124), Certified (n = 54), Approved Consultant (n = 15), Facilitator (n = 18), Trainer (n = 10), Trainer of trainers (n = 4)	239 clinicians	Web-based survey	Descriptive statistics, ANOVA/ χ analyzes	***	In total, 76% of respondents felt EMDR training had adequately prepared them. For those feeling un-prepared, ongoing training and consultation and more practice during trainings were sought. Most respondents (88%) reported positive reactions from colleagues regarding their EMDR use. Primary reasons for not using EMDR were preferring a previous modality, not feeling competent, client refusal, and discomfort suggesting it. Of those clinicians still using EMDR, 25% stated rapid results as the primary reason. Other reasons were feeling more effective as a clinician and an increase in referrals.
10.	Hasandedic-Dapo (2021)	Turkey	To investigate the thoughts and experiences of psychologists regarding EMDR	Qualitative	Age range: 25–50 Gender: Not reported Qualification: At least a master's degree in psychology (n = 20)	20 psychologists	Online interviews—questionnaire consisted of open-ended questions	Phenomenological approach	*****	Themes identified: Positive personal or anecdotal experiences with EMDR; Perception that EMDR is primarily used for trauma; EMDR is used as an adjunct therapy; Obstacles to EMDR training/certification; Limited knowledge and information about EMDR among psychologists and the general population.
11.	Hasanovic et al., (2021)	Bosnia	To describe the experiences of education, clinical practice, and supervision of EMDR psychotherapy in the process of obtaining European accreditation	Mixed methods, cross-sectional, web-based survey	Age: Not reported Gender: 6 male, 30 female Job title: Psychologist (n = 25), Specialist Psychiatrist (n = 5), Specialist Educator (n = 2), Medicine (n = 3), Social Worker (n = 1).	36 clinicians	Web-based survey	Descriptive statistics, qualitative analysis (type not reported)	**	Themes identified: Problems in practicing EMDR therapy; Experience in practicing EMDR therapy and experience with supervisors.

(*Continued*)

TABLE 1. Characteristics of Included Studies (*Continued*)

No.	Reference	Country	Research aim	Study design	Participants	Sample	Data	Analysis	Quality rating	Overview of key findings
			of EMDR trainees from Bosnia and Herzegovina.							
12.	Jones-Smith (2018)	United States	To explore the perceptions of therapists about EMDR as a tool to assist adult women survivors of child sexual abuse.	Qualitative	Age range: Not reported Gender: 2 male, 8 female Ethnicity: White ($n = 4$), Italian ($n = 1$), African American ($n = 3$), Russian ($n = 1$), Puerto Rican ($n = 1$) Years using EMDR: 3–13	10 therapists	Semi-structured interviews	Phenomenological	*****	Themes identified: Perceived effects of EMDR; Therapists perceived EMDR as more effective in treating child sexual abuse trauma than other treatment options; Perceived role of EMDR in a treatment program; The right time to introduce a client into EMDR; Strategies for implementing EMDR.
13.	Phillips et al. (2021)	United Kingdom	To explore therapists' experience of using EMDR with clients experiencing psychosis.	Qualitative	Age range: Not reported Gender: 5 male, 25 female Qualification: Therapists formally trained in EMDR. Job title: Psychologist ($n = 13$), Psychotherapist ($n = 6$)	20 therapists	Semi-structured interviews	Thematic analysis	*****	Themes identified: Familiarity with psychosis and EMDR; Acceptability of EMDR; The importance of systemic factors; Keeping key therapy principles in mind.
14.	Vuong (2019)	United States	The purpose of this study is to explore a clinician's viewpoint on the efficacy of EMDR treatment on victims of domestic violence.	Mixed methods	Not reported	6 clinicians	Interviews	Not reported		Themes identified: Emotional responses; Daily Challenges with Trauma Symptoms; Clinicians' Perspectives; Helpfulness.

Note. ANOVA = analysis of variance; CBT = cognitive behavioral therapy; EMDR = eye movement densensitization and reprocessing; PTSD = posttraumatic stress disorder.

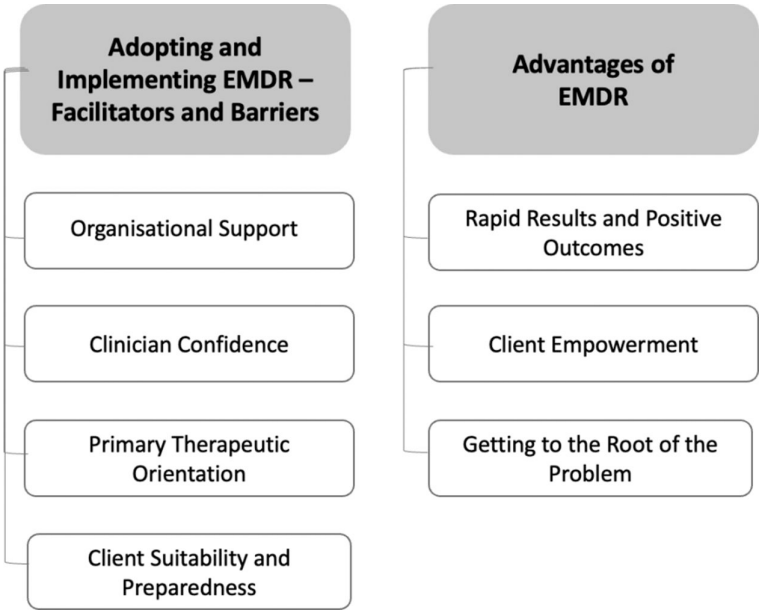

Figure 2. Diagram of themes and subthemes.

(Hasanović et al., 2021; Phillips et al., 2021). This is illustrated by one clinician who stated:

> I also learn a lot from other members who, in every case, present a new, interesting experience, and from which I often learn how to be creative and relaxed with EMDR and at the same time stick to the frameworks and protocols. (Hasanović et al., 2021, p. 9)

Moreover, clinicians also described a lack of organizational support as a barrier to the adoption and implementation of EMDR. In terms of organizational culture, EMDR was described by clinicians in the study conducted by Cook et al. (2009) as "not how we do trauma work" within the service and clinicians explained that there was a lack of encouragement or expectation to train in this approach, which acted as a barrier to training (Cook et al., 2009, p. 6). Furthermore, the cost of EMDR training in terms of time, cost, and lack of funding within services was specifically reported as being barriers to adopting the approach in two studies (Farrell & Keenan, 2013; Hasandedic-Dapo, 2021). This was illustrated by one clinician who reported: "It's pretty expensive to get certified, and it took a lot of time, usually entire weekends to go through the trainings, which not many people can afford to devote" (Hasandedic-Dapo, 2021, p. 21). Clinicians across five studies reflected on a lack of support from colleagues within the workplace as a barrier to the use of EMDR, which included colleagues lacking an understanding of EMDR (Dunne & Farrell, 2011; Hasandedic-Dapo, 2021), disagreements from colleagues that led to perceived bullying and cessation of referrals (Dunne & Farrell, 2011), a lack of recognition of the work (Phillips et al., 2021), and negative feedback and skepticism regarding the validity of the approach from colleagues (Brendler, 2017). Furthermore, a lack of ongoing supervision was also reported as a key barrier to implementation, particularly from an experienced supervisor (Dunne & Farrell, 2011; Farrell & Keenan, 2013; Hasanović et al., 2021; Phillips et al., 2021). In the study conducted by Farrell and Keenan (2013), 10% of clinicians who failed to complete level 2 of EMDR training cited a lack of funding by their organization and a lack of EMDR supervision provision as the top two reasons for discontinuation of the approach. In addition, this study also reported that 148 of the 485 participants reported practicing without any clinical supervision. However, these findings should be considered in the context of the lower quality rating of the study conducted by Farrell and Keenan (2013), with this article scoring two stars on the MMAT. Lastly, logistical issues that included a lack of time and appropriate workplace conditions were also cited as barriers to the implementation of EMDR (Dunne & Farrell, 2011; Hasanović et al., 2021).

Clinician Confidence. Clinicians' confidence in EMDR as a credible and efficacious intervention as well as their confidence in their ability to

implement the approach was discussed by clinicians in eight studies as an important factor influencing their experience of adopting and implementing the approach. For some clinicians, personally experiencing the effects of EMDR during the training process that involved experiential practice exercises increased their confidence in the approach and facilitated their adoption of the approach (Cook et al., 2009; DiGiorgio et al., 2004; Grimmett & Galvin, 2015; Hasandedic-Dapo, 2021). This was illustrated by one participant who reported:

> I went to the first level of EMDR training… and I was the person they were demonstrating on, and while I didn't have very deep trauma, it helped with the memory that I had. So I feel pretty positive about it and I want to continue my education in EMDR (Hasandedic-Dapo, 2021, p. 19119).

Furthermore, some clinicians highlighted that it was the observability of the effects of EMDR in clients, either as observed by themselves or by colleagues, that positively influenced their adoption of the approach and motivated them to continue their training and practice. This was outlined by one clinician who stated: "A client at the time had a cathartic experience using EMDR and that convinced me that there was something in this approach. That was what really sold it to me" (Dunne & Farrell, 2011, p. 185). Similarly, in the study conducted by Grimmett and Galvin (2015), the most common reason cited for pursuing training in EMDR was having heard about its positive effects from colleagues.

In terms of barriers to using EMDR, clinicians in the comparative study conducted by Cook et al. (2009) outlined a perception that EMDR lacks credibility as a barrier to adoption. EMDR was discussed as feeling more like a "social movement" or "money-making proposition" to the clinicians in this study (Cook et al., 2009, p. 5). In addition, clinicians in the site who chose not to adopt EMDR perceived the approach as lacking "theoretical soundness" and all reported that they would not use EMDR in large part because they did not understand the mechanism of change in comparison to other therapeutic approaches (Cook et al., 2009, p. 6). Several clinicians expressed concerns about the credibility of EMDR, equating it with invalid therapies and procedures and questioned its empirical basis. Speaking about their reaction to hearing about EMDR, one clinician stated: "It sounded like a far-fetched almost crazy idea that something that seemed so simple could treat PTSD. It seemed 'out there,'" and further described it as "gimmicky" (Cook et al., 2009, p. 6). It is important to note that the majority of barriers to adopting EMDR identified were only reported in the study conducted by Cook et al. (2009), though the quality of this article was rated highly.

Furthermore, in six studies, clinicians reported that their own "anxiety and confidence" (Dunne & Farrell, 2011, p. 184) impacted their ability to implement EMDR into their clinical practice. Some clinicians reported feeling worried about "retraumatizing" the client or making things worse for them (Brendler, 2017, p. 75; Dunne & Farrell, 2011, p. 184), and spoke about the fear of what might happen if "EMDR goes wrong" (Phillips et al., 2021). A lack of comfort and confidence in describing EMDR to clients due to clinicians' own feelings of discomfort and incompetence with the therapy approach was also reported as a barrier in two studies (Brendler, 2017; Grimmett & Galvin, 2015). Clinicians who were using EMDR infrequently for these reasons proposed wanting additional training to increase their level of skill and confidence (Cook et al., 2009). In addition, a third of clinicians not using EMDR in clinical practice in the study conducted by Keenan and Farrell (2013) considered that the EMDR training they received was insufficient in enabling them to feel suitably equipped and confident in using the approach. Furthermore, 24% of clinicians in the study conducted by Grimmett and Galvin (2015) reported that they felt unprepared following their EMDR training.

Primary Theoretical Orientation. In addition, clinicians' primary theoretical orientation was identified by clinicians as an important factor influencing their experience of implementing EMDR into clinical practice. Indeed, in the study conducted by Dunne and Farrell (2011), there was a statistically significant association, between orientation and experiencing difficulties in incorporating EMDR into clinical practice, with those of analytic (75%) or humanistic/experiential (70%) orientation experiencing more difficulties than those of behavioral/cognitive (32%) or integrative orientation (27%) who had fewer challenges. Difficulties with EMDR included being focused, structured, and technique oriented, which was felt to be at odds with exploratory approaches in particular (DiGiorgio et al., 2004; Dunne & Farrell, 2011). Interestingly, in the study conducted by Grimmett and Galvin (2015), 57% of Gestalt therapists (n = 4) had discontinued the use of EMDR and reported that this decision was due to

the lack of emotional connection and depth offered by the therapeutic approach. This was in comparison to integrative therapists, whereby none of these clinicians had stopped using EMDR. Furthermore, the number one-ranked negative experience using EMDR reported by clinicians in the study conducted by Grimmett and Galvin (2015) was preferring another modality. Clinicians appeared to experience some discomfort in working in a manner that was at odds with their primary approach. This is illustrated by one clinician who reported: "I understood that when I start treatment with EMDR, I only apply EMDR, so it seems a shame/I am sorry to give up my previous knowledge and skills in which I have invested a lot both materially and mentally" (Hasanović et al., 2021, p. 7).

Furthermore, reflecting the influence of primary theoretical orientation on implementing EMDR, the study conducted by DiGiorgio et al. (2004) identified that the three included therapists included all deviated from the EMDR protocol at times by either adding or subtracting from the standard protocol. Therapists were likely to adhere to aspects of the model that were more consistent with their primary theoretical orientation, and leave out aspects that were most at odds with their traditional way of working. For example, the psychodynamic and humanistic therapists in this study reported that they often leave out cognitions as part of the protocol as it feels artificial to them at times, whereas the cognitive-behavioral therapist did not leave out cognitions. Thus, the therapists' primary theoretical orientation appears to influence clinicians' experiences implementing the approach and adhering to the protocol.

Client Suitability and Preparedness. Clinicians across eight studies identified client suitability and preparedness as an important factor influencing their experience of adopting and implementing EMDR in clinical practice (Brendler, 2017; DiGiorgio et al., 2004; Dunne & Farrell, 2011; Farrell et al., 2013; Grimmett & Galvin, 2015; Hasanović et al., 2021; Jones-Smith (2018); Phillips et al., 2021). In terms of facilitating the use of EMDR, clinicians discussed the importance of ensuring the client is well-informed about EMDR in order to successfully implement the intervention (Brendler, 2017; Phillips et al., 2021), with one clinician stating: "I make sure they're super educated about EMDR… just kind of hearing what their information about EMDR is and then making sure they understand, you know, usually checking in about EMDR, getting a history" (Brendler, 2017, p. 66). In addition, another key aspect of preparing the client for EMDR was building a strong therapeutic alliance (Brendler, 2017; Farrell et al., 2013; Jones-Smith, 2018; Phillips et al., 2021). Clinicians within these studies spoke about the importance of building an alliance with their clients before embarking on EMDR and it was considered a key feature of successfully implementing the intervention, with one clinician stating: "It is the therapeutic relationship, I think, which plays an important role in successful outcome with EMDR" (Farrell et al., 2013). In addition, systemic support was outlined as another facilitator to implementing EMDR, in terms of the client having a good network of support with the multidisciplinary team as well as personal supports within their lives (Phillips et al., 2021). Furthermore, resourcing the client was the final aspect of preparation discussed by clinicians, which involved spending time ensuring clients had the appropriate resources and stabilization techniques to provide them with the stability required to implement EMDR (Brendler, 2017; Phillips et al., 2021).

Moreover, in terms of barriers to the use of EMDR, clinicians across five studies outlined several client presentations they deemed unsuitable for EMDR, due to the nature of the symptoms or aspects of the presentation that would make it difficult to successfully engage the clients. Client presentations mentioned were those actively self-harming or suicidal (Jones-Smith, 2018), clients with psychosis (Jones-Smith, 2018; Phillips et al., 2021), clients who were dissociative or chronically avoidant (DiGiorgio et al., 2004; Dunne & Farrell, 2011), those with very low self-esteem or who were multiply traumatized (DiGiorgio et al., 2004), or children with disabilities due to clinicians' difficulty in adjusting the instructions to these children's level (Hasanović et al., 2021). Client resistance or skepticism toward the therapy was also outlined as a potential barrier to implementation (DiGiorgio et al., 2004; Hasanović et al., 2021; Jones-Smith, 2018; Phillips et al., 2021), which was illustrated by one clinician who stated: "I quickly give up on this kind of approach if I see that the client is not particularly receptive to it. In that case, I choose an alternative approach" (Hasanović et al., 2021, p. 7). In the study conducted by Grimmett and Galvin (2015), 10% of cognitive-behavioral therapists were no longer using EMDR on the basis of client refusal or the lack of client interest in EMDR. Moreover, participants discussed how the lack of stability within the client's life in terms of ongoing stressors was an additional barrier to implementing EMDR. For example, one

clinician outlined how if a client was experiencing an ongoing life stressor such as a divorce or illness within the family, then it would be an inappropriate time to open up a trauma (Jones-Smith, 2018). Similarly, it was reported that if the client was using substances to cope or did not have permanent shelter or housing, then implementing EMDR would not be suitable (Phillips et al., 2021).

Theme 2: Advantages of EMDR Therapy. The theme "advantages of EMDR therapy" discussed the unique advantages clinicians perceived EMDR to possess. This theme included three main subthemes: "rapid results and positive outcomes," "client empowerment," and "getting to the root of the problem."

Rapid Results and Positive Outcomes. A number of studies reported the quick rate of change EMDR provides as a unique advantage of the therapeutic approach (Grimmett & Galvin, 2015; Hasandedic-Dapo, 2021; Hasanović et al., 2021; Jones-Smith, 2018; Phillips et al., 2021). EMDR was believed to resolve problems faster than other therapeutic approaches and lead to new insights emerging quickly for clients (Hasanović et al., 2021), though this article received a lower quality rating of two stars on the MMAT. In the study conducted by Phillips et al. (2021), one clinician stated: "what struck me with EMDR is, helping people to process the traumatic memories quickly, quicker than some other ways" (Phillips et al., 2021). In the study conducted by Grimmett and Galvin (2015), rapid results were reported by 25% of clinicians as the main reason for using EMDR. Furthermore, clinicians in the study conducted by Jones-Smith (2018) also alluded to the long-term and lasting nature of the effects.

Indeed, many clinicians reported positive outcomes experienced by clients when utilizing EMDR (Hasandedic-Dapo, 2021; Hasanović et al., 2021; Jones-Smith, 2018; Phillips et al., 2021). In the study conducted by Grimmett and Galvin (2015), 80% of the clinicians surveyed (n = 239) reported positive treatment outcomes from their clients, with 7% reporting negative outcomes. In terms of trauma memories, clinicians described these memories no longer "hijacking" the client, as outlined further by one clinician: "They don't go back there. They think, 'That thing happened to me and that was really awful. I wish it didn't happen.' They're able to think about it as a memory as opposed to re-experiencing it" (Jones-Smith, 2018). Furthermore, clinicians also reported effective outcomes working with fears, leading to improvements in relationships, improvements in sleep, less shame, and less feelings of defectiveness (Hasandedic-Dapo, 2021; Jones-Smith, 2018).

Client Empowerment. An additional benefit of EMDR according to clinicians was that of client empowerment. Clinicians spoke about clients having "a lot of control over the process" within EMDR (Phillips et al., 2021). Clients were described as being "in the driver's seat" during the therapy, which was felt to be advantageous and assist them in getting their needs met (Jones-Smith, 2018). Furthermore, the fact that EMDR does not require clients to talk about their traumatic experiences out loud was also discussed as an important advantage of the therapy and an aspect of the process that empowers clients (Cook et al., 2009; Phillips et al., 2021). This was reflected by one clinician who stated:

> 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…so the person doesn't have to go over and over again, telling me about the worst things that ever happened to them. (Phillips et al., 2021)

This was also felt to be helpful for clients in allowing them to bypass shame (Cook et al., 2009) and helpful for therapists in providing less opportunity for vicarious trauma to occur (Phillips et al., 2021).

Getting to the Root of the Problem. Clinicians spoke about the benefits of EMDR as a therapeutic approach in the context of its holistic nature, "treating the mind, body and spirit" (Jones-Smith, 2018) in comparison to other traditional talk therapies. Clinicians spoke about EMDR as a holistic and somatic approach that involved working with the client's body which was felt to be a unique advantage of the approach (Jones-Smith, 2018). In working at a deep level and "more thoroughly" (DiGiorgio et al., 2004, p. 243), clinicians also discussed the benefit of EMDR in that it allows the client to be taken back to the moment to process the trauma at a deep level, incorporating the physical sensations, which then allows for a change in "perspective and bodily sensations" (DiGiorgio et al., 2004, p. 242; Jones-Smith, 2018). EMDR was described as being an effective intervention for allowing clients to process their memories with

greater emotional intensity and work at a deeper level (DiGiorgio et al., 2004).

Discussion

This mixed method systematic review was conducted to gain insight into clinicians' views and experiences of EMDR therapy. Fourteen studies were included in this review, which comprised of seven qualitative studies, four mixed method studies, and two quantitative studies. Two main themes and seven subthemes were identified within the data and will be discussed further below.

Clinicians identified a range of factors, which either facilitated or impeded their adoption and implementation of EMDR as a therapeutic approach. These included factors related to the organization, the therapist, the intervention, and the client. Organizational support in terms of EMDR being a part of the organizational culture, the provision of funded training opportunities, encouragement from colleagues to train in the approach, and the provision of supervision were identified as key factors facilitating the clinicians' adoption and implementation of EMDR as an approach. Indeed, this was paralleled with the barriers to EMDR that clinicians identified, which included EMDR not being part of the organizational culture, a lack of funding to train in the approach, and a lack of available supervision for clinicians. This reflects the important role organizations play in terms of whether a therapeutic approach is adopted and implemented within a service. These findings are consistent with the work of Beidas and Kendall (2010), who reviewed research focusing on the dissemination of evidence-based practice and put forth two key aspects of the integration process: (a) how training influences clinicians' knowledge and behavior and (b) how the workplace environment, including organizational support and clients, influences how clinicians adopt a new practice. This is also consistent with the study conducted by Cook et al. (2009), who found endorsement by respected therapists and availability of training opportunities as key factors influencing the willingness to adopt a new therapeutic approach. Thus, it is important that organizations ensure clinicians are provided with opportunities to train in evidence-based therapies to provide clients with the opportunity to avail of evidence-based interventions, as well as providing the supports required to facilitate the ongoing implementation of the approach.

The importance and availability of effective and supportive supervision and consultation were highlighted as paramount to clinicians' ability to implement EMDR within their practice. In accordance with the literature, clinical supervision is considered a core component of clinical practice within mental health and has been proposed as the most important factor in developing competencies within clinical practice (Falender et al., 2004; Stoltenberg, 2005). Furthermore, the research has identified the importance of having ongoing clinical supervision in practice in order to assist with encouraging the use of the therapeutic approach posttraining (Holloway & Neufeldt, 1995), as well as helping the clinician to maintain fidelity to the treatment approach (Bearman et al., 2017). The results of this systematic review also highlighted how ongoing and available supervision can be helpful in providing emotional support and assisting clinicians in gaining confidence working with EMDR. This may be an important factor to consider given that an identified barrier to using EMDR in practice was a lack of confidence and an anxiety regarding their ability to practice EMDR safely and effectively, which may be influenced by a lack of training, knowledge, and experience in the area. Furthermore, supervision was also discussed as an important resource to assist with continued learning and education, including receiving information and advice on how to overcome challenges and stick to the protocol. Indeed, according to Bearman and colleagues (2017), initial training is a key aspect of educating the clinician about a therapeutic approach, but ongoing supervision is important in terms of actually implementing the therapy skillfully (Herschell et al., 2010). It is also possible that the provision of regular and effective supervision may be an important protective factor to mitigate against some of the other identified barriers to implementing the therapy, such as a lack of therapist confidence in their skills, anxiety about EMDR potentially worsening the client, and difficulty implementing EMDR in the context of other theoretical orientations. Furthermore, it may be a supportive platform to discuss some of the workplace issues that may emerge, or client-related barriers that may be present.

In terms of clinicians' confidence in EMDR as an approach, it emerged that their experiences during training in terms of the experiential learning component were an important factor, which influenced their adoption of the approach and motivated them to continue their training and implementation. Indeed, it has been argued that a training program that encompasses an active rather

than a passive learning approach is more likely to be successfully implemented into clinical practice posttraining and thus this may be a strength of the EMDR training and increase clinicians' confidence in the approach (Cross et al., 2007). This finding is also consistent with the work of Beidas and Kendall (2010), who also identified how training influences clinicians' knowledge and behavior, which then plays an important role in whether an intervention is integrated into practice.

The impact of theoretical orientation also emerged as an important factor to consider in terms of clinicians' experience of integrating the therapy into clinical practice. This review highlighted that some clinicians may choose to personalize or alter the protocol, which may be influenced by their own primary theoretical orientation. Indeed, EMDR is a secondary psychotherapeutic approach, which means therapists training in EMDR have already been thoroughly trained in other primary approaches such as psychodynamic, humanistic, and cognitive-behavioral therapy and may have developed their own personal style of treatment. Thus, the results of this review raises the question of the importance of treatment fidelity in the implementation of EMDR. Studies have indicated that EMDR is a robust treatment in some ways, with effects and outcomes found to be unaffected by some changes to the protocol, such as variations in the mode of bilateral stimulation utilized during EMDR therapy (Foa et al., 2019). However, studies have also identified that omitting the aspects of the protocol can lead to poorer outcomes, for example, in analyzing procedures used in phobia studies utilizing EMDR, it was found that studies that omitted more than half of the EMDR protocol achieved poorer outcomes than those who adhered to the full protocol (Shapiro, 1999). However, there is a lack of recent research in this area and thus this warrants further exploration in the literature. It should be noted that this review excluded studies where there was a clear adaptation to the protocol, such as combining the therapy with another specific therapeutic intervention to create an adapted form of EMDR. Thus, this body of literature may be useful in gaining a deeper insight into additional deviations that clinicians make, the rationale for same, and the outcomes of these approaches.

In addition, a lack of client suitability and readiness was identified as a barrier to implementing EMDR in clinical practice. Within this subtheme, clinicians discussed the lack of client interest or preference as a factor that prevents the implementation of EMDR. This finding highlights the important consideration of client preferences as a factor influencing the implementation of a therapeutic approach. Indeed, NICE guidelines make reference to this in terms of their guidance to consider EMDR for a diagnosis of PTSD or clinically important symptoms of PTSD "if the person has a preference for EMDR" (NICE, 2019). Furthermore, current guidelines for evidence-based practice indicate that treatment decisions should be made in the context of client preferences (APA Presidential Task Force on Evidence-Based Practice, 2006). It is therefore important to explore and consider the factors that influence clients' decision-making regarding therapy preferences and for future research to explore the information clients consider in deciding whether to pursue EMDR. Providing support for this recommendation, a meta-analysis of 35 studies conducted by Swift et al. (2018) found improved outcomes and decreased drop-out rates for clients whose preferences were accommodated compared to those who were nonmatched to a preferred therapeutic approach. It is of interest that clinicians highlighted a number of presentations that they deemed unsuitable for EMDR, which appeared to vary within studies. This highlights a need for further research to be conducted and for clear guidelines to be published regarding the use of EMDR for a range of client presentations.

Strengths and Limitations

To our knowledge, this is the first systematic review of studies investigating clinicians' views and experiences of EMDR therapy. As outlined by Cook et al. (2009), clinicians are key stakeholders in terms of the adoption and continued use of a therapy as they not only determine their own probability of using the approach but also may impact how receptive their clients are to undergoing the treatment approach. Thus, this review provided important insights into clinicians' experiences of adopting and integrating EMDR. The inclusion of quantitative, qualitative, and mixed methods studies strengthened the review in that it allowed for a more comprehensive insight into clinicians' views and experiences of EMDR, which is a relatively new area. This review was also inclusive of gray literature, which mitigated against publication bias. However, there are several limitations to this review that are important to highlight. The heterogeneity of the studies

included in terms of research aims and study designs made it more difficult to collate the data and due to the variability across studies, a meta-analysis was not deemed suitable to analyze the quantitative data. Furthermore, due to the nature of the research, clinicians who chose not to adopt the approach, who discontinued the approach, or did not use it in a manner compatible with further training were underrepresented within the review. The study conducted by Cook et al. (2009) was a comparative case study between two sites, one of which adopted EMDR and one of which rejected its adoption, and thus this study provided the greatest insight into the barriers to adoption. Additional research in this area would be of use to gain additional insight into the factors that may impede the decision to conduct training in EMDR. Studies were excluded if they were not written in the English language, which therefore may have led to publication bias and exclusion of relevant studies from different cultures. Finally, full texts were unavailable for three potentially relevant studies due to the lack of response from authors or the failure to provide any contact information.

Future Research. Future research endeavors in the field of EMDR could benefit from an examination of the comparative experiences of clinicians utilizing a variety of trauma-focused therapies. Such investigations would provide valuable insight into the relative effectiveness and efficiency of different treatment approaches, and could aid in the development of more refined and individualized treatment protocols. Additionally, it would be helpful for additional research to involve both EMDR therapists and clients to gain a more comprehensive understanding of the reasons for EMDR's effectiveness, as well as any potential limitations or side effects.

Conclusion

This mixed methods systematic review was conducted to gain an in-depth understanding of clinicians' perspectives and experiences with EMDR. The study aimed to identify the facilitators and barriers for the adoption and implementation of EMDR, as well as to explore clinicians' perceptions of the advantages of this therapeutic approach. The findings provide valuable insight into the factors that influence the dissemination and implementation of psychological treatments, and can inform future efforts to promote the use of evidence-based practices in clinical settings.

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Appendix A: Search Strategy for Each Database

1. PsychINFO—746 Results

(DE "Eye Movement Desensitization Therapy" OR EMDR OR "eye movement desensitization") AND (DE "Mental Health Personnel" OR DE "Clinical Psychologists" OR DE "Psychotherapists" OR DE "Counselors" OR DE "Clinicians" OR clinician* OR professional* OR practitioner* OR psychologist* OR therapist* OR psychotherapist* OR psychoanalyst* OR counsellor* OR experience* OR qualitative OR viewpoint* OR standpoint* OR encounter* OR reaction* OR use* OR utility OR evaluation* OR account* OR arrative* OR impression*)
Limiter: English
Years: 1991–2021

2. PUBMED

("Eye Movement Desensitization Reprocessing"[Mesh] OR "eye movement desensitization" OR EMDR) AND ("Counselors"[Mesh] OR "Psychotherapists"[Mesh] OR clinician* OR professional* OR practitioner* OR psychologist* OR therapist* OR psychotherapist* OR psychoanalyst* OR counsellor* OR narrative* OR analyst* OR staff OR personnel OR training) AND ("Personal Narratives as Topic"[Mesh] OR "Personal Narrative" [Publication Type] OR "Narration"[Mesh] OR "Attitude of Health Personnel"[Mesh] OR "Attitude" [Mesh] OR view* OR opinion* OR perception* OR perspective* OR belie* OR attitude* OR experience* OR qualitative OR viewpoint* OR standpoint* OR encounter* OR reaction* OR use* OR utility OR evaluation* OR account* OR narrative* OR impression*)
Limiter: English
1992–2021

3. CINAHL—123 Results

(MH "Eye Movement Desensitization and Reprogramming" OR EMDR or "eye movement desensitization") AND (MH "Psychotherapists" OR "psychotherapist*" OR MH "Psychologists" OR "psychologist*" OR MH "Counselors" OR narrativ OR counsellor* OR clinician* OR professional* OR practitioner* OR psychologist* OR therapist* OR psychotherapist* OR psychoanalyst* OR analyst* OR personnel OR staff OR training) AND (MH "Psychotherapist Attitudes") OR (MH "Qualitative Studies+") OR (MH "Narratives") OR (MH "Interviews") OR view* OR opinion* OR perception* OR perspective* OR belie* OR attitude* OR experience* OR qualitative OR viewpoint* OR standpoint* OR encounter* OR reaction* OR use* OR utility OR evaluation* OR account* OR narrative* OR impression*
Limiter: English
1994–2021

4. SCOPUS—379 Results

("Eye Movement Desensitization Therapy" OR EMDR OR "eye movement desensitization")AND (clinician* OR professional* OR practitioner* OR psychologist* OR therapist* OR psychotherapist* OR psychoanalyst* OR counsellor* OR arrative* OR analyst* OR staff OR personnel OR training) AND (view* OR opinion* OR perception* OR perspective* OR belie* OR attitude* OR experience* OR qualitative OR viewpoint* OR standpoint* OR encounter* OR reaction* OR use* OR utility OR evaluation* OR account* OR arrative* OR impression*)
Limiter: English
1994–2021

5. Web of Science—329 Results

("Eye Movement Desensitization Therapy" OR EMDR OR "eye movement desensitization") AND (clinician* OR professional* OR practitioner* OR psychologist* OR therapist* OR psychotherapist* OR psychoanalyst* OR counsellor* OR analyst* OR staff OR personnel OR training) AND (view* OR opinion* OR perception* OR perspective* OR belie* OR attitude* OR experience* OR qualitative OR viewpoint* OR standpoint* OR encounter* OR reaction* OR use* OR utility OR evaluation OR account* OR narrative* OR impression*)
Limiter: English
1994–2021

6. EMBASE—283 Results

("eye movement desensitization and reprocessing"/de OR emdr OR "eye movement desensitisation") AND ("psychotherapist"/de OR "clinician"/de OR "clinical psychology"/exp OR "counselor"/exp OR "mental health care personnel"/de OR clinician* OR professional* OR practitioner* OR psychologist* OR therapist OR psychotherapist OR psychoanalyst OR counsellor* OR arrative* OR analyst* OR staff OR personnel OR training) AND ("experience"/de OR "health personnel attitude"/de OR "attitude"/de OR "belief"/de OR "qualitative"/de OR "reaction"/de OR view* OR opinion* OR perception* OR perspective* OR belie* OR attitude* OR experience* OR qualitative OR viewpoint* OR standpoint* OR encounter* OR reaction* OR use* OR utility OR evaluation* OR account* OR arrative* OR impression*)
Limiter:

1994–2021

7. Applied Social Science Index—472 Results

EMDR OR "eye movement desensitization") AND (clinician* OR professional* OR practitioner* OR psychologist* OR therapist* OR psychotherapist* OR psychoanalyst* OR counsellor* OR arrative* OR analyst* OR staff OR personnel OR worker) AND (view* OR opinion* OR perception* OR perspective* OR belie* OR attitude* OR experience* OR qualitative OR viewpoint* OR standpoint* OR encounter* OR reaction* OR use OR utility OR evaluation* OR account* OR arrative* OR impression*)
Limiter: English

1993–2021

ProQuest—3,990 Results

("Eye Movement Desensitization Therapy" OR EMDR OR "eye movement desensitization") AND (clinician* OR professional* OR practitioner* OR psychologist* OR therapist* OR psychotherapist* OR psychoanalyst* OR counsellor* OR arrative* OR analyst* OR staff OR personnel OR training) AND (view* OR opinion* OR perception* OR perspective* OR belie* OR attitude* OR experience* OR qualitative OR viewpoint* OR standpoint* OR encounter* OR reaction* OR use* OR utility OR evaluation* OR account* OR arrative* OR impression*)
Limiter: English

Appendix B: Inclusion and Exclusion Criteria

TABLE 1. Eligibility Criteria for Studies in the Systematic Review

Inclusion criteria	Exclusion criteria
Participants: mental health clinicians eligible/using EMDR. Study type: qualitative studies, mixed methods studies, or quantitative studies that report on clinicians' views or experiences of EMDR. Outcomes: studies that focus on clinicians' personal views and/or experiences of EMDR in terms of the training and/or delivery of the approach (traditional protocol only). Studies must exclusively focus on EMDR only. Country: any Language: English	Participants: non-mental health clinicians eligible/using EMDR (e.g., clients). Study type: case studies, clinical reports, editorials, opinion pieces, books, reviews, papers not reporting primary research findings. Outcomes: studies whereby clinicians' views and experiences of EMDR are not represented, or are not analyzed separately within mixed sample studies. Studies reporting on their experience of a specifically adapted form of EMDR (e.g., where EMDR has been integrated with another specific therapy intervention to form a new adapted intervention, or where EMDR has been applied in an adapted format such as via group/online). Studies that use "EMDR clinicians" as a sampling strategy but are investigating another phenomenon of interest that is the focus of the article. Or where "EMDR clinicians" are used as a sample but asked about their experience of EMDR only from a "client perspective" during the training role-plays. Studies whereby clinicians outline/describe how EMDR was applied to a client without reflecting on their own views and/or experience of this process (i.e., a client case study). Mixed outcome studies whereby clinicians are reflecting on their experience of both EMDR and other therapeutic approaches within the same survey/interview and results are mixed. Country: none excluded language: nonEnglish language studies

Appendix C: Quality Control Table Using Mixed Methods Apprasial Tool

Qualitative Studies

			Evaluation items				
Author and publication year	**S1**	**S2**	**1**	**2**	**3**	**4**	**5**
Hasandedic-Dapo (2021)	Y	Y	Y	Y	Y	Y	Y
Phillips et al. (2021)	Y	Y	Y	Y	Y	Y	Y
Cook et al. (2009)	Y	Y	Y	Y	Y	Y	Y
Jones-Smith (2018)	Y	Y	Y	Y	Y	Y	Y
Brendler (2017)	Y	Y	Y	Y	Y	Y	Y

(*Continued*)

Qualitative Studies (*Continued*)

Author and publication year	S1	S2	Evaluation items 1	2	3	4	5
DiGorgio et al. (2004)	Y	Y	Y	Y	Y	N	Y
DiNardo & Marotta-Walters (2019)	Y	Y	Y	Y	Y	Y	Y

Screening Questions:
S1: Clear research questions
S2: Relevant data to answer the research question

Evaluation:

1. Is the qualitative approach appropriate to answer the research question?
2. Are the qualitative data collection methods adequate to address the research questions?
3. Are the findings adequately derived from the data?
4. Is the interpretation of results sufficiently substantiated by data?
5. Is there coherence between qualitative data sources, collection, analysis, and interpretation?

Quantitative Studies

Author and publication year	S1	S2	Evaluation items 1	2	3	4	5
Edmond et al. (2016)	Y	Y	Y	CT	Y	Y	Y
Grimmett & Galvin (2015)	Y	Y	Y	Y	CT	CT	Y

Screening Questions:
S1: Clear research questions
S2: Relevant data to answer the research question
4.1. Is the sampling strategy relevant to address the research question?
4.2. Is the sample representative of the target population?
4.3. Are the measurements appropriate?
4.4. Is the risk of nonresponse bias low?
4.5. Is the statistical analysis appropriate to answer the research question?

Author and publication year	S1	S2	Evaluation items 1.1	1.2	1.3	1.4	1.5	4.1	4.2	4.3	4.4	4.5	5.1	5.2	5.3	5.4	5.5
Dunne and Farrell (2011)	Y	Y	Y	Y	Y	Y	Y	Y	CT	Y	CT	Y	Y	Y	Y	Y	Y
Farrell & Keenan (2013)	Y	Y	Y	Y	CT	N	N	Y	Y	CT	CT	Y	CT	Y	Y	Y	CT
Farrell et al. (2013)	Y	Y	Y	N	Y	Y	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Hasanovic et al. (2021)	Y	Y	CT	Y	CT	Y	Y	Y	CT	CT	CT	Y	N	Y	Y	Y	CT
Voung (2018)	N	N	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Mixed Methods Studies

S1: Clear research questions
S2: Relevant data to answer the research question
1.1. Is the qualitative approach appropriate to answer the research question?
1.2. Are the qualitative data collection methods adequate to address the research questions?
1.3. Are the findings adequately derived from the data?
1.4. Is the interpretation of results sufficiently substantiated by data?
1.5. Is there coherence between qualitative data sources, collection, analysis, and interpretation?
4.1. Is the sampling strategy relevant to address the research question?
4.2. Is the sample representative of the target population?
4.3. Are the measurements appropriate?
4.4. Is the risk of nonresponse bias low?
4.5. Is the statistical analysis appropriate to answer the research question?
5.1. Is there an adequate rationale for using a mixed methods design to address the research question?

5.2. Are the different components of the study effectively integrated to answer the research question?
5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?
5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?
5.5. Do the different components of the study adhere to the quality criteria of each tradition?